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WISCONSIN LABORERS' HEALTH FUND
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Wisconsin Laborer's Health Fund
4633 LIUNA Way Suite 201
DeForest, WI 53532
Claims 608 842-9101
Eligibility 608 842-9102

ANNOUNCING IMPORTANT CHANGES TO THE PLAN

Date: December 2022

To: Active Employees, Non-Medicare-Eligible Retired Employees, and Their Eligible Dependents Participating in the Wisconsin Laborers' Health Fund

From: The Board of Trustees

As the Board of Trustees of the Wisconsin Laborers' Health Fund (the Fund or Plan), we are pleased to announce new changes to the Plan. This letter provides a summary of 5 changes to the Plan. In the near future, you will receive more detailed information on these changes. This notice also updates the summary of benefits and coverage for the coverage period September 1, 2022, to August 31, 2023. Please file this letter with your Plan-related documents for easy reference.

Change Number 1: DOT Physical Exam Coverage – effective August 29, 2022

The Plan now covers Department of Transportation physical exams as a preventive care service. This means the Regular Plan will cover 100% of the exam, when provided by an in-network provider, without application of your deductible. The Bare Bones Plan will cover the DOT physical exam as a preventive service by an in-network provider at 30% coinsurance after the deductible is met through December 31, 2022. Beginning January 1, 2023, the Bare Bones Plan will cover 100% of the exam, consistent with other preventive care changes (see Change Number 3 below for more information).

Change Number 2: No Surprises Act – effective September 1, 2022

The No Surprises Act includes rules to protect you from surprise balance billing (balance bills are what non-network providers or facilities can charge you even if after you pay your deductible, copayment or coinsurance – also known as your "cost-sharing" amounts). Under these new rules, non-network providers can no longer send you these surprise balance bills in the following situations:

- Emergency services (not including ground ambulance services) from a non-network provider, facility, or air ambulance. This includes services you receive after you are in stable condition. An "emergency medical condition" means a medical condition so severe that a prudent layperson could reasonably expect that the absence of immediate medical attention to result in serious impairment to bodily functions or placing your health in serious jeopardy.
- When you receive certain services, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon services, hospitalist services, or intensivist services, from a non-network provider at a network hospital or ambulatory surgical center.

When balance billing is not allowed:

- You will pay only network cost-sharing amounts.
- Your cost-sharing amounts will be based on what the Fund would pay for the services had they been provided by a network provider.
- What you pay will count toward your network deductible and out-of-pocket limit.
- If the Fund denies a claim for a service protected from balance billing, you can submit the claim for external review at the end of the Fund's appeal process. Any such request for external review must

be received by the Fund Office no later than four months following the date your appeal was denied by the Trustees.

Non-network providers can ask you to give up your balance billing protections for post-stabilization services and other services you may receive from a non-network provider at a network hospital or ambulatory surgical center.

In addition to the balance billing protection, the No Surprises Act also provides the following protections for you:

- If a network provider or facility leaves the Anthem network, you may be able to receive care as if the provider or facility was still a network provider for up to 90 days so that you have time to transition to a network provider. You will have this option if you are inpatient, scheduled for nonelective surgery, or receiving care for a pregnancy, serious and complex condition, or terminal illness when your provider or facility leaves the Anthem network.
- If you can show that you received inaccurate information from Anthem that a provider was a network provider, then you will pay network cost-sharing for that claim. However, note that the non-network provider may still balance bill you for that claim.

Change Number 3: Affordable Care Act Changes – effective January 1, 2023

The Plan has considered itself to be a "grandfathered" health plan for purposes of Affordable Care Act compliance since March 2010. This means that the Plan has been complying with some, but not all, Affordable Care Act requirements. Effective as of January 1, 2023, the Trustees have decided to treat the Plan as "non-grandfathered," which means that the Plan will comply with all applicable Affordable Care Act requirements. For example, effective January 1, 2023:

- The out-of-pocket maximum for the Regular Plan and Retiree Plan is $4,500 per person or family for in-network providers and $10,000 per person or family for out-of-network providers. The out-of-pocket maximum for the Bare Bones Plan is $6,600 per person and $13,200 per family for in-network providers and $25,000 per person or family for out-of-network providers. Covered medical expenses, including copayments, deductibles and organ transplant expenses, are applied to the out-of-pocket maximum.
- Your prescription drug copayments will now count toward a separate prescription drug out-of-pocket maximum. For the Regular Plan and Retiree Plan, the prescription drug out-of-pocket maximum is $4,600 per person and $13,700 per family. For the Bare Bones Plan, the prescription drug out-of-pocket is $2,500 per person and $5,000 per family. Only prescription drug copayments will count toward the prescription drug out-of-pocket maximum.
- Preventive services for the Bare Bones Plan are now covered at 100% when provided by in-network providers. Additionally, the Plan covers all preventive services with an A or B recommendation from the United States Preventive Task Force, services described in guidelines from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Health Resources and Services Administration guidelines for children and women. For more information on what preventive care services are covered, you can visit www.healthcare.gov.
- If your appeal for health benefits is denied for reasons involving medical judgment (for example, medical necessity or experimental/investigational reasons), you may be able to request an external review from an independent review organization. Any request for external review must be received by the Fund Office within four months from the date of the notice from the Trustees that your appeal is denied.

Additionally, the out-of-network mental health and substance use disorder inpatient treatment coinsurance is changed to the standard out-of-network coinsurance. This means that you will pay 40% coinsurance for these services.

Change Number 4: Prescription Drug Provider Changes – effective January 1, 2023

Also effective January 1, 2023, the Plan's prescription drugs will be provided through Express Scripts (or "ESI"). **You will be receiving new ID cards** with the updated prescription drug information soon. For the most part, your prescription drug coverage is not changing. **Your copays are not changing.** You will continue to pay:

30 day supply – retail pharmacy (including Walgreens)	You pay:
• Generic Prescription	$8
• Formulary Brand Name Prescription*	$25
• Non-formulary Brand Name Prescription*	$40
31-90 day supply – mail order or Walgreens	
• Generic Prescription	$16
• Formulary Brand Name Prescription*	$50
• Non-formulary Brand Name Prescription*	$80
* If you request a brand name drug when a generic is available, you must pay the brand name copayment plus the difference in cost between the brand name drug and the generic drug.	

A few changes that will be implemented include:

- 90-day fills of long-term maintenance (non-specialty) medications will be available through Walgreens or the ESI Mail Order Pharmacy. As a reminder, you can obtain 1 initial fill and 2 refills of a 30-day supply but then you must obtain 90-day supply.
- Preventive care medications are covered at 100%.
- The Plan no longer uses the "high impact advocacy program."

Call ESI at 888-208-4492, go online at www.express-scripts.com, or download the Express Scripts mobile app for more information and to confirm drug coverage.

Change Number 5: Retiree Health Coverage Changes – effective January 1, 2023

If you are a non-bargained Employee, you no longer need to begin drawing your Social Security benefits to enroll in retiree health coverage. You may purchase retiree coverage through the Health Fund if you have been eligible for Health Fund benefits for the four-year period immediately before your retirement.

Questions?

If you have questions about the changes described in this letter or would like more information about Plan eligibility or the Fund's health benefits in general, contact the Fund Office at the address and telephone number shown at the top of this Notice.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

BENEFIT INFORMATION PACKET

Included in this packet are:

- Member Questionnaire and Beneficiary Designation with return envelope
- SBC Plan for Active Employees and Dependents: Regular / Bare Bones
- Very Important Notice – Initial COBRA Notification
- BPA Participant Portal
- Health Reimbursement Account (HRA) brochure and letters
- Anthem Changes - January 2016
- Anthem Identity Protection Services
- LiveHealth Online, 24/7 NurseLine, and Future Moms Program
- Diagnostic Services and Dental Emergencies - January 2015
- SAV-RX Prescription Benefit Program; SAV-RX Prescription Services brochure
- Amplifon Services and flyer
- Your Hearing Service Plan - EPIC Hearing Healthcare
- Notice of Prescription Drug Creditable Coverage
- EAP, Maternity & Biometric Screening thru Anthem BlueCross BlueShield
- Healics Health Screening Program
- Privacy Practices Notice
- Notice of Women's Health and Cancer Rights Act of 1998
- Patient Protection and Affordable Care Act – Grandfathered Health Plan
- Notice of Nondiscrimination and Accessibility Services under Section 1557 of the ACA
- Termination and Reinstatement
- Participant Exchange Notice
- Magnet
- Summary Plan Description, 2014 Edition
- Building & Public Works SPD letter
- Vacation Trust Fund SPD

Your Wisconsin Laborers' Health Fund Medical/Prescription Drug Identification (ID) Cards, EyeMed, and your Health Reimbursement Benefit card are mailed to you directly. These ID cards will list **only your name and unique ID number** and is **used for all covered dependents**

ACTION ITEM: Complete the Member Questionnaire and Beneficiary Designation form and return it in the enclosed envelope. *If you have adult children, under age 26, you add them using the Member Questionnaire and Beneficiary Designation form.* Refer to your Summary Plan Description for additional details on the definition of a dependent.

Your Delta Dental ID Card will be sent to you in a separate mailing. Your dental benefits are processed by Delta Dental of Wisconsin. Please advise your dentist that your **dental claims must be submitted to Delta Dental of Wisconsin, PO Box 828, Stevens Point, WI 54481-0821. Your Delta Dental Group Number is 54601.** Your dentist may also contact Delta Dental to verify coverage and obtain benefits. Their toll free number is 1-800-236-3712.

Please keep this information with your important records for future reference. If you have any questions or additional Medical/Prescription ID Cards are needed, please contact the Fund Office at 608-842-9102 or toll free @ 1-800-397-3373 between the hours of 8:00 am and 4:30 pm Central Time.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, call 1-800-397-3373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(January 1–December 31) **$300** Person or **$600** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. PPO preventive services, chiropractic services, and mental health/substance use disorder services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$100** Person for Emergency Room; **$300** Person for Organ Transplant; **$25** Person or **$75** Family for Dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	(January 1–December 31) PPO: **$4,500** Family; Non-PPO **$10,000** Family. Organ Transplant: **$10,000** per transplant	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, copayments, deductibles, balance billing and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com for a list of PPO providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment/visit	40% coinsurance	No charge for LiveHealth Online.
	Specialist visit	$15 copayment/visit	40% coinsurance	$15 copayment and deductible do not apply to PPO chiropractic care; charges up to $75 per visit for chiropractic care are covered; visits limited to 26 per calendar year. 50% coinsurance applies for TMJ services.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% coinsurance	Deductible applies to services received from Non-PPO providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance; no charge for chiropractic x-rays	40% coinsurance	Genetic testing limited to diagnostic testing with a $2,500 annual maximum per person. Annual maximum does not apply to preventive services, such as genetic testing for breast cancer.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	$8 copayment/fill retail; $16 copayment/fill mail order	$8 copayment/fill retail plus amounts over network provider cost	30-day supply retail; 90-day supply mail order; maintenance medications must be filled through the mail order program. Immunosuppressive drugs covered under the transplant benefit should be filled through mail order; cost sharing for immunosuppressive drugs will be determined on a case-by-case basis.
	Formulary brand drugs	$25 copayment/fill retail; $50 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$25 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	
	Non-formulary brand drugs	$40 copayment/fill retail; $80 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$40 copayment/fill retail; plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 deductible	10% coinsurance after $100 deductible	$100 deductible waived if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery, 50% coinsurance with $10,000 lifetime maximum per person; surgical treatment for morbid obesity limited to once per lifetime.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for mental health services; 10% coinsurance for substance use disorder services. Deductible does not apply.	No charge for mental health services; 10% coinsurance for substance use disorder services. Deductible does not apply.	No charge for LiveHealth Online.
	Inpatient services	10% coinsurance for mental health services; for substance use disorder, no charge for first occurrence, 10% coinsurance for second and subsequent occurrences. Deductible does not apply.	10% coinsurance for mental health services; for substance use disorder, no charge for first occurrence, 10% coinsurance for second and subsequent occurrences. Deductible does not apply.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copayment/visit	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Limited to 40 visits in a 12-consecutive month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility.
	Rehabilitation services	10% coinsurance for outpatient services. Inpatient services are not covered.	40% coinsurance for outpatient services. Inpatient services are not covered.	Coverage is provided for physical, respiratory, occupational and speech therapies. Outpatient visits are limited to 30 combined visits per lifetime.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 60 days per confinement.
	Durable medical equipment	10% coinsurance	40% coinsurance	Rentals not to exceed purchase price of equipment.
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursed up to $45; deductible does not apply	None; separately administered by EyeMed (866-800-5457).
	Children's glasses	Frames: No charge up to $130, 20% discount off balance over $130; Lenses: No charge standard/ polycarbonate non-progressive; deductible does not apply	Frames: Reimbursed up to $65; Lenses: Reimbursed up to $25 single vision and $24 polycarbonate; deductible does not apply	Lenses and frames covered once every 24 months; separately administered by EyeMed (866-800-5457). Fund Office administers reimbursement of out-of-pocket vision costs up to $250 per person per year.
	Children's dental check-up	No charge. Dental deductible does not apply.	No charge. Dental deductible does not apply.	None; separately administered by Delta Dental (800-236-3712).

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (with certain exceptions)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for certain diagnoses)
- Bariatric surgery (one surgery per lifetime, preauthorization required)
- Chiropractic care (26 visits per person per calendar year; $75 maximum per visit)
- Dental care (Adult) ($2,000 calendar year maximum per person; separately administered by Delta Dental)
- Hearing aids ($2,000 per person every 5 years)
- Non-emergency and emergency care when traveling outside the U.S. or Canada
- Private-duty nursing (only with hospice care)
- Routine eye care (Adult) (separately administered by EyeMed; Fund Office administers reimbursement of out-of-pocket costs up to $250 per person per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-397-3373.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-397-3373.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,220
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,590**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$40
Copayments	$1,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,080**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$60
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. You may be eligible to file for reimbursement of some of these expenses, as permitted by the plan's Health Reimbursement Arrangement. These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 800-397-3373.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-397-3373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(January 1–December 31) **$350** Person or **$700** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health/substance use disorder services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$100** Person for Emergency Room; **$300** per Person for Organ Transplant. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	(January 1–December 31) PPO: **$12,500** Family; Non-PPO: **$25,000** Family. Organ Transplant: **$10,000** per transplant	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, copayments, deductibles, balance billing, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com for a list of PPO providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	40% coinsurance	No charge for LiveHealth Online.
	Specialist visit	$20 copayment/visit	40% coinsurance	None
	Preventive care/screening/ immunization	30% coinsurance	40% coinsurance	Deductible applies to all services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	Genetic testing limited to diagnostic testing with a $2,500 annual maximum per person. Annual maximum does not apply to preventive services, such as genetic testing for breast cancer.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	$8 copayment/fill retail; $16 copayment/fill mail order	$8 copayment/fill retail plus amounts over network provider cost	30-day supply retail; 90-day supply mail order; maintenance medications must be filled through the mail order program. Retail immunosuppressive drugs covered under the Transplant benefit should be filled through mail order; cost sharing for retail immunosuppressive drugs will be determined on a case-by-case basis.
	Formulary brand drugs	$25 copayment/fill retail; $50 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$25 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	
	Non-formulary brand drugs	$40 copayment/fill retail; $80 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$40 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	None
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance after $100 deductible	30% coinsurance after $100 deductible	$100 deductible waived if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery is not covered; surgical treatment for morbid obesity limited to once per lifetime.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for mental health services; 25% coinsurance for substance use disorder services. Deductible does not apply.	No charge for mental health services; 25% coinsurance for substance use disorder services. Deductible does not apply.	No charge for LiveHealth Online.
	Inpatient services	25% coinsurance for mental health services; for substance abuse disorder, no charge for first occurrence, 25% coinsurance for second and subsequent occurrences. Deductible does not apply.	25% coinsurance for mental health services; for substance abuse disorder, no charge for first occurrence, 25% coinsurance for second and subsequent occurrences. Deductible does not apply.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	$20 copayment/visit	40% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Limited to 40 visits in a 12-consectuve month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility.
	Rehabilitation services	30% coinsurance for outpatient services. Inpatient services are not covered	40% coinsurance for outpatient services. Inpatient services are not covered.	Coverage is provided for physical, respiratory, occupational and speech therapies. Outpatient visits are limited to 30 combined visits per lifetime. Inpatient services are not covered and you must pay 100% of these charges.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	30% coinsurance	40% coinsurance	Limited to 60 days per confinement.
	Durable medical equipment	30% coinsurance	40% coinsurance	Rentals not to exceed purchase price of equipment.
	Hospice services	Not covered	Not covered	You must pay 100% of this service, even in-network.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult and Child)
- Habilitation services
- Hearing aids
- Hospice care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for certain diagnoses)
- Bariatric surgery (one surgery per lifetime, preauthorization required)
- Non-emergency and emergency care when traveling outside the U.S. or Canada

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-397-3373.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-397-3373.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$60
Coinsurance	$3,670
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,090**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$190
Copayments	$1,070
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,280**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$450
Copayments	$80
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$870**

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. You may be eligible to file for reimbursement of some of these expenses, as permitted by the plan's Health Reimbursement Arrangement. These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 800-397-3373.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND
BUILDING AND PUBLIC WORKS VACATION FUND

4633 Liuna Way
Suite 201
DeForest WI 53532-2510

MEMBER QUESTIONNAIRE AND BENEFICIARY DESIGNATIONS

This form will replace any questionnaire card on file so you must complete the entire form when making any changes.

MEMBER INFORMATION

NAME (First, M.I. Last)			SOCIAL SECURITY NO.
DATE of BIRTH	SEX ☐ MALE ☐ FEMALE	AREA CODE & TELEPHONE NO.	
MAILING ADDRESS	CITY	STATE	ZIP
MARITAL STATUS ☐ SINGLE ☐ WIDOWED	☐ MARRIED DATE of MARRIAGE_____	☐ DIVORCED DATE of DIVORCE_____	☐ DECLARED DOMESTIC PARTNERSHIP DATE of STATE DECLARATION_____
WHAT IS YOUR CURRENT LOCAL UNION?	HAVE YOU BEEN A MEMBER OF ANY OTHER LOCAL UNION? ☐ YES ☐ NO	WHAT WAS THE OTHER LOCAL UNION NUMBER?	WHEN WERE YOU A MEMBER OF THE OTHER LOCAL UNION?

SPOUSE/DECLARED DOMESTIC PARTNER INFORMATION

Name	Social Security No.	Date of Birth	Medicare Claim No. (HICN)
Does your spouse/declared domestic partner have other insurance coverage? ☐ YES ☐ NO IF YES PLEASE COMPLETE BELOW			
Name Of Insurance Company		Area Code & Telephone No.	
Address		Group No.	
Insured's I.D.	Effective Date	Type of Coverage ☐ FAMILY ☐ SINGLE COVERAGE	
Please check all boxes that apply ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION			

DEPENDENT CHILDREN INFORMATION

List below the name of all eligible children under 26 years of age. Eligible dependents are as defined in the plan document. If relationship of dependent is a child of a declared domestic partner or other, please explain what relationship the dependent is to you.

DEPENDENT First Name / M.I. / Last Name	Social Security No.	Date of Birth MM/DD/YY	RELATIONSHIP (check one) SON	DAUGHTER	STEP SON	STEP DAUGHTER	OTHER (explain)	DOES THIS DEPENDENT LIVE WITH YOU YES	NO ♦

Please provide copies of any court decrees (divorce, paternity, foster child placement or adoption) which apply to custody and/or insurance matters concerning the child(ren).

THIS INFORMATION WILL BE USED TO DETERMINE YOUR DEPENDENTS' ELIGIBILITY STATUS UNDER THE PLAN AND ALSO PRIMARY INSURANCE RESPONSIBILITY.

♦ If any of the children listed as dependents do not live with you, please provide:

Name of person child(ren) reside(s) with _____ Date of Birth _____

Relationship of the person(s) who the child(ren) resides(s) with _____

Address _____
Street City State Zip

YOU MUST COMPLETE THE OTHER SIDE OF THIS FORM

OTHER INSURANCE INFORMATION

SPECIAL INSTRUCTIONS: children who have the same other insurance coverage may be listed together. If this form does not include enough room to list all dependents and other insurance information, please attach a separate paper and follow the format provided. ***Please provide as much, information as possible.***

Are your dependents insured under any other health insurance different from the coverage listed under SPOUSE/DOMESTIC PARTNER INFORMATION? ☐ NO ☐ YES, if Yes, ☐ FAMILY or ☐ SINGLE COVERAGE ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION		
Policyholder's Name		Date of Birth
Relationship of policyholder to your dependent		
List who is covered under this policy name		Medicare HICN
Name of other insurance company		Area Code & Telephone No.
Address		
Effective Date	Group No.	Policy I.D. or Social Security No.

DEATH BENEFITS

NAME YOUR BENEFICIARY – Naming your beneficiary is important and you should update your beneficiary information whenever life events occur.

Beneficiary #1 Name _____ Phone Number _____

Address _____

_____

☐ Pension Fund● ☐ Health Fund ($12,000 Active member, $7,000 Retired member) ☐ Vacation Fund ★(Active member if applicable only)

Beneficiary #2 Name _____ Phone Number _____

Address _____

_____

☐ Pension Fund● ☐ Health Fund ($12,000 Active member, $7,000 Retired member) ☐ Vacation Fund ★(Active member if applicable only)

If you name more than one beneficiary for a specific death benefit, the benefit will be split equally between the listed beneficiaries.

Attach a separate sheet for additional beneficiaries using the above format.

ACCIDENTAL DEATH AND DISMEMBERMENT – Contact fund office or refer to the summary plan description.

● **SUBJECT TO ELIGIBILITY RULES OF THE WISCONSIN LABORERS' HEALTH FUND AND WISCONSIN LABORERS' PENSION FUND.** Contact Building Trades United Pension Trust Fund Office for information regarding Milwaukee Area Pension

★ **SUBJECT TO ELIGIBILITY RULES OF THE BUILDING WORKS VACATION FUND**

MEMBER STATEMENT

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I agree to promptly notify the fund trustees in writing in the event of: 1) a change in marital status due to divorce or legal separation; 2) the death or disability of a person named here; 3) the birth or adoption of a dependent child; 4) a child's dependent status changes due to age, marriage or financial independence.

I have enclosed copies of the following documentation if required

If you have dependent children:

Living with you ..... ☐ Birth Certificate

Not living with you ..... ☐ Court orders – paternity – Medical coverage

If you have dependent children that are not your son/daughter

☐ Guardianship or Custody Orders

☐ Foster child placement or adoption

☐ Divorce decree – 1st page, signature page, placement and medical coverage sections

If you are divorced and have dependent children:

☐ Divorce decree – 1st page, signature page, placement and medical coverage sections

If you have a disable child:

☐ Completed incapacitated child form and provide Medicare Claim Number (HICN)

If you have a Declared Domestic Partner:

☐ Certified copy of State Declaration of Domestic Partnership

If you formerly had a Declared Domestic Partner:

☐ Certified copy of Certification of Termination of Domestic Partnership

SIGNATURE _____ DATE _____

THIS FORM MUST BE SIGNED AND DATED BY PARTICIPANT.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, call 1-800-397-3373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(January 1–December 31) **$300** Person or **$600** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. PPO preventive services, chiropractic services, and mental health/substance use disorder services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$100** Person for Emergency Room; **$300** Person for Organ Transplant; **$25** Person or **$75** Family for Dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	(January 1–December 31) PPO: **$4,500** Family; Non-PPO **$10,000** Family. Organ Transplant: **$10,000** per transplant	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, copayments, deductibles, balance billing and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com for a list of PPO providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment/visit	40% coinsurance	No charge for LiveHealth Online.
	Specialist visit	$15 copayment/visit	40% coinsurance	$15 copayment and deductible do not apply to PPO chiropractic care; charges up to $75 per visit for chiropractic care are covered; visits limited to 26 per calendar year. 50% coinsurance applies for TMJ services.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	40% coinsurance	Deductible applies to services received from Non-PPO providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance; no charge for chiropractic x-rays	40% coinsurance	Genetic testing limited to diagnostic testing with a $2,500 annual maximum per person. Annual maximum does not apply to preventive services, such as genetic testing for breast cancer.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	$8 copayment/fill retail; $16 copayment/fill mail order	$8 copayment/fill retail plus amounts over network provider cost	30-day supply retail; 90-day supply mail order; maintenance medications must be filled through the mail order program. Immunosuppressive drugs covered under the transplant benefit should be filled through mail order; cost sharing for immunosuppressive drugs will be determined on a case-by-case basis.
	Formulary brand drugs	$25 copayment/fill retail; $50 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$25 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	
	Non-formulary brand drugs	$40 copayment/fill retail; $80 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$40 copayment/fill retail; plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 deductible	10% coinsurance after $100 deductible	$100 deductible waived if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery, 50% coinsurance with $10,000 lifetime maximum per person; surgical treatment for morbid obesity limited to once per lifetime.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for mental health services; 10% coinsurance for substance use disorder services. Deductible does not apply.	No charge for mental health services; 10% coinsurance for substance use disorder services. Deductible does not apply.	No charge for LiveHealth Online.
	Inpatient services	10% coinsurance for mental health services; for substance use disorder, no charge for first occurrence, 10% coinsurance for second and subsequent occurrences. Deductible does not apply.	10% coinsurance for mental health services; for substance use disorder, no charge for first occurrence, 10% coinsurance for second and subsequent occurrences. Deductible does not apply.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	$15 copayment/visit	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Limited to 40 visits in a 12-consecutive month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility.
	Rehabilitation services	10% coinsurance for outpatient services. Inpatient services are not covered.	40% coinsurance for outpatient services. Inpatient services are not covered.	Coverage is provided for physical, respiratory, occupational and speech therapies. Outpatient visits are limited to 30 combined visits per lifetime.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 60 days per confinement.
	Durable medical equipment	10% coinsurance	40% coinsurance	Rentals not to exceed purchase price of equipment.
	Hospice services	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursed up to $45; deductible does not apply	None; separately administered by EyeMed (866-800-5457).
	Children's glasses	Frames: No charge up to $130, 20% discount off balance over $130; Lenses: No charge standard/ polycarbonate non-progressive; deductible does not apply	Frames: Reimbursed up to $65; Lenses: Reimbursed up to $25 single vision and $24 polycarbonate; deductible does not apply	Lenses and frames covered once every 24 months; separately administered by EyeMed (866-800-5457). Fund Office administers reimbursement of out-of-pocket vision costs up to $250 per person per year.
	Children's dental check-up	No charge. Dental deductible does not apply.	No charge. Dental deductible does not apply.	None; separately administered by Delta Dental (800-236-3712).

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (with certain exceptions)
- Habilitation services
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for certain diagnoses)
- Bariatric surgery (one surgery per lifetime, preauthorization required)
- Chiropractic care (26 visits per person per calendar year; $75 maximum per visit)
- Dental care (Adult) ($2,000 calendar year maximum per person; separately administered by Delta Dental)
- Hearing aids ($2,000 per person every 5 years)
- Non-emergency and emergency care when traveling outside the U.S. or Canada
- Private-duty nursing (only with hospice care)
- Routine eye care (Adult) (separately administered by EyeMed; Fund Office administers reimbursement of out-of-pocket costs up to $250 per person per year)

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Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$1,220
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,590**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$40
Copayments	$1,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,080**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$300**
Specialist copayment	**$15**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$60
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. You may be eligible to file for reimbursement of some of these expenses, as permitted by the plan's Health Reimbursement Arrangement. These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 800-397-3373.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-397-3373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-397-3373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	(January 1–December 31) **$350** Person or **$700** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health/substance use disorder services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$100** Person for Emergency Room; **$300** per Person for Organ Transplant. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	(January 1–December 31) PPO: **$12,500** Family; Non-PPO: **$25,000** Family. Organ Transplant: **$10,000** per transplant	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, copayments, deductibles, balance billing, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com for a list of PPO providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	40% coinsurance	No charge for LiveHealth Online.
	Specialist visit	$20 copayment/visit	40% coinsurance	None
	Preventive care/screening/ immunization	30% coinsurance	40% coinsurance	Deductible applies to all services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	Genetic testing limited to diagnostic testing with a $2,500 annual maximum per person. Annual maximum does not apply to preventive services, such as genetic testing for breast cancer.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	$8 copayment/fill retail; $16 copayment/fill mail order	$8 copayment/fill retail plus amounts over network provider cost	30-day supply retail; 90-day supply mail order; maintenance medications must be filled through the mail order program. Retail immunosuppressive drugs covered under the Transplant benefit should be filled through mail order; cost sharing for retail immunosuppressive drugs will be determined on a case-by-case basis.
	Formulary brand drugs	$25 copayment/fill retail; $50 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$25 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	
	Non-formulary brand drugs	$40 copayment/fill retail; $80 copayment/fill mail order, plus the difference in costs between the brand name and generic, if generic is available	$40 copayment/fill retail plus the difference in costs between the brand name and generic, if generic is available, plus amounts over network provider cost	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	None
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance after $100 deductible	30% coinsurance after $100 deductible	$100 deductible waived if admitted as bed patient for at least 1 day within the three consecutive-day period after visiting the emergency room.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Coverage is for a semi-private room unless the patient's condition requires a private room. Orthognathic surgery is not covered; surgical treatment for morbid obesity limited to once per lifetime.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for mental health services; 25% coinsurance for substance use disorder services. Deductible does not apply.	No charge for mental health services; 25% coinsurance for substance use disorder services. Deductible does not apply.	No charge for LiveHealth Online.
	Inpatient services	25% coinsurance for mental health services; for substance abuse disorder, no charge for first occurrence, 25% coinsurance for second and subsequent occurrences. Deductible does not apply.	25% coinsurance for mental health services; for substance abuse disorder, no charge for first occurrence, 25% coinsurance for second and subsequent occurrences. Deductible does not apply.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	$20 copayment/visit	40% coinsurance	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Limited to 40 visits in a 12-consectuve month period; weekly costs not to exceed weekly cost for confinement in a skilled nursing facility.
	Rehabilitation services	30% coinsurance for outpatient services. Inpatient services are not covered	40% coinsurance for outpatient services. Inpatient services are not covered.	Coverage is provided for physical, respiratory, occupational and speech therapies. Outpatient visits are limited to 30 combined visits per lifetime. Inpatient services are not covered and you must pay 100% of these charges.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Skilled nursing care	30% coinsurance	40% coinsurance	Limited to 60 days per confinement.
	Durable medical equipment	30% coinsurance	40% coinsurance	Rentals not to exceed purchase price of equipment.
	Hospice services	Not covered	Not covered	You must pay 100% of this service, even in-network.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult and Child)
- Habilitation services
- Hearing aids
- Hospice care
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (for certain diagnoses)
- Bariatric surgery (one surgery per lifetime, preauthorization required)
- Non-emergency and emergency care when traveling outside the U.S. or Canada

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator, Wisconsin Laborers' Health Fund, Benefit Plan Administrators, 4633 LIUNA Way, Suite 201, DeForest, WI 53532-2514, Telephone 1-800-397-3373. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-397-3373.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-397-3373.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$60
Coinsurance	$3,670
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,090**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$190
Copayments	$1,070
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,280**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$350
Specialist copayment	$20
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$450
Copayments	$80
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$870**

*NOTE: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. You may be eligible to file for reimbursement of some of these expenses, as permitted by the plan's Health Reimbursement Arrangement. These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact: 800-397-3373.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

VERY IMPORTANT NOTICE – INITIAL COBRA NOTIFICATION

On April 7, 1986, a Federal Law was enacted (Public Law 99-272, Title X) — The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") — requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Wisconsin Laborers' Health Fund (the "Plan"). Both you and your spouse should take the time to read this notice carefully.

If you are an employee of a contributing employer and you are covered by the Plan, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage under the Plan for any of the following four reasons:

1. **The death of your spouse;**
2. **A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with a contributing employer;**
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

Dependent children of an employee covered under **the Plan have the right to choose continuation coverage if group health coverage is lost for any of the five following reasons:**

1. **The death of the employee-parent;**
2. **The termination of the employee-parent's employment (for reasons other than gross misconduct) or** a reduction in the employee-parent's hours of employment with a contributing employer;
3. Parent's divorce or legal separation;
4. The employee-parent becomes entitled to Medicare; or
5. The dependent ceases to be a "dependent child" under the **terms of the Plan.**

In addition, there may be a right to continuation coverage for certain eligible retirees and their spouses, surviving spouses, and dependent children if a Title 11 Bankruptcy proceeding is commenced with regard to a contributing employer. If this occurs, you should contact the Plan Administrator concerning your rights.

Effective as of January 1, 1997, the definition of "qualified beneficiary" for COBRA purposes also includes a child born to or **placed for adoption with a covered employee during the period of the employee's continuation coverage. Thus, once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or placement for adoption).**

Under the law, the employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event or **the date on which coverage would end under the Plan because of the event, whichever is later. Your employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement. When the Plan Administrator is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the (i)** date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect continuation coverage to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group **health insurance coverage under the Plan will end.**

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months.

An 18-month period of continuation coverage may be extended for up to 11 months (for a total of up to 29 months of continuation coverage) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the employee's termination or reduction in hours and if the Plan Administrator is timely notified within 60 days of such determination (and within the initial 18-month continuation coverage period). Effective as of January 1, 1997, the 11-month extension also applies if a qualified beneficiary becomes disabled at any time within the first 60 days of the 18-month continuation coverage period, provided that the Plan Administrator is timely notified of the disability, as described above. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18- or 29-month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the initial qualifying event. You should notify the Plan Administrator immediately if a second qualifying event occurs during your continuation coverage period.

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

1. The Plan Sponsor no longer provides any group health coverage;
2. The premium for your continuation coverage is not timely paid (within the applicable grace period);
3. The individual becomes covered under another group health plan (as an employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but does not apply to the individual because he or she has been credited with at least 12 months of creditable health coverage, which ended no more than 62 days before coverage under the new plan began.
4. The individual becomes entitled to Medicare; or
   coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Plan Administrator within 30 days of any such final determination.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Plan reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Under the law, you may be required to pay up to 102 percent of the applicable premium during the 18- or 36-month period of continuation coverage. However, during the additional 11 months of continuation coverage (for disability), you may be required to pay up to 150 percent of the applicable premium.

This notice is a summary of the law and is therefore general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about the law, please contact the Plan Administrator at 4633 LIUNA Way, Suite 201, DeForest, WI 53532, or by phone (608) 842-9101. Also, if you have changed marital status, or if either you or your spouse has changed addresses, please notify the Plan Administrator immediately.

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

IMPORTANT NOTICE TO PARTICIPANTS

August 2017

To All Employees and Dependents:

UPDATED BPA WEBSITE

Benefit Plan Administration of Wisconsin, Inc. (BPA) would like to introduce you to our website for accessing your benefits. You can access the website by going to www.wilbenefits.com

This website includes the following information related to the Health Fund:

- Enrollment Forms.
- Loss of Time Forms.
- Medical Checklist Form.
- Summary Plan Descriptions for Health, Pension, and HRA
- Participant Notices.
- Summary of Benefits and Coverage (SBC).

Be sure to take advantage of this helpful information readily available to you online. Additional information will be added periodically.

(over)

MemberXG

MemberXG is designed to improve member access to benefit information, including the convenience of access from your mobile device.

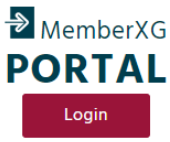
Navigation and user tools make the site easy for you to use. It also uses the latest in website best security practices so you can use it with confidence that your information is safe.

MemberXG contains the following information. Benefit information follows HIPAA regulations and will only display to the appropriate user. Only the member can see information for dependents under the age of 18.

- Dashboard – the landing page which contains navigation to other benefit pages.
- Demographics – displays demographics for a member and/or dependent(s).
- Eligibility – displays past and present eligibility for multiple benefits.
- Deductibles – displays the deductible maximums and the amounts applied to them.
- Health Claims – displays claims processed by the Plan.
- Work History – displays a member's work history for the last five years.

Here are the steps to follow to create your MemberXG account:

1. Go to the BPA website at: www.wilbenefits.com.
2. Click the MemberXG portal link to the right



3. On the initial MemberXG screen, click the Create Account box in the upper right corner of the initial MemberXG screen.
4. Enter the following information into the screen:
    - User Type - either Member or Dependent
    - Email Address
    - Confirm Email Address
    - First Name
    - Last Name
    - Last four digits of your Social Security number (SSN)
    - Date of Birth (MM/DD/YYYY format)
    - Zip Code/Postal Code

- Mobile Phone number (optional)

5. Click Next.
6. Enter a password, confirm the password, answer three Security Questions, and select the Terms of Use and Privacy Policy checkbox.
7. Click Finish. The account is created, and you are returned to the initial MemberXG screen. You also will receive an access code which will be sent to the email address that you entered when you created your MemberXG account. **Note: For security purposes, each time you log in from a new computer/device, you must enter a new access code**.
8. From the initial MemberXG screen, enter the email address you used to set up the MemberXG account and the password, and click Login.
9. Enter the access code you received in your email to access the Dashboard screen.

Write down your MemberXG login information to keep for future access to this site.

Please keep this Notice with your Summary Plan Description (SPD) for future reference. If you have any questions, please feel free to contact the Fund Office.

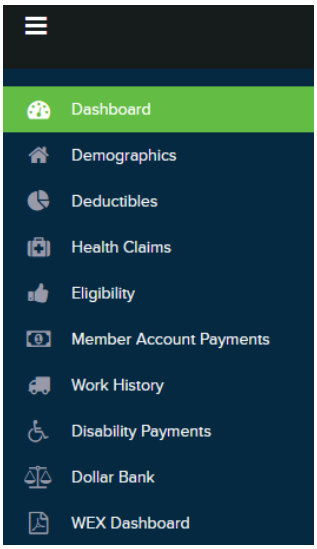
Sincerely,

The Wisconsin Laborers' Health and Pension Fund

Member Online Portal:

We have now made it even easier to view your hours, deductibles, claims, HRA balance etc. When you go to www.wilbenefits.com you can now click on the ***MemberXG Portal Login*** link and it will take you directly to the online website. If you have never signed up, you will need to Create an Account.

Once logged in, you can view a variety of benefits, including your HRA balance. You need to use the scroll arrows or the Menu Bar (3 dashes in upper left corner) to see your options.



Be sure to click on the WEX Dashboard Icon to view your HRA balance. Please also make sure you allow or disable your pop-ups as the WEX icon takes you to another website.

As always, if you have any questions, please call the Fund office at:

Claims.....608-842-9101

Eligibility 608-842-9102

Pension.....608-842-9103

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

December 2015

Health Reimbursement Arrangement Plan (HRA)

Dear Participant and Family:

Enclosed you will find the Wisconsin Laborers' Health Fund's HRA brochure that introduces this new benefit effective with services incurred January 1, 2016 and after. The HRA will help you pay for eligible healthcare expenses for yourself and your eligible dependents.

You may use your HRA for reimbursement of qualified out of pocket expenses such as your deductible, copay, and patient liability coinsurance. Your HRA may also be used for expenses such as self-pays and COBRA premiums. A full description of eligibility and how to use your HRA is included in the enclosed brochure.

You will receive a convenient debit card for your use. Instructions for using the debit card and how to submit paper claims are included in the brochure.

Please read the brochure carefully and share it with your family.

For More Information
If you have any questions about Fund-provided coverage, please call the Fund Office at (608) 842-9102 or toll-free at (800) 397-3373.

Please keep the HRA brochure with your Summary Plan Description (SPD) for easy reference. Receipt of this document does not constitute a determination of your eligibility.

Sincerely,

The Board of Trustees

This cover letter and the enclosed brochure, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

Statement of Grandfathered Status
The Wisconsin Laborers' Health Fund believes this Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding the protections that apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at (608) 846-1742 or toll-free at (800) 397-3373.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

TO ALL ACTIVE AND RETIRED PLAN PARTICIPANTS
WHO HAVE A BALANCE IN THEIR HEALTH REIMBURSEMENT ACCOUNT (HRA)

July 2018

Dear Participants:

The Board of Trustees of the Wisconsin Laborers' Health Fund (the "Fund" or "Plan") is pleased to offer a Health Reimbursement Account (HRA) and HRA debit card to eligible Plan participants. This Notice sets forth the mandatory requirements from the Internal Revenue Service regarding the use of your HRA debit card and the process which will apply beginning August 1, 2018.

When to Use Your HRA

You can use the funds in your HRA to pay for non-reimbursable healthcare expenses you and your eligible dependents incur while you are an active employee, and after you retire (if you are eligible for retiree coverage and have an HRA balance). Such eligible expenses include, but are not limited to, your deductible, copays and coinsurance, and certain healthcare expenses for medical, prescription drug, dental, hearing and vision care. Refer to the "*2019 Health Reimbursement Account (HRA) Brochure*" sent to you for complete details on what qualifies as an eligible expense. An eligible medical expense is further described in Section 213(d) of the Internal Revenue Code. The IRS document is available on the member portal or at www.IRS.gov

How to Use Your HRA Debit Card

To make it easy for you to access the funds in your HRA, you have been provided with a debit card that you can use at the point-of-service or point-of-sale to pay for eligible expenses out of your HRA as you incur them. Note that the debit card has been provided only as a way for you to pay for those expenses that are eligible under the HRA. The HRA debit card ***is not*** a credit card.

Note that the current, active debit card is blue in color. If you still have a red card, throw it out. If you need the newer blue card, contact the Fund Office.

You should maintain copies of receipts for any expenses incurred with the HRA debit card. Beginning August 1, 2018, you will be required to provide the Fund Office with a copy of your receipt for certain types of expenses. When applicable, the Fund Office will send a letter to you requesting that a copy of your receipt be sent to the Fund Office. The quickest and most convenient ways for you to send a copy of your receipt to the Fund Office are through the WEX link on the member portal at www.wilbenefits.com. You can upload your receipt on the member portal by selecting "I Want To" file a claim.

If the Fund Office does not receive a copy of the receipt within 30 days of the date of its letter, you will receive a second notice. If the Fund Office does not receive a copy of the receipt within 20 days of the date of the second notice, use of your debit card will be suspended until a copy of the requested receipt is received. Suspension of your debit card will end within 10 business days of the Fund Office's receipt of the needed document.

If the debit card purchase and receipt do not qualify as an eligible expense, you will need to reimburse the HRA fund. You will then have those monies available to you for a future qualified expense.

Claims and Reimbursement Procedures

If you do not use your debit card to pay for an eligible expense or if your debit card is not accepted (for example, if you use an unapproved vendor), you **must** submit a written claim form to the Fund Office within one year of the date you incurred the expense in order to receive reimbursement. Mail the completed form and any required documentation to the Fund Office at the address shown at the top of this Notice.

To limit administrative expenses, the Fund requires that requests for reimbursement be for a minimum of $100. If you do submit claims for less than $100, the Fund will hold them until the total reimbursement reaches a minimum of $100.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

For more information about how your HRA works, refer to the "*2019 Health Reimbursement Account (HRA) Brochure*." Also, please file this Notice with your copy of the HRA brochure for easy reference.

If you have any questions about your HRA, please contact the Fund Office at the address and telephone number shown at the top of this Notice.

Sincerely,

Board of Trustees

LiUNA!

WISCONSIN LABORERS DISTRICT COUNCIL

Feel the Power

WISCONSIN LABORERS' HEALTH FUND

Health Reimbursement Arrangement (HRA) Brochure

2019

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Fund Office
HRA Claims Administrator

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510
Telephone: 608-846-1742 or 800-397-3373
Email: **wlhra@bpalja.com**

Administrative Manager

Benefit Plan Administration of WI, Inc.

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510
608-846-1742 or 800-397-3373
Email: **wlhra@bpalja.com**

Dear Participant:

The Board of Trustees of the Wisconsin Laborers' Health Fund is pleased to provide our participants with comprehensive healthcare coverage. Realizing that no two participants are alike, the Fund provides a Health Reimbursement Arrangement (HRA), which gives you the flexibility to use the Plan in the way that best meets your—and your family's—needs.

The Plan's HRA is designed to provide reimbursement of certain healthcare expenses on a tax-free basis. You can use it to pay for non-reimbursable healthcare expenses you and your dependents incur while you are an active employee and after you retire (if you are eligible for retiree coverage) to help offset your out-of-pocket healthcare costs. This booklet explains how the HRA works for you.

We encourage you to read this brochure carefully to help you understand how your HRA works and how it can benefit you.

If you have any questions about your HRA benefit, please feel free to contact us at 608-846-1742 or 800-397-3373. You can also email us at **wlhra@bpalja.com**.

Sincerely,
Board of Trustees

CONTENTS

HRA HIGHLIGHTS

If you are enrolled in other group health plan coverage and the coverage does not provide minimum value, or if you fail to provide proof of other coverage, your reimbursements will be limited. If you are enrolled in coverage other than the Wisconsin Laborers' Health Fund, and have questions about what items can be reimbursed, please contact the Fund Office at 608-846-1742 or 800-397-3373.

The more you work, the more contributions are made to your HRA account and the more your HRA account grows, tax-free.

Plus, money in your HRA account and amounts reimbursed for eligible expenses are not included in your income, which means you aren't taxed on this money.

How the Fund's Health Reimbursement Arrangement (HRA) works:

- You are eligible for the HRA if you work for an employer that contributes to the Health Fund on your behalf and you are enrolled in coverage through the Health Fund or through other group health plan coverage. If you are enrolled in other group health plan coverage through your spouse or domestic partner, that coverage must provide minimum value and you must provide proof of coverage.
- When you are initially eligible for Plan coverage and employer contributions are received on your behalf, an HRA account is established in your name.
- For each hour of contributions made on your behalf on and after June 1, 2015, a portion of the hourly contribution rate is credited to your HRA account.
- You determine how you want to use the money in your HRA account. You can use it as you incur eligible healthcare expenses or save up and use it in the future.
- A debit card is sent to you that you can use to pay your eligible out-of-pocket expenses as you incur them or you can claim reimbursement for other items such as coinsurance.

Money in your HRA account may be used to pay for eligible healthcare expenses as defined in Section 213(d) of the Internal Revenue Code (refer to page 7). The IRS document is available on the member portal or at **www.IRS.gov.**

A wide range of expenses are eligible for reimbursement if you are enrolled in coverage through the Health Fund, including:

- Payments for coverage, including: self-payment contributions to continue coverage under the Plan when you are not working enough hours, COBRA continuation coverage self-payments, retiree coverage self-payments; and
- Other out-of-pocket costs like deductibles, copayments and coinsurance.

You can also use the funds in your HRA account to pay for non-reimbursable healthcare expenses you and your eligible dependents incur while you are an active employee, and after you retire (if you are eligible for retiree coverage and have an HRA account balance).

HRA ELIGIBILITY

You are eligible for the HRA if you work for an employer that contributes to the Health Fund on your behalf and you are enrolled in coverage through the Health Fund or other group health plan through your spouse or domestic partner. If you are enrolled in other group health plan coverage, it must provide minimum value and you must provide the Fund Office with proof of such coverage. Alternatively, if you enroll in other group health plan coverage and that coverage does not provide minimum value, then reimbursements under the HRA Plan benefit will be limited. Those reimbursements include the reimbursement of copayments, coinsurance, deductibles and premiums for the other group health plan coverage, to the extent such premiums are paid on an after-tax basis, as well as medical care as defined under Internal Revenue Code Section 213(d) that does not constitute an essential health benefit.

Once you are eligible for coverage under the Health Fund, HRA contributions are credited to an HRA account established in your name and you can begin to access your HRA account balance. Only HRA contributions earned during the 12-month eligibility period are credited to your HRA account.

You are eligible for reimbursement of covered expenses incurred by you and any of your eligible dependents whom you can claim as a dependent on your tax return.

If you become ineligible or are never eligible for coverage under the Health Fund, your HRA contributions will be frozen and possibly forfeited.

While contributions are only made on your behalf while you are working for a contributing employer in a bargaining unit position or through a participation agreement, you do not have to be an active participant to use your HRA account. Your HRA account balance is available as long as you have money in your HRA account and are eligible for active or retiree health coverage, provided you have not waived coverage under the HRA. In addition, your HRA account balance is available to your surviving spouse and/or eligible dependents for reimbursement in the event of your death.

Continued Eligibility

Your eligibility for HRA contributions is based on your continued eligibility for the Health Fund. Once you are eligible, your eligibility will continue as described in the *Eligibility* section of your SPD (Summary Plan Description), provided the required contributions are made on your behalf. You will continue to receive HRA contributions as long as you are actively working. Once you retire or terminate employment, no contributions are made into your HRA account.

Refer to information in the *Life Events* section of this brochure regarding what occurs if you refuse to work or stop working.

When Eligibility Ends

Your eligibility to use your HRA account ends on the earliest date of the following occurrences:

The Trustees reserve the right to discontinue contributions to your HRA at any time.

- The date you waive coverage under the HRA; or
- The date your balance in your HRA account equals $0; or
- The date you are no longer eligible for the Health Fund.

In addition, your HRA funds may also be frozen if you refuse to work or stop working, as described in the *Life Events* section of this brochure.

After Eligibility Ends

You should file a claim for reimbursement online or with the Fund Office as soon as possible. If your claim is not filed within one year of the date of the expense, your claim will be denied.

After you are no longer eligible for the Health Fund, you may continue to submit eligible expenses for reimbursement from your HRA account for expenses you incurred while eligible, unless your account is frozen. However, contributions into your HRA account will stop.

If you lose eligibility due to a lack of hours, and then become eligible again, the contributions for some portion of the hours you worked during the period of ineligibility will be deposited into your HRA once you regain eligibility for Health Fund coverage. If you re-establish eligibility prior to a two-year break, then any HRA credits that you earned during the ineligibility period will be credited to your HRA account balance. If your break is longer than two years, then only those HRA contributions you earned in the two-year period immediately prior to your re-established eligibility date will be credited to your HRA account balance.

Opting Out of HRA Coverage

Annually on January 1, you are allowed to permanently opt out of HRA coverage and waive future reimbursements from your HRA account.

For instance, you may wish to opt if you cannot have access to an HRA because you are receiving a subsidy for the premiums of an individual insurance plan purchased from a state or federal Health Insurance Marketplace.

If you opt out, you will not receive any contributions toward your HRA account and the balance in your HRA account will be frozen. Note that when your account is frozen, it may be reinstated (refer to the *Life Events* section).

If you terminate employment, you may elect to forfeit your HRA account balance at any time, unless an opt-out was elected in which case, your HRA account will be frozen.

YOUR HRA ACCOUNT

Establishing the Account

When you are initially eligible for the Health Fund and employer contributions are received on your behalf, an HRA account is established in your name and a portion of the employer contributions made on your behalf is credited to that account.

The Plan establishes and maintains an HRA account for each eligible participant to track contributions, reimbursements and available balances.

The more you work for a contributing employer, the more contributions are made to your HRA, which means your HRA continues to grow.

Contributions

Your HRA account is funded ***exclusively*** through contributions made by your employer on your behalf in accordance with the collective bargaining agreement applicable to you. All contributions credited to your HRA account are assets of the Health Fund; you are not vested in contributions made on your behalf and you may use your HRA account only for the purposes stated in the governing Plan document.

The HRA account will be funded at an hourly rate determined by the Trustees. Only amounts contributed above the Health Fund rate set by the Board of Trustees will be credited to your HRA account.

If you work under a reciprocity agreement, reciprocal contributions will first be allocated to your HRA account and then the balance will be applied toward the monthly cost to maintain Health Fund coverage. If your HRA account balance falls under the amount needed to maintain eligibility, you will need to pay the amount necessary to maintain coverage under this Plan.

If money remains in your HRA at the end of a year, it rolls over into the next year, allowing you to save for future healthcare expenses.

Your HRA Account Balance

Your HRA account balance is the total of employer contributions made on your behalf to the HRA account minus any reimbursements you receive from your HRA account.

The amount available for reimbursement of eligible expenses is the amount credited to your HRA account, less prior reimbursements and any administrative fees. Contributions made on your behalf will be credited to your HRA account within 30 days of receipt by the Health Fund. Therefore, there may be a lag between the time contributions are required on your behalf and when they are available for you to use.

If you lose your HRA debit card, you will have to pay an administrative charge of $10 for the cost of sending you a new one. This amount will be deducted from your HRA balance.

Tax Status

Contributions credited to your HRA account are not taxable income when made and generally are not taxable when paid out as eligible benefits. However, certain actions may cause your HRA account to be taxable. For instance:

- You receive reimbursement from your HRA account for contributions for health coverage that are paid or could have been paid pre-tax from an IRC Section 125 plan;
- Reimbursements are made for individuals that are not “dependents,” as defined under IRC Section 152; and
- Your dependents may still receive reimbursements from the HRA account balance for eligible expenses in the event of your death.

Contact your tax expert to ensure that expenses reimbursed from your HRA are non-taxable under the Internal Revenue Code (IRC).

If you submit an expense for reimbursement under the Plan’s HRA, you cannot deduct that expense on your tax return.

LIFE EVENTS

If You Do Not Work Enough Hours

When you, your spouse, and/or your dependents are eligible for COBRA continuation coverage, your HRA balance may be used for self-payments to continue this coverage.

If you do not work enough hours to continue eligibility for the Health Fund, you may use your HRA to make self-payments to continue your coverage (if eligible). You must contact the Fund Office and complete any necessary paperwork to use your HRA balance towards any required self-payment amounts, including COBRA continuation coverage. You do not receive employer contributions to your HRA for hours for which you are making self-payments; however, you will receive contributions for hours you work.

If You Refuse or Stop Working

If you refuse to work or stop working, your HRA account will be frozen beginning on the first day of the first month following the date that you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions and then you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is not with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Your frozen HRA account will be forfeited (in other words, closed and forever unavailable to you) as of the first day of the 12th month following the month you are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area. If, however, prior to forfeiture, you return to work for an employer that is required to make contributions to the Health Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, your account will not be forfeited. **(Note: If your frozen account is not forfeited, it may be reinstated on the first day of the month following the month in which you satisfy the Plan's initial eligibility requirements.)**

EXAMPLE:

John was called to work on August 1, 2018 but refused to work or stopped working under a collective bargaining agreement with the District Council or its affiliated Local Unions. He subsequently started working in the construction industry in a non-laborers trade, or in a laborers' trade or sub-trade in the restricted area, so his HRA account was frozen on September 1, 2018.

If John's HRA account remains frozen for 12 months, his account will be forfeited on August 1, 2019. But, if John returns to work prior to the forfeiture, let's say on June 1, 2019, and he works consecutively 600 hours between June 1, 2019 through May 31, 2020, and the Fund receives contributions from his employer for 600 hours on June 1, 2020, John's account could be reinstated when the eligibility requirements are met.

When You Retire

In order to receive retiree benefits through the Health Fund, you must be eligible for retiree coverage and make self-payments for that coverage.

While contributions are only made to your HRA account while you are an active employee, you can use your HRA account for reimbursement of expenses in retirement. When you retire, your HRA account balance is carried forward until no balance remains or until you are no longer eligible for coverage under the Health Fund.

You may use the balance in your HRA towards your self-payments for retiree coverage. In addition, you may also use your HRA account to pay for any eligible expenses you incur during retirement.

No contributions are put into your HRA account once you retire, unless you return to work for which contributions are required to be made on your behalf. If you enroll for Medicare Part D (prescription drug coverage), you will not be eligible for prescription drug reimbursements from your HRA account.

In the Event of Your Death

Your HRA will continue to be available to provide reimbursement for your surviving dependents' eligible expenses in the event of your death. In other words, your HRA account balance is available to your surviving spouse and/or eligible dependents after your death. Your spouse and/or dependents may use your HRA account to pay for eligible expenses (including expenses you incurred before your death) or to make self-payments to continue coverage until the earliest of when your HRA account balance is zero or the Plan ends. However, in no event will amounts be paid in cash to any person for other than reimbursement of an eligible expense (for example, there are no lump sum distributions of the HRA account balance as a death benefit).

If you have no surviving spouse and/or other eligible dependents at the time of your death, any balance in your HRA will be forfeited and become a part of the Plan's general assets.

While your surviving spouse and/or dependents may continue to use your HRA account, no further employer contributions will be made to the HRA account.

If You Take an FMLA or USERRA Leave of Absence

If you take a leave of absence that qualifies under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), the HRA account will be treated as if you were still an active employee. You must notify the Fund of your leave. However, if your leave is not subject to FMLA or USERRA, such leave will be treated as a termination of participation.

WHAT IS OR IS NOT AN ELIGIBLE EXPENSE

Expenses Eligible for Reimbursement

You determine how you want to use the money in your HRA account. As you, your spouse and/or your covered dependents incur eligible healthcare expenses, you can use the money in your HRA account to pay for those expenses. You can also save up and use the money in your HRA account in the future.

Examples of eligible expenses, as defined by the Plan include:

- Coverage costs, including self-payment contributions or premiums:
  - To continue Health Fund coverage when you are not working enough hours;
  - For COBRA continuation coverage;
  - For retiree coverage, if eligible; and
  - Amounts you and your spouse pay for group health coverage through your spouse's employer only if the premiums are paid on an after-tax basis and could not have been paid under an IRC Section 125 Plan. Please contact the Fund Office for additional information.
- Healthcare expenses, including:
  - Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; and
  - Expenses not covered, or only partially covered, under the Plan, such as expenses that exceed benefit maximums.

Healthcare expenses may include medical, prescription drug, dental, hearing and vision expenses.

In general, expenses eligible for reimbursement only include those that:

- Are incurred while you are eligible for coverage under the Plan's HRA;
- You, your spouse, and/or your eligible dependents are required to pay;
- Are not reimbursed by insurance or any other source; and
- You, your spouse, and/or your dependents have not taken (or will not take) as a tax deduction.

An eligible medical expense is defined as an expense paid for care as described in Section 105 and Section 213(d) of the Internal Revenue Code.

Again, if you are enrolled in other group health plan coverage and the coverage does not provide minimum value, or if you fail to provide proof of other coverage, your reimbursements will be limited. If you are enrolled in coverage other than the Wisconsin Laborers' Health Fund, and have questions about what items can be reimbursed, please contact the Fund Office.

Please note that federal and state tax regulations are subject to change. **The above eligible expenses are only examples; it is not a complete list and does not include the provisions relating to each individual expense.**

Expenses Not Eligible for Reimbursement

Expenses not eligible for reimbursement from the HRA account include any item that does not constitute "medical care" as defined in Internal Revenue Code Section 105 or Section 213(d), such as:

- Individual health insurance premiums for active participants.
- Funeral and burial expenses.
- Health club or fitness program dues or equipment for general well-being, paid to improve your general health or to relieve physical or mental discomfort even if the program is necessary to alleviate a specific medical condition, such as obesity, unless you have a physician's letter stating a specific diagnosis and prescribing the membership or equipment.

- Personal use items such as cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements taken to maintain your own good health.
- Uniforms and special clothing, such as maternity clothing.
- Over-the-counter medications and other medical supplies without a prescription (except insulin).
- Long-term care services.
- Cosmetic or Reconstructive Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic or Reconstructive Surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Sickness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Household and domestic help (even though recommended by a qualified physician due to a participant's or dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child with discipline issues to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.
- Premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable; however, Medicare Part B, Medicare Part D and Medicare supplemental plan premiums (for those not enrolled in Fund coverage) are reimbursable for terminated employees, including retired employees or dependents of deceased employees who are spending down the HRA account balance.
- Prescriptions for retirees who have enrolled in a Medicare Part D plan.
- Any expense reimbursed or reimbursable from another source.

For more information, refer to IRS Publication 502 titled, "Medical and Dental Expenses." Go to **https://www.irs.gov/forms-pubs/about-publication-502**.

YOUR DEBIT CARD

How to Use Your HRA Debit Card

The HRA debit card is not a credit card.

To make it easy for you to access the funds in your HRA account, you are provided with a debit card that you can use at the point-of-service or point-of-sale to pay for eligible expenses out of your HRA account as you incur them. Note that the debit card is only being provided as a way for you to pay for those expenses that are eligible under the HRA.

You may use the debit card at the point of service or point of sale for eligible medical expenses at medical care providers or at approved merchants who provide health-related services and products and who accept the Plan's card. For example, you may use the card for medical office visit copayments, deductibles and coinsurance or for prescription drugs.

Check your debit card balance at any time by logging onto **www.bpalja.com**.

You should retain copies of receipts for any expenses incurred with the HRA debit card. You are required to provide the Fund Office with a copy of your receipt for certain types of expenses. When applicable, the Fund Office will send a letter to you requesting that a copy of your receipt be sent to the Fund Office.

Send a copy of your receipt to the Fund Office through the WEX link on the member portal at **www.bpalja.com**.

You can upload your receipt on the member portal by selecting "Dashboard" and then "I Want To" file a claim.

If the Fund Office does not receive a copy of the receipt within 30 days of the date of its letter, you will receive a second notice. If the Fund Office does not receive a copy of the receipt following the second notice, use of your debit card will be suspended until a copy of the requested receipt is received. Suspension of your debit card will end within 10 business days of the Fund Office's receipt of the needed document. If the receipt is not received, the expense may be reported as taxable income.

If the debit card purchase and receipt do not qualify as an eligible expense, you will need to reimburse the HRA account. You will then have those monies available to you for a future qualified expense. If the monies are not reimbursed, the expense may be reported as taxable income.

Debit Card Misuse

Refer to the next section for more information on claims and reimbursement procedures.

You must only use the card to pay for Medical Expenses as defined in section 213(d) of the Internal Revenue Code. In addition, you must not seek reimbursement under any other source (such as a health savings account or individual insurance plan) for any expense paid for with the card and you must retain sufficient documentation (including invoices and receipts) for any expenses paid with the card. The Plan will automatically deactivate your card when you become ineligible for the Plan (for active employees) and when you opt out of the HRA.

If the Plan seeks to verify a purchase and you do not respond to the request for additional information or if the Plan determines there is an improper payment, the Plan must follow certain correction procedures under IRS rules. For instance, the Plan may deactivate your card until you submit the requested documentation or repay the improper amount. In addition, the amount may be deducted from your other claim reimbursements or the amount may be treated as a bad debt. The amount may also be reported as taxable income.

CLAIMS AND REIMBURSEMENT PROCEDURES

An eligible expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, charged for, or pays for the medical care. Expenses incurred before an employee, retired employee or eligible dependent first becomes covered by the HRA are not eligible for reimbursement from the HRA account. This section explains the Plan's claims and reimbursement procedures.

When to Submit a Claim

If you do not use your debit card at the time of service to pay for expenses or your debit card is not accepted (for example, if you used an unapproved vendor), you must submit a written claim form to the Fund Office to receive a reimbursement check. Checks that are not cashed for 12 months after the end of the calendar year in which the expense was incurred will be forfeited to the Fund. Checks for approved claims will be sent within 30 days of the receipt of the claim.

Written claim forms for reimbursement of any eligible expense must be submitted to the Fund Office within one year of the date you incurred the expense in order for you to receive reimbursement.

While requests for reimbursement can be made at any time, to limit administrative expenses, the Plan requires that requests for reimbursement be for a minimum of $100. Therefore, you generally have to hold your requests for reimbursement until you have at least $100 in eligible expenses. If you do submit claims for less than $100, the Fund will hold them until the total reimbursement reaches a minimum of $100. In addition, the amount reimbursed for any eligible expense will not exceed your HRA account balance at the time reimbursement is requested. In the event your Plan coverage ends, you may submit eligible expenses totaling less than $100 to close out your HRA account.

Reimbursement is paid directly to you; you are responsible for paying any providers. To limit administrative expenses, the Plan requires that requests for reimbursement be for a minimum of $100. Hold your requests for reimbursement until you have a total of at least $100 in eligible expenses.

All expenses must be incurred prior to being considered for reimbursement except for certain advance payments for orthodontia services.

How to Submit a Claim

Reimbursement requests must be accompanied by a properly completed form, which can be obtained on the online Consumer Portal or from the Fund Office. The form will include a statement that you must sign verifying that the eligible expenses:

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source;
- For premiums paid for other coverage have not been paid or are not eligible for payment on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with the form, you must provide any of the following, as applicable:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge;
- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment;
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 plan;
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs); and
- Any additional documentation requested by the Plan.

If you need an HRA reimbursement form, please contact the Fund Office or download the form by logging onto **www.bpalja.com**.

It's a good idea to make a copy for your records of all materials you submit.

Materials you submit will not be returned to you. You may also submit claims directly through the online link.

Again, if you, your spouse, and/or your dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB(s), will be considered eligible for reimbursement. In completing the claim, you will need to provide the following information:

- The person or persons who incurred the medical care expenses;
- The date and nature of the incurred expense;
- The amount of the requested reimbursement; and
- A statement that these expenses have not been reimbursed and are not reimbursable through any other source including a Health Flexible Spending Account (FSA). If you have a FSA, such as through a spouse's employer, you must have expenses paid through the FSA first, before you request a reimbursement through the HRA account.

Where to File a Claim

You must file a claim for reimbursement with the Plan within one year of the date of the expense or your claim will be denied.

The quickest and most convenient way to file a claim is through the online Consumer Portal located at **www.bpalja.com**. However, you can mail a completed form and any required documentation to:

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510

Claim Decisions

A request for reimbursement of an eligible expense is considered a claim. Claim decisions are subject to the Plan's claims procedures for healthcare claims listed in your SPD. If your request for reimbursement is denied, you may appeal the decision. Review the *Claim Filing and Appeal Information* section of your Summary Plan Description (SPD) document for more information on how to appeal a denied claim.

Coordination of Benefits

Reimbursements available under the HRA account are intended to be solely for eligible expenses not previously reimbursed or reimbursable elsewhere. To the extent an eligible expense is payable or reimbursable from another source, that other source must pay or reimburse before reimbursement from the HRA account. If there is any question as to what source should pay benefits first, please refer to the *Coordination of Benefits* section of your SPD for specific information on the Plan's coordination of benefits provisions.

If you, your spouse, and/or your dependents have other coverage, you must first submit any claim for reimbursement of eligible healthcare expenses to the other plan before submitting it for reimbursement from your HRA account. Any portion of your eligible expenses that is not reimbursed after submission to the other plan can be submitted for reimbursement from the HRA account.

If eligible healthcare expenses are covered by both the HRA Plan and by a Health FSA, then the HRA Plan is not available for reimbursement of such medical care expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Tax Consequences

The Plan makes no guarantee that any amounts reimbursed to you, your spouse, or your dependents under the HRA will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA are excludable, and to notify the Plan if you have any reason to believe that such payment is not excludable. If payments made to you are not excludable, you may be liable for any harm your action causes to the Plan.

The Plan may be disqualified if reimbursement under the HRA is made on a tax-free basis when the payment does not qualify for tax-free treatment under the Internal Revenue Code. In this situation, you will be required to indemnify and reimburse the Plan for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

A FINAL NOTE

The HRA was created to help you to use the Health Fund in the way that best meets your needs. This brochure is a summary of the Health Fund's HRA as of January 1, 2019, and is intended to serve as an addition to your Summary Plan Description (SPD)/Plan Document; however, it is not meant to interpret or change provisions of the SPD/Plan Document. Your SPD/Plan Document describe the Plan's eligibility requirements, benefits and related terms and conditions of the Plan in more detail. Please keep this brochure with your SPD/Plan Document. If you have any questions, please contact the Fund Office.

The HRA is a part of the Health Fund and as such is subject to the Plan's provisions relating to all applicable provisions as listed in the Plan's SPD/Plan Document. Benefits will be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other laws applicable to group health plan to the extent required by such laws.

The HRA is intended to qualify as a medical reimbursement plan under §105 and §106 of the Internal Revenue Code of 1986, as amended, and related regulations, and as a health reimbursement arrangement, as defined under IRS Notice 2002-45. Eligible HRA Expenses reimbursed under the HRA are intended to be eligible for exclusion from your gross income under §105(b) of the Internal Revenue Code of 1986, as amended.

The Plan will establish and maintain a Health Reimbursement Arrangement with respect to each eligible participant but will not create a separate fund or otherwise segregate assets for this purpose. These Health Reimbursement Arrangement accounts are recordkeeping accounts with the purpose of keeping track of contributions and available reimbursement amounts.

In the event of any inconsistencies between this brochure and actual HRA Plan Document provisions, the terms of the Plan Document will govern. The Board of Trustees reserves the right to amend, modify, or terminate the HRA Plan at any time.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the healthcare reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at 608-846-1742 or 800-397-3373. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or via **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

LiUNA!

WISCONSIN LABORERS DISTRICT COUNCIL

Feel the Power

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

January 2016

Dear Participant & Family:

As Trustees of the Wisconsin Laborers' Health Fund, we are pleased to announce some changes to the Plan, Anthem has expanded its network of providers and has added identity protection services and dental coverage has been expanded for dental services related to cancer. This letter provides details of these changes.

Anthem Changes Effective January 1

Anthem Network Expands

Anthem Blue Cross Blue Shield has contracted with Dean Health System, St. Mary's Madison Hospital, St. Mary's Janesville Hospital, and St. Clare Hospital effective January 1, 2016. This means that the Health Fund will now only have one network in Wisconsin, Anthem Blue Preferred Plus POS. The Anthem networks associated with this Plan are listed below with their contact information. There are no changes to benefits.

PPO Providers		
In Wisconsin	Anthem Blue Preferred Plus POS	800-810-2583 www.anthem.com
Outside Wisconsin	Anthem National BlueCard PPO	800-810-2583 www.anthem.com

Anthem Identity Protection Services Added

Anthem Blue Cross Blue Shield identity protection services are included for free with your medical coverage. Coverage is automatic as long as you are eligible for coverage under the Fund; however, you must enroll for monitoring. Identity protection services are provided through AllClear. If you would like to enroll for credit monitoring, identity theft monitoring, identity repair, identity theft insurance, or *ChildScan* for minors, call AllClear at 1-855-227-9830. Enclosed is an overview of Anthem Identity Protection Services.

Expanded Dental Services Effective April 1, 2015

We have expanded coverage for dental services related to cancer to include the following services as long as the service is Medically Necessary:

- Any dental services, including dental surgery, provided by a Physician or Surgeon that are for the treatment of cancer or as a result of related cancer treatment (without the 24-month limit) will be covered at the coinsurance for Comprehensive Major Medical Benefits.
- For Standard Plan participants: If the service is performed by a Dentist in the Delta Dental network, the Plan's coinsurance will be 75%; if performed by an out-of-network dentist, the out-of network coinsurance rate of 60% will apply. The Bare Bones Plan does not provide dental coverage. Dental coverage for retirees is optional.

Statement of Grandfathered Status

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Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Please keep this announcement with your Summary Plan Description benefit booklet. If you have any questions about these changes, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

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Anthem BlueCross BlueShield

Identity Protection Services

Overview

Why are identity protection services being provided?
We believe your personal information should stay that way—personal. That's why we're taking industry-leading steps to help you keep your information safe. Identity protection is now available with our eligible health plans beginning January 1, 2016 and for as long as you have active medical coverage with us.

Why AllClear ID?
AllClear ID is a leader in customer security and identity protection. They give you easy access to identity protection services.

Is it safe to share my information with AllClear ID?
AllClear ID takes lots of steps to keep your information safe. All information you provide – including passwords and PINs – is stored securely.

Will AllClear ID sell or share my personal information with third parties?
No. AllClear ID takes your privacy very seriously. They do not sell, rent, or share your personal information with any third party for marketing purposes. Please see their Privacy Policy to learn more https://allclearid.com/legal/privacy-policy.

Eligibility

Who's eligible for these new services?
Subscribers (the person who holds the eligible medical health plan policy) and dependents on their policy are eligible for identity protection services. As long as you have active medical coverage with us as of January 1, 2016, you'll be eligible for identity protection services.

Who's not eligible for these new services?
Members in Federal programs, such as Medicare, are not currently eligible; if this changes we'll let you know. Individuals who only have specialty products, such as dental insurance, or non-health products are not eligible.

What services are being offered to protect my child's identity?
Any eligible member under the age of 18 on your active medical health plan is covered by *AllClear Identity Repair* services (no enrollment required) and *AllClear ID ChildScan* (if you enroll them in this coverage). *AllClear ID Child Scan* is only available to children under the age of 18 because adult credit monitoring services are not available to minors. *AllClear ID ChildScan* actively scans databases to see if your child's Social Security number is being used illegally. If fraud is found, an investigator will help to repair your child's identity.

Who will receive the notification about these services?
Only the subscriber (the person who holds the eligible medical health plan policy) will receive the notice. Children and adult dependents will not. However, all members are eligible for identity protection services as long as they have an active medical health policy.

AllClear ID services

Identity Repair Services

What is AllClear Identity Repair?
AllClear Identity Repair provides identity repair assistance to help fix identity theft issues and return your information to its proper condition. If there's a potential problem with your credit or you're concerned about identity theft, just contact AllClear ID at any point while you're an active health plan member at 1-855-227-9830. The investigator will help you determine if there is a problem and help you recover financial losses, restore your credit, and make sure your identity is returned to its proper condition.

Do I need to do anything to sign up for AllClear Identity Repair?
No, *AllClear Identity Repair* is automatically available with no enrollment required. Simply call AllClear ID at 1-855-227-9830 at any point while you're an active medical health plan member if you need help.

Credit and Identity Theft Monitoring Services

What are AllClear Credit and Identity Theft monitoring?
This service includes credit monitoring, identity theft monitoring, identity repair, identity theft insurance, and *ChildScan* for minors.

How does AllClear ID Credit Monitoring work?
AllClear Credit Monitoring looks at your credit activity and sends alerts when banks and creditors use your identity to open new accounts.

How does AllClear Identity Theft Monitoring work?
AllClear Identity Theft Monitoring alerts you if personal information is reported to AllClear ID by industry security professionals such as the FBI. This can include Social Security numbers, credit card numbers, PIN numbers, bank account logins, and other online logins (emails & passwords). You'll be alerted when your information is reported and an investigator can look into the situation.

Do I need to do anything to sign up for AllClear Credit and Identity Theft monitoring?
Yes. You must enroll in order to take advantage of any of these services. If you're interested in signing up, go to anthemcares.allclearid.com. Once you reach the secure site you'll be asked for your name and e-mail address. Next, you'll get an email with a redemption code and instructions on creating an online account. When enrolling, you'll need to provide your name, contact information, Social Security number and the unique redemption code. You can also sign up by calling 1-855-227-9830, Monday – Saturday from 8:00 AM to 8:00 PM CST.

What is the identity theft insurance policy and how does it work?
Identity theft insurance is a zero-deductible policy included in the *AllClear Credit and Identity Theft Monitoring* service. It will reimburse you for certain fees, lost wages, and fraud losses in the event of fraud. The full policy terms can be found here: https://allclearid.com/legal/insurance.

Will I be billed for this service?
There is no separate charge for these services described above. Identity protection is now available with our eligible health plans beginning January 1, 2016 and for as long as you have active medical coverage with us.

Will AllClear ID bill me for these services?
No, unless you specifically ask them to. AllClear ID purposely does not collect a method of payment when you enroll in this service, and therefore cannot automatically bill you. If you enroll in the *AllClear Credit and Identity Theft monitoring*, you'll receive an email at the end of the coverage period letting you know coverage is expiring. These notices will include two options:

1) An option to renew coverage if you still have active medical coverage with us; and
2) An option to continue the services, at a discounted rate, if you no longer have active medical coverage with us, but want to continue the services with AllClear ID. A form of payment will be requested only if you elect to continue the services at your own expense.

Information about enrolling

May I use my email address to enroll a family member?
Every adult must have a unique email address to enroll. That's because your email address is the user name for your account. We also use your email address to send you updates. A parent or guardian may use their email address to enroll their children in AllClear ID service.

Can I use my redemption code to enroll my family members, too?
No, each redemption code may only be used once. You should request a unique redemption code for each eligible family member at: https://anthemcares.allclearid.com

Why isn't my redemption code working?
If you have trouble with your redemption code, please:

1. Check that you have typed the right URL in your browser. Be sure to use the "https://" when typing in the URL (not "www").
2. Make sure you've typed in the redemption code exactly as it appears in your email notice. Copy and paste the code into the redemption box to reduce the chance of an error.

I'm hearing impaired. How do I talk to someone?
Toll free services for hearing impaired are available 24 hours a day, 365 days a year by using a Telecommunications Relay Service (TRS). The relay service will take text messages from the caller and relay them to the AllClear ID representative and send the information back to the caller via the TTY service. Remember that AllClear ID's service support hours are Monday – Saturday from 8:00 AM to 8:00 PM CST.

Do I need to provide my personal information or SSN to AllClear ID?
You only need to provide AllClear ID with personal information if you enroll in *AllClear Credit and Identity Theft Monitoring* or if it's needed by AllClear ID to help you with an identity repair service. This personal information allows AllClear ID to monitor, investigate, and/or repair your identity.

Information about timing

When does this new protection start and when does it end?
Identity protection services will be provided to all eligible members with medical health plan coverage as of January 1, 2016. They'll be made available for as long as you have an active medical health plan.

Do I need to enroll in the monitoring services when I get the notice to qualify for the service?
No enrollment is required to take advantage of *AllClear Identity Repair Services.* Enrollment is required to take advantage of *AllClear Credit and Identity Theft Monitoring.* Eligible members can enroll at any time during the calendar year. Services are available as of January 1, 2016.

What happens if I am no longer a member? Will my identity protection coverage end?
If your medical health plan coverage ends or you cancel your medical health plan coverage, you will no longer be eligible for Identity protection services. If you re-enroll in one of our eligible health plans later, you would again be eligible for these services.
Will AllClear ID continue to honor my services if I end or cancel my medical health plan coverage during the year?
AllClear ID services will continue through the end of the calendar year.

Information about AllClear ID

When and how will I get alerts?
If you're enrolled in *AllClear Credit and Identity Theft Monitoring* and suspicious use of your personal information is detected, you'll be notified directly by phone or e-mail.

Does AllClear ID monitor my existing bank accounts for fraudulent activity?
No, AllClear ID doesn't monitor daily activity of your bank or credit card accounts. You can monitor your bank accounts by setting up account alerts, which are provided, free of charge to customers by most banks and credit unions. AllClear ID can assist eligible individuals in setting up these alerts for your credit card and bank accounts. It's also recommended to review your monthly statements for unusual activity.

Information about suspected fraud

What do I do if I suspect insurance coverage or medical fraud?
If you believe someone has stolen your medical health insurance or medical information, or you notice a change in your medical records, please contact your health plan right away by calling the Member Services number on your ID card.

What if someone steals my identity?
If you become a victim of identity theft, you can take advantage of the *AllClear Identity Repair* services. The incident will be fully investigated, creditors, law enforcement and other parties will be contacted, and you will be informed throughout the entire process. Simply call AllClear ID at 1-855-227-9830 and an investigator will work to help fully repair and restore your identity.

I think someone is using my identity. What should I do?
If you think someone is using your personal information, please contact AllClear ID to open an investigation. If you need help, simply call AllClear ID at 1-855-227-9830 at any point while you're an active medical health plan member.

What happens if I have a fraud problem and I already cancelled my medical health plan coverage?
Your *AllClear Identity Repair* services will be honored through the end of the calendar year. If there's a potential problem with your credit or you're worried about identity theft, just contact AllClear ID at 1-855-227-9830 to speak with an investigator.

Information about the Anthem cyber-attack

I already have identity protection through Anthem, Inc. Do I need to do anything now?
No. If you enrolled with AllClear ID after the Anthem, Inc. cyber-attack in 2015, you don't need to do anything. However, when that protection coverage ends after two years, you can enroll in the new offering if you're still an active medical health plan member.

What if I'm eligible for services as part of the 2015 cyber-attack but never enrolled?
You can still enroll by accessing AnthemFacts.com. Information on how to enroll can be found on the AnthemFacts.com website.

LiveHealth Online, 24/7 NurseLine, and Future Moms Programs

Provided by Wisconsin Laborers

LiveHealth Online

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.* The program is available 365 days a year, 24 hours a day, seven days a week (including holidays) anywhere you have an internet connection.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at a cost that is same as your office visit copay or $49 per visit, subject to deductible and coinsurance, depending on your health plan benefits.
- Private, secure and convenient online visits.

Common treatments include:

- Cold/fever/flu
- Allergies
- Pink eye
- Sinus pain
- Sore throat
- Headache
- Vomiting
- Diarrhea
- Bronchitis
- Cold Sores
- Minor rashes
- Hives
- Trouble sleeping
- Ear pain

To access this program:

1. Log on to **LiveHealthOnline.com**.
2. Click **Sign Up** in the top right corner of the screen.
3. Complete the form to create your account and click **Finish**.
4. Review the physician profiles to select the one that's right for you and begin your consultation.

You will need your ID number from your ID card when creating your account in order for Anthem to identify you as a Plan participant.

LiveHealth Online is not intended for medical emergencies. If you experience an emergency, always call 911.

24/7 NurseLine – Call **1-866-670-1565**

Anthem's 24/7 NurseLine provides access to a registered, trained nurse over the phone anytime, anywhere. Registered nurses can help you understand your symptoms and medical condition or prescribed course of treatment. Nurses are trained to address common health care concerns, provide medical information, health education and assist you in accessing health care. The most frequent reasons for calls are:

- Pediatrics concerns
- Digestive system disorders
- Bone/muscle/joint concerns
- General health education
- Dermatology

Future Moms

Future Moms provides support to help achieve healthier pregnancies, deliveries and babies. The program is designed to help expectant mothers focus on early prenatal interventions, risk assessments and education by using a comprehensive, systematic and personalized management approach. Key features include:

- Registered nurses with obstetrics experience
- 24/7 toll-free telephone access to nurses and coaches
- Education on pregnancy care and topics
- Lifestyle management and behavioral change counseling
- Pharmacy and nutritional counseling
- Coordination of services and referrals
- Screening for pre-delivery and postpartum depression
- A thorough assessment and risk analysis for each participant

Call 1-877-351-8389 to join this program at no cost!

Anthem BlueCross BlueShield

*As legally permitted in certain states.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

< Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. >

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

January 2015

Dear Participant & Family:

As Trustees of the Wisconsin Laborers' Health Fund, we are pleased to announce an enhancement to the Plan's coverage of diagnostic services and dental emergencies, effective with dates of service on or after January 1, 2015.

Diagnostic Services

Effective January 1, 2015, the Plan will cover initial diagnostic services, even if the treatment for the diagnosis is not covered. The medical services will include office visits, outpatient laboratory or x-ray examinations, and related fees charged by a radiologist or pathologist for diagnosis of an injury or sickness that are ordered by a physician and are performed in a physician's office, clinic, or hospital outpatient department. Diagnostic genetic testing is not included in this Plan change. Applicable copays, deductibles and coinsurances apply. All other Plan exclusions, limitations, maximums and exclusions apply. However, if the condition is excluded under the Plan then treatment of the condition or services to monitor the condition will not be covered.

General Exclusion 12 is modified to read as follows: Inpatient or outpatient charges resulting from behavioral problems, conduct disorders, learning disabilities, and developmental delays. Treatment of these conditions is excluded.

General Exclusion 22 is modified to remove fertility tests from the exclusion.

Dental Emergencies

Effective January 1, 2015, the Plan will cover dental emergencies that require you to go to the Emergency Room on weeknights, weekends, and holidays under the Comprehensive Major Medical Benefit. You will still have to pay the ER Deductible of $100, major medical deductible, and the coinsurance. Like any other medical emergency, a dental emergency must meet the following definition:
An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, that are severe enough that the lack of immediate medical attention could reasonably be expected to result in: (1) the patient's health being placed in serious jeopardy; (2) bodily function being seriously impaired; or (3) serious dysfunction of a bodily organ or part.

Example: Martin had a toothache that started on Tuesday, but it was only a slight toothache and he ignored it for a few days. By Saturday evening, the toothache was unbearable and his jaw was swollen. Martin went to the ER where they determined that he had an abscess. The ER staff provided medications to stabilize his symptoms, so that he could go a dental provider to have his dental problem treated.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Please keep this announcement with your Summary Plan Description benefit booklet. If you have any questions about these changes, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

5480655v3/01577.001

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

SAV-RX PRESCRIPTION BENEFIT PROGRAM

Should you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please contact Sav-Rx. Their website is www.savrx.com or call toll free at 1-800-228-3108.

How to Use the Benefit — Present your ID card and your prescription to the pharmacist. The pharmacist will dispense your medication, submit the claim to Sav-Rx electronically, and notify you of the amount which you are required to pay.

The prescription benefit allows for a 30-day supply or 100 units, whichever is greater, with a limit of two refills at the local pharmacy. **MAINTENANCE MEDICATIONS MUST COME FROM THE MAIL ORDER PROGRAM.**

The plan covers all federal legend drugs, state restricted drugs, compounded medications, insulin, injectable medications, needles & syringes, immune altering drugs, retin a (diagnosis required over age 25), dexedrine (diagnosis required over age 25), imitrex vials, imitrex auto injector, diabetic medication, diabetic supplies, ulcer medication, mental health drugs, non-steroidal anti-inflammatory drugs, accutane (diagnosis required over age 25), diabetic lancets, glucometer and cox inhibitors in quantities of a 30 day supply or 100 units, whichever is greater, not to exceed one year.

The plan will exclude over the counter items and devices, injectable fertility medication, federal legend vitamins, blood products, serums, rhogam, rogaine, genetically engineered drugs, oral fertility medication, anorexiants (diet medication), anabolic steroids, children's vitamins, bee sting kits, yohimbine, male sexual dysfunction medication, ostomy products, growth hormones and allergy serums.

Retail Co-payment — The co-payment for generic medications will be $8
The co-payment for brand name medications will be $25
The co-payment for non-formulary brand name medications will be $40

Save money using the Sav-Rx Mail Order Program — The Mail Order Program was designed to allow members to receive a 90-day supply of maintenance medication (e.g. heart medication, blood pressure medication, diabetic medication etc). Whenever you start a new maintenance medication, the initial fill and two refills can be obtained with applicable co-pays through your local pharmacy. Any subsequent refills must be obtained through the Sav-Rx Mail Order Program. Step-by-step instructions on how to use the Sav-Rx Mail Order Program are provided in the Mail Order Brochure.

Mail Order Co-Payment — The co-payment for generic medications is $16
The co-payment for formulary brand name medications is $50
The co-payment for non-formulary brand name medications is $80

MAIL ORDER FORM

PLEASE PRINT CLEARLY. Enclose this form with your prescription(s) and payment.

MEMBER INFORMATION

CARDHOLDER NAME

CARDHOLDER ID #	DOB (MO/DAY/YR)	☐ MALE ☐ FEMALE

ADDRESS

CITY	STATE	ZIP

DAYTIME PHONE	EVENING PHONE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)

DOB (MO/DAY/YR)	☐ MALE ☐ FEMALE

IMPORTANT

You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise.

☐ By checking this box, I elect to receive brand drugs for all prescriptions in this order. By making this choice, I understand that I will be responsible for the **applicable copay PLUS the difference in cost.**

Please do not send cash.

☐ Check or money order enclosed

☐ Charge to my credit card

CARDHOLDER NAME

CREDIT CARD NUMBER	EXPIRATION DATE

CARDHOLDER SIGNATURE

Make checks payable to:

Sav-Rx Pharmacy

P.O. Box 8 Fremont, NE 68026

If mailing address for patient is different than cardholder address, please contact Sav-Rx.

HOW TO USE YOUR SAV-RX CARD

Our network of more than 65,000 pharmacies provides prescription services at convenient locations across the country. In addition to more than 3,000 independent pharmacies, Sav-Rx cards are also accepted at every major chain pharmacy. To locate a network pharmacy near you, call Sav-Rx or you may visit www.savrx.com.

RETAIL PHARMACY

You may present your card at any of over 65,000 retail network pharmacies nationwide to purchase your prescription medication. Your pharmacist may call Sav-Rx with any questions 1-800-228-3108.

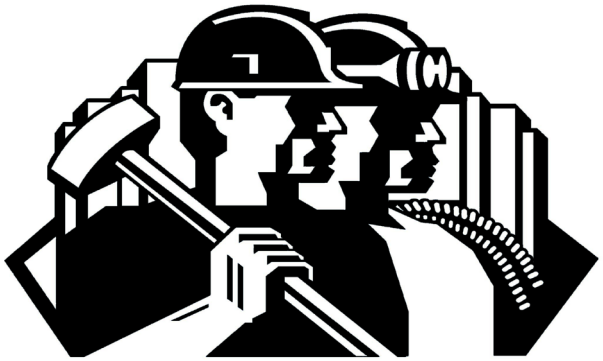
MAIL ORDER

You may also order prescription medication from the Sav-Rx Mail Order Pharmacy. The mail order should be used for your long-term maintenance medications. Using the Sav-Rx mail order may offer some cost savings to you. Regular orders are processed within 24 hours of receipt and mailed First-Class for convenient home delivery.

Your doctor may E-scribe new prescriptions to Sav-Rx or call in a new prescription to Sav-Rx at 1-800-228-3108. You may also mail your prescription to Sav-Rx PO Box 8 Fremont, NE 68026. **Please note that your payment is required with every order.** Be sure to reference your Sav-Rx identification number with each prescription. Additional mail order forms are available at www.savrx.com.

Refills may be called in 24 hours a day, 7 days a week to 1-800-228-3108. You may also request a refill online at www.savrx.com or download the Sav-Rx App from the App Store or Google Play.

Wisconsin Laborers' Health Fund



PRESCRIPTION DRUG PLAN ADMINISTERED BY:

SAV-RX *Prescription Services*

1-800-228-3108

Sav-Rx Prescription Services

Frequently Asked Questions

1. How much do I pay for my prescriptions?

RETAIL PHARMACY (UP TO 30 DAYS SUPPLY)	
Generic	$8.00
Formulary	$25.00
Non Formulary	$40.00
Brand w/ Generic	$40.00 + Difference in cost
MAIL ORDER (UP TO 90 DAYS SUPPLY)	
Generic	$16.00
Formulary	$50.00
Non Formulary	$80.00
Brand w/ Generic	$80 + Difference in cost
SPECIALTY (UP TO 30 DAYS SUPPLY)	
Generic	$8.00
Formulary	$25.00
Non-Formulary	$40.00
Brand w/ Generic	$40.00 + Difference in cost

2. When do I use the mail service?

You may order any prescribed medication, but the mail order service should be used for medications that you will be taking for more than 30 days. This will save you and your Fund money. All regular orders are processed within 24 hours of receipt, and mailed First-Class.

3. How do I get the best value in my pharmacy benefit?

The best way to ensure that you are getting the best value in your pharmacy benefits is to use generics whenever they are available.

Many brand name drugs do not have a generic equivalent; however, a generic drug is available within the same therapeutic class, which is designed to treat the same symptoms. It is recommended that whenever you visit with your physician, you discuss the importance of using generics whenever they are available because it will save you money at the pharmacy.

4. What is a formulary?

A formulary is a list of preferred products. The formulary considers treatment options on a therapeutics basis first, then based upon cost effectiveness. Generic medications, when they are available and considered equivalent to their brand counterpart, are always preferred over brand name products. When similar brand name medications are available to treat a condition, the formulary helps physicians and patients consider treatment options in order of cost effectiveness.

Please visit our website at:

www.savrx.com

5. What medications are covered?

Most maintenance medications are covered by your plan. These include, but are not limited to: insulin, diabetic testing supplies and more. Please refer to your Summary Plan Description for specific coverage rules.

Certain classes are excluded from coverage such as: fertility, weight loss products, cosmetic products, over the counter medications and drugs used for experimental purposes.

Some medications may require prior approval such as injectables and specialty medications. Some medications may be subject to quantity limits and/or step therapy.

Please contact Sav-Rx Prescription Services with any questions regarding your medications.

SAV-RX *Prescription Services*

Call to find out more about your prescription copays, network locations and clinical programs. An agent will be ready to provide you with personalized, professional assistance 24/7.

1-800-228-3108

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

Announcing Access to a NEW Hearing Service Program for Participants Enrolled in the Regular Plan or the Retiree Plan

July 2018

Dear Active and Retired Plan Participants:

As the Board of Trustees of the Wisconsin Laborers' Health Fund ("Fund" or "Plan"), we are pleased to announce that effective August 1, 2018, you will have access to a hearing service program offered through Amplifon Hearing Health Care ("Amplifon").

Amplifon's program will complement the hearing aid benefits available to you and your eligible dependents by providing you with access to credentialed audiologists and hearing aid dispensers who offer discounts off the manufacturers' suggested retail price on major brands of hearing aids.

You can still contact Anthem at 800-810-2583 to locate and/or schedule your initial hearing exam with an Anthem in-network ear, nose and throat (ENT) physician. Once you complete your initial hearing exam, you can call Amplifon's call center at 866-674-3979 and speak with a Patient Care Advocate who will schedule an appointment for you with an Amplifon provider for hearing aid selection and fitting. Amplifon's call center is open 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday.

For further information on Amplifon's services, visit www.amplifonusa.com/wilaborers or call 866-674-3979.

THE PLAN'S HEARING AID BENEFIT IS NOT CHANGING

If you are enrolled in the Regular Plan or the Retiree Plan (and not the Bare Bones Plan), you and your eligible dependents are still eligible to receive the hearing aid benefits offered by the Fund. This means that the Plan will continue to cover 100% of your hearing aid expenses, up to $2,000 per person in any consecutive five-year period.

Covered hearing aid expenses include the allowable charge for a necessary hearing aid instrument, as determined by a licensed otologist or an otolaryngologist (ENT). A hearing aid device replaced without obtaining a new prescription is a covered expense, provided the original device was covered by the Plan and a valid prescription for the original device (from a qualified otologist or otolaryngologist) is on file with the Fund Office.

Epic's Hearing Service Program Reminder
You will also continue to have access to the hearing service program provided by EPIC Hearing Healthcare as another complement to the Fund's hearing aid benefits. This hearing service program provides you with access to EPIC's national network of independent and credentialed audiologists and ENT physicians who perform hearing evaluations and offer discounts off the manufacturers' suggested retail price on all major brands of hearing aids. You can call EPIC at 866-956-5400 to set up a hearing evaluation with an EPIC network provider. The call center is open 8:00 a.m. to 8:00 p.m. Central Time, Monday through Friday.

STATEMENT OF GRANDFATHERED STATUS

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

FOR MORE INFORMATION

Please refer to your Summary Plan Description (SPD) booklet for complete Hearing Aid Benefit information and keep this announcement with your SPD booklet for easy reference.
If you have any questions about your hearing aid benefits or any other Plan benefit, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

Your hearing health care program - for life

Brought to you by Wisconsin Laborers' Health Fund

We offer...

Custom hearing solutions - we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

Continuous Care - one year free follow-up care, two years free batteries, and a three-year warranty.

Risk-free 60-day trial - 100% money-back guarantee.

Hearing aid low price guarantee - if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

Accessing your discount is as easy as...

1. Call Amplifon at 866-674-3979 and we'll find a provider near you.
2. We'll explain the Amplifon process and help you schedule an appointment.
3. We'll send information to you and the provider, ensuring your discount is activated.

www.amplifonusa.com/wilaborers

amplifon Hearing Health Care

Discount Card

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your discount, call 866-674-3979 today!

amplifon Hearing Health Care

Additional money-saving offer!

$50 off one hearing aid* -or- $125 off two hearing aids*

Call 866-674-3979 today!

Act now!

*Savings on top of our already discounted pricing. Please bring this offer with you to your appointment.

EPIC HEARING HEALTHCARE

MEMBER | SAVINGS

EPIC HSP members save up to 60% off of retail on brand name hearing aids from major manufacturers through the EPIC Hearing Service Plan.

- Phonak
- Unitron
- Hansaton
- Resound
- Starkey
- Signia
- Widex
- Oticon

Technology Levels	Typical MSRP	EPIC HSP Price	Member Savings
Entry	$1,400	$495	**$905**
Essential	$1,650	$999 / $1,199	**$550**
Standard	$2,250	$1,299 / $1,499	**$850**
Advanced	$2,700	$1,899 / $2,099	**$700**
Premium	$3,500	$2,399 / $2,499	**$1,050**

WELLNESS REWARDS | PROGRAM

ListenHear • LiveWell

Participants who complete the four fun, educational hearing health related activities in the Listen Hear, Live Well hearing wellness program receive *Wellness Reward Coupons* for additional savings on their hearing purchase! Go to **www.listenhearlivewell.com** on your desktop computer or mobile device to participate.

- **$200 off** Premium Level Devices*
- **$100 off** Advanced Level Devices*
- **$50 off** Standard Level Devices*

Wellness Reward Coupons are applied to each device that is purchased!

*applies to all Standard, Advanced, and Premium level hearing aid makes/models; cannot be combined with any other offers or promotions

Call EPIC today to start the process to better hearing.

1 866.956.5400

www.epichearing.com/registration

EPIC HEARING HEALTHCARE

Hear Better • Live Well

Welcome

EPIC HSP members have access to the largest hearing care provider network in the country and substantial savings on top tier manufacturer brand devices and related professional services through the **EPIC Hearing Service Plan**.

Provider Network

The EPIC network is comprised of professional Audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states.

Hearing Aid Technology

The EPIC Hearing Service Plan gives you access to all name brand hearing aid technology by the top tier hearing aid manufacturers at reduced prices, 30%-60% below MSRP; maximizing your value and savings.

How it Works

Contact an EPIC hearing counselor today. The hearing counselor can answer any questions you may have about the plan and coordinate your referral to a nearby participating provider. If the provider recommends you obtain hearing aids, an EPIC counselor will contact you to coordinate your coverage and payment. You will receive a 45 day trial period.

Warranty & Batteries

All hearing aids, with the exclusion of the Entry Level, come with the EPIC guaranteed warranty which covers repair, damage, and one time loss for three years. (Entry level is one year). Each hearing aid purchase includes a one year to lifetime supply of hearing aid batteries at no additional cost. *excludes Entry Level Products; Premium hearing devices include a lifetime battery supply

Wisconsin Laborers' Health Fund

Notice of Creditable Coverage
For Distributions Prior to October 15, 2018

Prepared by
Segal Consulting
October 2018

Notice of Prescription Drug Creditable Coverage
Wisconsin Laborers' Health Fund

Important Information about Your Prescription Drug Benefits and Medicare Prescription Drug Coverage

This Notice has information about:

- Medicare Prescription Drug Coverage that is available to everyone with Medicare.
- How the Wisconsin Laborers' Health Fund's existing prescription drug benefits are, on average for all active and retired Plan participants and their dependents, at least as good as standard Medicare Prescription Drug Coverage.
- What your choices are and what happens to your coverage under the Wisconsin Laborers' Health Fund if you elect Medicare Prescription Drug Coverage.
- Where to find more information to help you make decisions about your prescription drug coverage.

The Wisconsin Laborers' Health Fund provides prescription drug coverage for all participants. You do **not** need to enroll for Medicare Prescription Drug Coverage since you have creditable coverage available under the Wisconsin Laborers' Health Fund.

This Notice explains the options you have under Medicare Prescription Drug Coverage and can help you decide if you want to enroll. Please read this Notice carefully and keep it in a safe place for future reference.

Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage is available to anyone with Medicare. Most people must pay a monthly premium for Medicare Prescription Drug Coverage. For people with limited resources, extra help paying for Medicare Prescription Drug Coverage is available. Medicare Prescription Drug Coverage is insurance provided by private companies that have been approved by Medicare. Medicare Prescription Drug Coverage is available through Medicare Advantage (like an HMO or PPO) and Medicare Prescription Drug Plans.

All Medicare plans provide at least a standard level of coverage as set by Medicare. Some Medicare plans offer better coverage for a higher monthly premium.

Individuals entitled to Medicare Part A or enrolled in Medicare Part B can enroll for Medicare Prescription Drug Coverage when they first become eligible for Medicare and each year from October 15th through December 7th. If a Medicare eligible individual loses or drops prescription drug coverage under the Wisconsin Laborers' Health Fund, the individual may be eligible for a two (2) month Special Enrollment Period to sign up for Medicare Prescription Drug Coverage. More detailed information about Special Enrollment Periods can be found in the *Medicare & You* booklet sent to Medicare eligible individuals each fall.

Existing Coverage as Good as Standard Medicare Prescription Drug Coverage

The Wisconsin Laborers' Health Fund has determined that the Plan's existing prescription drug benefits are "creditable coverage," which means coverage under the Wisconsin Laborers' Health Fund is, on average, expected to pay as much (or more in some cases) in claims for all participants as standard Medicare Prescription Drug Coverage.

Keep this Notice. If you enroll for Medicare Prescription Drug Coverage, you will need a copy of this Notice when you enroll. This Notice verifies that you have creditable coverage and that you are not required to pay the higher premium penalty.

Because your current prescription drug benefits under the Wisconsin Laborers' Health Fund are, on average, as good as Medicare standard coverage, you can choose to stay covered under the Wisconsin Laborers' Health Fund and join a Medicare plan later and not be subject to higher premiums.

Your Choices and the Consequences

You should compare your current coverage, including which medications are covered, with the coverage and cost of the Medicare plans in your area.

If you do not enroll for Medicare Prescription Drug Coverage, you will continue to receive prescription drug benefits under the Wisconsin Laborers' Health Fund (as long as you are otherwise eligible to continue Plan coverage). Remember that the

Wisconsin Laborers' Health Fund also provides medical and other benefits, in addition to prescription drug benefits. You will continue to receive all current benefits for which you are eligible.

- **Active Participants and Their Dependents:** If you are an active participant or the dependent of an active participant and enroll for Medicare Prescription Drug Coverage, you will continue to be eligible for the Fund's prescription drug benefits. However, your prescription drug benefits will be coordinated with Medicare if you enroll.
- **Retirees and Their Dependents:** If you are a retiree or dependent of a retiree and are eligible and enroll for Medicare Prescription Drug Coverage, you will no longer receive prescription drug benefits under the Wisconsin Laborers' Health Fund. You will continue to be eligible to receive medical benefits under the Wisconsin Laborers' Health Fund. However, your monthly self-payments for coverage under the Wisconsin Laborers' Health Fund will not change as a result of not receiving prescription drug benefits under the Fund. Also, remember that for most people there is a monthly premium for Medicare Prescription Drug Coverage.

  If you or your dependents enroll for Medicare Prescription Drug Coverage, lose Wisconsin Laborers' Health Fund prescription drug benefits, and later decide to drop Medicare Prescription Drug Coverage, you will be given a one-time opportunity to re-enroll for the Fund's prescription drug benefits. Contact the Fund Office for more information.

  If you drop *all* coverage under the Fund, enroll for Medicare Prescription Drug Coverage, and later drop Medicare coverage, retiree coverage under the Wisconsin Laborers' Health Fund cannot be reinstated because once retiree coverage ends, it may not be reinstated unless you return to work and satisfy the eligibility requirements for active coverage.

Note to Medicare-Eligible Individuals: If you drop or lose your coverage under the Wisconsin Laborers' Health Fund and do not enroll for Medicare Prescription Drug Coverage after your current coverage ends, you may pay more for Medicare Prescription Drug Coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Prescription Drug Coverage, your monthly premium for Medicare Prescription Drug Coverage will increase. The increase will be at least 1% per month for every month that you were eligible but did not have coverage. For example, if you go 19 months without coverage, your monthly premium penalty will always be at least 19% higher than what most other people pay. You will have to pay this higher premium penalty as long as you have Medicare Prescription Drug Coverage. In addition, you may have to wait until the next open enrollment period (October 15th through December 7th each year) to enroll.

For More Information about Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug Coverage is available in the *Medicare & You* handbook that Medicare publishes each fall and sends to Medicare beneficiaries. You may also be contacted directly by Medicare Prescription Drug Plans. You can also get more information about Medicare Prescription Drug Coverage from the following resources:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number is included in the *Medicare & You* handbook).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited resources, extra help paying for Medicare Prescription Drug Coverage is available. Additional information is available from the Social Security Administration by:

- Visiting www.socialsecurity.gov.
- Calling 1-800-772-1213 (TTY users should call 1-800-325-0778).

For More Information About this Notice or the Health Fund's Prescription Drug Benefits

If you have any questions about this Notice or would like more information about your prescription drug benefits under the Wisconsin Laborers' Health Fund, please call the Fund Office.

In the future, the Wisconsin Laborers' Health Fund will periodically send you an updated copy of this Notice for your records. You also may request a copy of this Notice at any time by contacting the Fund Office.

Date: October 2018
Contact: Fund Office

Entity/Sender: Wisconsin Laborers' Health Fund
Address: 4633 Liuna Way, Suite 201, DeForest, Wisconsin 53532-2514
Telephone Number: 1-608-846-1742 or 1-800-397-3373

Benefits under the Wisconsin Laborers' Health Fund are not vested or guaranteed. Full details of the Wisconsin Laborers' Health Fund are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.

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WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

ANNOUNCING PLAN CHANGES

Date: May 2019

To: Active and Non-Medicare-Eligible Retired Employees and Their Eligible Dependents Participating in the Wisconsin Laborers' Health Fund

From: The Board of Trustees

As your Board of Trustees of the Wisconsin Laborers' Health Fund (the "Fund" or "Plan"), we are pleased to announce the implementation of a new Employee Assistance Program (EAP), maternity care benefit and biometric screening services for you and your eligible dependents. Please read this Summary of Material Modifications (SMM) in its entirety as it provides details about these new benefits.

New Employee Assistance Program (EAP) Through Anthem BlueCross BlueShield—Effective June 1, 2019

Everybody has problems and issues they deal with from time to time. And while you may talk to family, friends, spiritual advisors and/or coworkers about your troubles, that may not be all you need. That's why the Fund is contracting with Anthem BlueCross BlueShield to provide you with access to Anthem's Employee Assistance Program (EAP).

Anthem has a national network of over 22,000 EAP professionals, including psychologists, social workers, marriage and family therapists, counselors and psychiatric nurses, who can help you deal with life challenges like:

- Stress and/or anxiety
- Depression
- Suicidal thoughts
- Personal and/or emotional challenges
- Grief or loss
- Marital, relationship and family issues
- Alcoholism, drug use and addiction

You will never receive a busy signal, which means that you will have direct access to a customer care representative or clinician 24 hours a day, seven days a week. **All discussions with an EAP counselor will be kept confidential** (except those that pose a threat to someone's safety, such as a child abuse situation; such calls will be an exception to the counseling confidentiality rule).

93% of Anthem's EAP professionals also participate in the BlueCard® PPO mental health/substance abuse provider network.

The EAP will also provide you and your eligible dependents with:

- ***Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue)***. If there are any issues that cannot be effectively addressed within the three counseling sessions, you may be able to discuss them further with a clinician if they are covered services under the Plan's mental health or substance abuse benefits.
- ***Work-life services*** (including child and elder care resources).
- ***One legal consultation (up to 30 minutes per issue per benefit year)*** for issues such as divorce/custody, criminal matters, estate planning/wills/trusts, real estate, landlord/tenant matters, bankruptcy, personal injury/malpractice cases, small claims, adoption and will preparation. The EAP also has a library of legal forms that you can access online and use for a variety of consumer, medical and family situations.
- ***Telephonic financial consultations*** for issues like bankruptcy, budgeting (to cope with reduction in household earnings, reduce debt, or save money, for example), buying a home for the first time, major life-event planning (wedding, adoption, divorce), college fund planning, credit card debt (lowering rates, consolidating debt), retirement planning and foreclosure prevention.
- ***Access to "myStrength."*** This is an online and mobile "health club for the mind" app you can use to help you manage stress, depression or other matters that you're having difficulty coping with.
- ***Unlimited access to the EAP's website (www.AnthemEAP.com)***. Access the website when you need to locate an EAP provider. The site also offers information on several subjects, including aging, work/life balance, parenting, child and elder care, and more. Just log on at any time using the login ID: Wisconsin Laborers.

We highly recommend that you contact the EAP if and when you ever need assistance coping with a difficult matter. It will be worth your while. To reach an EAP specialist, call Anthem at 800-865-1044.

Note: Certain services available under the EAP may not be covered under the Plan. For example, the Plan does not provide benefits for marriage counseling or other non-referenced legal services. However, these services are offered by the EAP.

New Maternity Benefit—Effective March 1, 2019

The Plan now offers an $800 weekly benefit in connection with a live birth for active eligible female employees. The benefit is payable for six (6) weeks per live birth, for a traditional delivery, and eight (8) weeks for a cesarean section delivery.

> The Plan will continue to provide benefits for a mother and/or newborn child for hospital confinement in connection with childbirth of at least 48 hours following a normal vaginal delivery or at least 96 hours following a cesarean section.

Enhanced Biometric Screening Coverage Through BPA—Effective July 1, 2019

Effective July 1, 2019, biometric screening services will be provided through our Fund Administrator, Benefit Plan Administration of WI, Inc. (BPA), instead of HMC HealthWorks. You will not be required to undergo a biometric screening in order to be covered by the Plan. *Your participation in the program is voluntary.* However, we recommend that you take advantage of this benefit. It will be available at **NO COST** to you. Additionally, when you (and your spouse or eligible domestic partner, if applicable) get a biometric screening performed, you will be rewarded. Here's how it will work:

For Active Plan Employees:

- If you undergo a biometric screening during the period ***July 1, 2019 through June 30, 2020***, you will have the choice of either waiving the annual medical deductible that will apply in 2020 and 2021 ***OR*** receiving a $150 gift card (your spouse and/or your eligible domestic partner, if applicable, will receive a $150 gift card, as well). Note that if you are married or have an eligible domestic partner and you choose to waive the annual medical deductibles, your spouse or eligible domestic partner must agree to waive the deductibles, as well.

  In addition, regardless of whether you choose to have the annual medical deductibles waived or to receive a $150 gift card, if the results of your screening test are considered out of range, $100 will be contributed to your Health Reimbursement Arrangement (HRA) if and when you complete a mandatory ***coaching*** program. Information about the mandatory coaching program is provided later in this document.

- If you undergo biometric screening during the period ***July 1, 2020 through June 30, 2021***, you (and your spouse or eligible domestic partner, if applicable) may choose to either have your 2022 annual medical deductible waived or receive a gift card. If you choose the gift card, one in the amount of $225 will be awarded to you, but only if you pass the screening tests. If the screening tests are not passed, you (and your spouse and/or your eligible domestic partner, if applicable) will receive the following:

  - an initial gift card in the amount of $75; and
  - a second gift card in the amount of $150 once you complete a mandatory ***coaching*** program.

  In addition, if you (and your spouse or domestic partner, if applicable) elect to have the 2021 annual medical deductible waived and the results of your screening test are considered out of range, $100 will be contributed to your HRA, but only upon completion of the mandatory ***coaching*** program.

For Non-Medicare-Eligible Retired Employees:

- If you undergo a biometric screening during the period ***July 1, 2019 through June 30, 2020***, you will receive a $150 gift card.
- If you undergo biometric screening during the period ***July 1, 2020 through June 30, 2021*** and you ***pass*** all of the screening tests, a $225 gift card will be awarded to you. However, if you ***do not pass*** all of the screening tests, the following will occur:

  - you will initially receive a $75 gift card instead; and
  - then you will receive a second gift card for $150 once you complete a mandatory coaching* program through Case Management Specialists, Inc. (CMS).

You Will Receive a Health Report—After you complete the screening, your test results will be sent to you. The health report will be kept confidential and will not be shared with your employer.

About the Coaching Program—The coaching program will be administered by Case Management Specialists, Inc. (CMS). We believe the CMS coaching program is a valuable complement to your biometric screening benefit. If the results of your screening show that you are considered out-of-range for certain health-related conditions (like BMI, diabetes, back pain, coronary heart failure, high blood pressure or high cholesterol), a wellness coach will contact you and help you set the necessary goals to improve your health and live a healthier lifestyle.

More to Come—Be on the lookout for additional information in the mail about the biometric screening program, well before the program's implementation date.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform.The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Note that additional information will be sent to you in the mail soon about the biometric screening benefit. In the meantime, if you would like more information about the benefit and/or the new EAP program and maternity benefit, contact the Fund Office at the address and telephone number shown at the top of this Notice.

In addition, please file this SMM with your Plan-related documents for easy reference.

This announcement, which serves as a Summary of Material Modifications, contains only highlights of recent changes to the Wisconsin Laborers' Health Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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Important Instructions

It is REQUIRED to complete the 1st page of the Health Screening Program Consent and Authorization form, which includes two signatures. The next 2 pages of the Health Risk Questionnaire is optional. However, it is preferred that you complete the Questionnaire as well.

Provide the above completed forms to your Primary Care Physician "PCP", along with the PCP form at the time of your appointment. Your physician will need to complete and provide ALL your biometrics on this form. ALL forms must be faxed together to Healics. You will find Healics' contact information on the PCP form.

Please keep in mind, it is your responsibility to provide ALL forms to Healics for processing.

Thank you

Healics
With you for life

Health Screening Program
Consent and Authorization

Barcode

The purpose of this voluntary health screening program offered through the sponsor employer is to gather sufficient information, so you can receive an informative confidential Healics™ Health Risk Report from Healics Inc. ("Healics").

Employer: **Wisconsin Laborers Health Fund**

Have you completed a Healics health risk assessment before? ❒ Yes ❒ No

Please print name:_____ Date of birth:_____
(Last Name) (First) (MI) (mm/dd/yyyy)

Mailing address:_____ City:_____ State:_____ Zip:_____

Best contact number:(_____)_____ Work phone number:(_____)_____ Gender: ❒ Male ❒ Female

Regarding the sponsor employer, are you the: ❒ Employee ❒ Spouse of employee

If you are a spouse, what is the employee's name? _____Employee Date of Birth:_____

If you are the employee and the sponsor employer has multiple shifts, which shift do you work? ❒ 1st shift ❒ 2nd shift ❒ 3rd shift

I wish to participate in this voluntary health screening/health risk assessment (HRA) offered by the sponsor employer and conducted by Healics. I understand that Healics is the program vendor and it subcontracts with others, such as examiners (to take measurements and to draw blood via venipuncture, oral swab, or fingerstick methods) and Clinical Reference Laboratory (to analyze the blood sample).

I understand the health screening program, including any possible consultation or follow-up, is not a substitute for a full examination by my own physician. I will arrange any appropriate follow-up examinations. The health coaching process that may be included is a support system, which utilizes goal setting, identification of obstacles and action planning to improve physical health. All information provided in the coaching sessions are suggestions. All suggestions should be cleared with a medical doctor before implementing. I understand that there are possible risks associated with venipuncture or fingerstick methods including, but not limited to, risk of infection, discomfort, bruising and, in unusual situations, more serious risks (including death). I agree that Healics is not liable for such risks when Healics is acting properly, and that I will assume the risk of injuries, including death, damages or loss, which I may sustain as a result of my participation in the assessment. I consent to the taking of blood from me by a qualified examiner. **I understand that I may refuse to sign this Consent, but if I do so, I will not be processed as a participant in the health-screening/HRA program.** I understand that Healics and its vendors generally are required by law to maintain the confidentiality of the medical information I provide through the HRA. The medical information includes my biometric results and other information about the manifestation of a disease or disorder. Healics uses this information to provide services to me and / or my spouse, such as an analysis of certain health risk factors. Healics is restricted by privacy law in how my or my spouse's medical information can be used or disclosed. For example, the Genetic Information Nondiscrimination Act generally prohibits Healics from disclosing to my employer my spouse's genetic information (which generally includes his or her health status). Such spousal information generally cannot be made available to managers, supervisors or others at the employer who make employment decisions, or anyone else in the workplace. Healics has established privacy and security policies and procedures that discuss how my medical information will be properly held, used and disclosed. I knowingly and voluntarily provide my Consent.

Signature (required to process results): _____ **Date**: _____

If this Consent is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual:_____

I authorize Healics to release my name as a participant, my participation status in the program, and certain other limited health "information" (i.e., my nicotine results and scores) to sponsor employer for the purposes of administering the wellness program. In the event sponsor employer offers a bonus or incentive related to the program, I authorize Healics to release Information to sponsor employer — as well as companies engaged by sponsor employer and/or Healics — for purposes of administering the bonus or incentive related to the program and/or providing me with follow-up coaching, counseling or related services. All other health information resulting from the health risk assessments will be held confidentially and not shared with sponsor employer. I understand the following:

- **I may refuse to sign this Authorization, but if I do so, I will not be processed as a participant in the health screening/HRA program.**
- Sponsor employer may condition my enrollment in a health plan or eligibility for benefits upon my executing this Authorization.
- This Authorization is effective until the earlier of: (1) the date it is revoked or superseded; or (2) one year after the date I signed it.
- I may revoke this Authorization at any time, in writing provided to Healics, Attn: Privacy Officer at 8919 W. Heather Ave., Milwaukee, WI 53224. My revocation will not be effective until received by Healics and will not be effective: (1) regarding any disclosure that Healics has made prior to receipt of my revocation; or (2) if this Authorization was obtained as a condition of obtaining insurance coverage.
- I have the right to request access to health information I have authorized to be used or disclosed pursuant to this Authorization. I may arrange to inspect my health information or obtain copies of my health information by contacting the Healics Privacy Officer at 1-800-HEALICS.
- Information disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected by federal privacy standards.
- A photocopy will be as valid as the original.
- If a disclosure is required by law (e.g., pursuant to a judge's written order), Healics or its representative may be required to make the disclosure.
- I may request a copy of this Authorization.

Signature (required to process results): _____ **Date**: _____

If this Authorization is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual: _____

This constitutes stand-alone documents that are separately: (1) a consent form; and (2) an authorization to disclose health information. Any other documents which are attached to this document are done so for your convenience, in order to ensure that the documents are not misplaced. Please proceed to the attached or following documents and complete the questions. If your doctor has prescribed any medication, you must stay on that medication for the health screen.

Medical History

1 Have you ever been diagnosed or treated for any of the following conditions? (check box if yes)

Allergies ❒	
Arthritis ❒	
Asthma ❒	
Back or neck pain ❒	
Cancer ❒	
Depression/anxiety ❒	
Diabetes (Type 1) ❒	
Diabetes (Type 2) ❒	
Fibromyalgia ❒	
Heart attack ❒	
Heart conditions ❒	
Heartburn/acid reflux ❒	
High cholesterol ❒	
High blood pressure ❒	
Irritable Bowel Syndrome/Crohn's ❒	
Kidney disease ❒	
Liver disease ❒	
Lung disease ❒	
Lymes disease ❒	
Migraine headache ❒	
Obesity ❒	
Sleep disorder/trouble sleeping ❒	
Stroke ❒	
Thyroid disease ❒	
Other condition(s) ❒	
None of the above ❒	

Are you taking prescription medication for any of the following conditions? (check box if yes)

Allergies ❒
Arthritis ❒
Asthma ❒
Back or neck pain ❒
Cancer ❒
Depression/anxiety ❒
Diabetes (Type 1) ❒
Diabetes (Type 2) ❒
Fibromyalgia ❒
Heart attack ❒
Heart conditions ❒
Heartburn/acid reflux ❒
High cholesterol ❒
High blood pressure ❒
Irritable Bowel Syndrome/Crohn's ❒
Kidney disease ❒
Liver disease ❒
Lung disease ❒
Lymes disease ❒
Migraine headache ❒
Obesity ❒
Sleep disorder/trouble sleeping ❒
Stroke ❒
Thyroid disease ❒
Other condition(s) ❒
No prescription medications used ❒

2 Pregnancy (Females only)

Are you pregnant? No ❒ Yes ❒ | Trimester 1st ❒ 2nd ❒ 3rd ❒ | Pre-pregnancy weight _____

Are you postpartum (0-12 months)? No ❒ Yes ❒ | Delivery date (mm|dd|yyyy) | | | | | | | | |

Lower of pre-pregnancy or postpartum weight _____

3 Weekly Exercise On average, how many minutes per week do you exercise (excluding work activity), in which your rate of breathing and heart rate increases for a total of 10 minutes or longer?	150 mins or greater ❒	75-149 mins ❒	74 mins or less ❒

4 Ergonomics On average, how many hours per day do you spend:	9+ hrs	7-9 hrs	3-6 hrs	Less than 3 hrs
Sitting	❒	❒	❒	❒
Standing	❒	❒	❒	❒
Performing repetitive motions	❒	❒	❒	❒

5 Sleep On average, how many hours a day do you sleep?	9+ hrs ❒	7-9 hrs ❒	3-6 hrs ❒	Less than 3 hrs ❒

Do you experience interrupted sleep, sleep apnea, difficulty with quality sleep? No ❒ Yes ❒

6 Nicotine

Have you ever used products containing nicotine?

No ❒

I did, but I quit ❒ Quit date (mm|dd|yyyy) | | | | | | | | |

Current nicotine user ❒

I currently use nicotine in the following way(s):

Cigarettes ❒	Chew/dip/pouches ❒
Cigars ❒	Nicotine Replacement Therapy (gum/patch/lozenge) ❒
Pipe ❒	Electronic cigarettes (vaping) ❒

7 Alcohol

How often do you have a drink containing alcohol?

Never ❒ One time per month or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week ❒

How many drinks containing alcohol do you have on a typical day?

0 ❒ 1-2 ❒ 3-4 ❒ 5-6 ❒ 7+ ❒

How often do you have six or more drinks on one occasion?

Never ❒ Less than once per month ❒ Monthly ❒
Weekly ❒ Daily or almost daily ❒

8 Safety

In the last 30 days, how often have you read/written texts or emails, viewed/responded to social media or watched videos on a phone or electronic device while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

In the last 30 days, how often have you been drowsy, dozed while driving or fallen asleep while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

9 Stress

Indicate how often the following apply to you:	Always	Usually	Sometimes	Never
I feel stress from work issues	❒	❒	❒	❒
I feel stress from family/personal relationships	❒	❒	❒	❒
I feel stress from financial concerns/issues	❒	❒	❒	❒
I feel stress from health concerns/issues	❒	❒	❒	❒

10 Worksite Productivity

In the past four weeks, how often did the following keep you from working all or most of the day?	Always	Usually	Sometimes	Never
Illness	❒	❒	❒	❒
Injury	❒	❒	❒	❒
Emotional well-being	❒	❒	❒	❒

11 Readiness to Change

How would you like to enhance or improve your quality of life? Please rate your readiness to change using the key below:

Nicotine use	1	2	3	4	5	NA
Alcohol use	1	2	3	4	5	NA
Exercise habits	1	2	3	4	5	
Eating habits	1	2	3	4	5	
Stress management	1	2	3	4	5	
Weight management	1	2	3	4	5	
Sleep habits	1	2	3	4	5	
Financial management	1	2	3	4	5	

Readiness to Change key:

1 = I don't have a concern, I'm doing well in this area.
2 = I've begun making a positive change in the area, but need to maintain.
3 = I'm ready to start and want more information (used for program planning by your employer).
4 = I would like to start, but concerns are holding me back.
5 = I have a problem but I am not ready to make a positive change.
NA = Not Applicable

12 Interest Survey

Identify wellness topics of interest to you (used for program planning by your employer).

Personal health coaching ❒	Back/neck health ❒	Blood pressure ❒
Stretching ❒	Fitness ❒	Cholesterol ❒
Financial wellness ❒	First aid/CPR ❒	Workplace programs/seminars ❒
Sleep health information❒	Men's health ❒	Nutrition ❒
Nicotine cessation ❒	Stress management ❒	Weight management❒
Women's health ❒	Emotional well-being program ❒	Employee Assistance Programs ❒

13 Primary Care Provider

Do you have a Primary Care Provider? No ❒ Yes ❒

Have you had an annual physical with your Primary Care Provider in the last 12 months? No ❒ Yes ❒

Do you share your health screening results with your Primary Care Provider? No ❒ Yes ❒

14 Perceived Health

In general, how would you rate your physical health? Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒

15 Self-Reported Health Measurements

Height: ☐☐ feet ☐☐ inches Weight: ☐☐☐ pounds

Thank you for completing the Health Assessment!

Primary Care Provider (PCP) Form - Biometric Screening

Wisconsin Laborers Health Fund is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance.

The following information is needed to meet the requirements of participation in the screening:

Date of Biometric Results: _____

Participant Information and Biometrics (to be completed by PCP)

Name	
Date of Birth	
Best Contact Number	
Height	
Weight	
Blood Pressure	
Inches around waist at belly button to nearest ¼"	
Participant uses nicotine products (Yes or No)	

Blood Tests (to be completed by PCP - <u>provide result for ALL tests listed</u>)

Total Cholesterol	
LDL Cholesterol	
HDL Cholesterol	
Chol/HDL Ratio	
Triglycerides	
Glucose	

PRIMARY CARE PROVIDER (PCP) - contact Healics, Inc. at the number listed below if you have any questions regarding the blood test requirements.

_____ _____

PCP Name (Printed) PCP Signature and Date

PARTICIPANT - mail this form <u>along with the</u> health assessment questionnaire to:

Healics, Inc., ATTN: HRA Processing Dept
8919 W. Heather Avenue
Milwaukee, WI 53224

OR fax to 414-375-1639

Contact Healics with questions at 414-375-1600 or 800-432-5427

Wellness Year 1 (July 1, 2019 – June 30, 2020)

Acceptable Ranges

- Body mass index (BMI) ≤ 27.5kg/m2
- Total cholesterol < 200mg/dL
- Blood pressure ≤ 140/90mmHg
- Non-fasting glucose ≤ 200mg/dL

If you fail the BMI target, you now have the option to substitute your body fat measurement instead. The following shows the normal recommended body fat percentages by gender. You must fall within the applicable range to satisfy the marker.

Males	**Females**
24.9	35.9

If you fail the Total Cholesterol target, you now have the option to substitute your Total Cholesterol: HDL ratio. The following shows the recommended Total Cholesterol: HDL Ratio by gender.

	Males	**Females**
Average Risk	5.0	4.4

*All telephonic coaching for this period **must begin no later than July 30, 2020**, as the coaching must be completed no later than September 30, 2020. It is your responsibility to plan your coaching sessions ahead of the completion date.*

WISCONSIN LABORERS' HEALTH FUND

What Do I Do After Reading My Health Report?

If you did not meet the Fund's acceptable biometric ranges you may participate in health coaching. If you participate and complete health coaching, you would be entitled to a one-time $100 Health Reimbursement Account (HRA) credit. The $100 credit will be posted to your HRA after the Health Fund receives confirmation that you have completed your coaching. (NOTE: the HRA credit does not apply to Early Retirees).

Your Healics Risk Level/Score is presented here with corresponding coaching sessions. Your individualized scorecard is based on national standards. We encourage you to speak with your Health Coach and decide how you would like to plan your health goals.

If you meet the acceptable biometric ranges, you are NOT required to do any coaching sessions.

Risk Level/Score	Coaching Sessions	Total Sessions
Minimal (86-100)	Report Consultation	1
Moderate (71-85)	Report Consultation +1	2
Medium (61-70)	Report Consultation +2	3
High (51-60)	Report Consultation +3	4
Extreme (50 or less)	Report Consultation +3	4

***Health coaching is available to all risk levels; maximum limit of four sessions.**

You should expect to receive a call from a CMS Health Coach within one month of receiving your health report. **If you have significant concerns regarding your health, or one month has passed and you have not heard from a Health Coach, please contact CMS at 262-563-6460.** All coaching sessions must begin no later than July 30, 2020.

Remember that health and wellness changes are behaviors that occur over time. To achieve the best overall results, take advantage of your health coaching. Not rushing through health and wellness has been shown to be a good recipe for success!

CMS CASE MANAGEMENT SPECIALISTS, INC.

Healics With you for life

BPA Benefit Plan Administration of Wisconsin, Inc.

WISCONSIN LABORERS' HEALTH FUND
PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

This Privacy Practices Notice is from the Wisconsin Laborers' Health Fund (referred to further on as the "Fund", "health plan", "we" or "our"). It is being sent on behalf of the Board of Trustees of the Fund (the "Board"), which is the sponsor of the Fund.

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to the Board whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to the Board for certain limited purposes. We may disclose your medical information to the Board to administer your group health plan if the Board explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Person:	Mark Traino
Telephone:	608-278-9500
Fax:	608-278-9505
Address:	2901 W. Beltline Highway, Suite 100 Madison, WI 53703

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal

duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2013 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Board of Trustees: We may disclose to the Board, as the sponsor of the Fund, whether you are enrolled or disenrolled in the Fund.

We may disclose summary health information to the Board to use to obtain premium bids for the health insurance coverage offered under the Fund in which you participate or to decide whether to modify, amend or terminate the Fund (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in the Fund to the Board to administer the Fund. Before we may do that, the Board must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see the Fund's plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations; to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically.If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agreed upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the beginning of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the beginning of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the beginning of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the beginning of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that

notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

State Law: As a condition of Plan participation, the Board requires that the privacy rights of you, your spouse and dependents be governed only by HIPAA and the laws of the State of Wisconsin (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974, as amended), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to Wisconsin's choice of law provisions.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

QB\22712727.1

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

Notice of Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Wisconsin Laborers' Health Fund's Medical Benefits, as required by the WHCRA of 1998, provide coverage in connection with a mastectomy.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Fund Office at 1-608-842-9101 or toll free at 1-800-397-3373.

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Patient Protection and Affordable Care Act
Grandfathered Health Plan

The Wisconsin Laborers' Health Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Wisconsin Laborers' Health Fund at 1-608-842-9101 or toll free at 1-800-397-3373.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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4633 LIUNA WAY, SUITE 201
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TOLL FREE: 800-397-3373

Notice of Nondiscrimination and Accessibility Services under Section 1557 of the Affordable Care Act

The Wisconsin Laborers Health Fund (the "Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund provides the following services free of charge to qualifying individuals:

- Aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Fund Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Wisconsin Top 15 Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-846-1742.
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-846-1742.
Cushite	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-608-846-1742.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-846-1742.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-846-1742.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-846-1742.
Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-846-1742.
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-608-846-1742.
Karen	ymol.ymo;= erh>uwdRAunD AusdmtCd<AerRM>Ausdmtw>rRpXRvXAwvXmbl.vXmphRAeDwrHRb.ohM. vDRIAud; 1-608-846-1742.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-846-1742.
Cambodian	ុរបយ័តៈ េបើសិនអ្កនិយ ាយ ែខ្មរ, េសវាជំនួ យេផ្នកភាសា េ ើយមិនគិតឈ ួល គឺមានសំប់បំេរីអ្កេ ើ ទូរស័ព 1-608-846-1742
Arabic	تنك تدحتت ركذا ةغلل، نإف تامدخ ةدعاسملا ةيوغلا رفاوتت كل ناجملاب. لصتا مقرب1742 - 846-608-1مقر ظوحلم: اذإ
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-846-1742.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-846-1742.번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-608-846-1742.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

July 2018

Dear Active Plan Participants:

As the Board of Trustees of the Wisconsin Laborers' Health Fund ("Fund" or "Plan"), we recognize how important it is for you to have a clear understanding of the Plan's provisions. This Summary of Material Modifications (SMM) provides details about new Plan rules regarding termination and reinstatement of employee eligibility and your Health Reimbursement Arrangement (HRA) account, which go into effect on August 1, 2018. Please read this SMM in its entirety and store it with your other important Plan documents.

Termination of Employee Eligibility

Effective August 1, 2018, your eligibility for Plan benefits can terminate on the last day of any month in which you are called to work but you refuse to, or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is **not** with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

Example:

Let's say you are called to work on August 1, 2018, and you refuse or you stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area, your eligibility for benefits will end on August 31, 2018.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Reinstatement of Employee Eligibility

Effective August 1, 2018, if your Plan eligibility ends because you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area,, you may again become eligible upon meeting the Plan's "Initial Employee Eligibility" requirements. This means that you can again become eligible for benefits on the first day of the first calendar month that follows any 12 consecutive calendar months in which you are credited with at least 600 hours of covered work.

Example:

Let's say your Plan eligibility ends on August 31, 2018, for either of the reasons described above. If the Fund receives more than 600 hours of contributions from your employer on your behalf between December 1, 2018 and November 30, 2019, you will be eligible for coverage on December 1, 2019.

If you are credited with at least 600 hours of covered work in less than 12 consecutive calendar months, you will become eligible for benefits again on the first day of the first calendar month that follows the date on which the 600 hours are credited to you.

Example:

Let's say your Plan eligibility ends on August 31, 2018, for either of the reasons described above. If the Fund receives more than 600 hours of contributions from your employer on your behalf between January 1, 2019 and July 31, 2019 (in less than 12 consecutive months), you will be eligible for coverage on August 1, 2019.

Health Reimbursement Arrangement (HRA)—Freezing and Forfeiture of the Account

As long as you are eligible for Plan coverage (including when you are eligible to continue coverage by making self-payments), the Fund maintains a Health Reimbursement Arrangement (HRA) account for you, through which you can receive reimbursement for eligible medical expenses that you and your dependents incur, which are not covered by the Plan.

Effective August 1, 2018, your HRA account will be frozen beginning on the first day of the first month following the date that you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and then you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is **not** with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Your frozen HRA account will be forfeited (in other words, closed and forever unavailable to you) as of the first day of the 12th month following the month you are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area If, however, prior to forfeiture, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, your account will not be forfeited. [**Note**: If your frozen account is not forfeited, it may be reinstated on the first day of the month following the month in which you satisfy the Plan's initial eligibility requirements.]

Example:

Let's say you are called to work on August 1, 2018, and you refuse or you stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working in the construction industry in a non-laborers trade, or in a laborers' trade or sub-trade in the restricted area, your HRA account will be frozen on September 1, 2018. If your HRA account remains frozen for 12 months, your account will be forfeited on August 1, 2019. If prior to forfeiture, let's say June 1, 2019, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, and you work consecutively each month from June 1, 2019 through May 31, 2020, and the Fund receives contributions from your employer for 600 hours on June 1, 2020, your account could be reinstated on July 1, 2020.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

If you have any questions regarding the Plan's eligibility provisions or your Plan benefits in general, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

December 2018

To All Active Employees and Dependents:

The health insurance marketplaces (previously referred to as "exchanges") were created as part of the Patient Protection and Affordable Care Act ("ACA" or "Health Care Reform"). The Fund previously provided a Notice which described how the marketplaces work and noted the eligibility potential for premium tax credits to help pay for coverage.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you also will learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

The Trustees feel that is it important to provide you with this Notice to give you additional information on the marketplaces and how your participation in the Plan impacts these new options. **Most importantly, the Trustees want to assure you that your eligibility for coverage under the Plan is not affected by the existence of such marketplaces. As long as you continue to meet the Plan's eligibility requirements, you will remain eligible for coverage under the Plan.**

Your eligibility for Plan coverage generally makes you ineligible for premium tax credits through the Marketplace. The coverage provided by the Plan is considered "affordable" and provides "minimum value" under the federal government's guidelines. Because the Plan's coverage is affordable to you and provides minimum value, you will not be eligible to receive any premium tax credits. However, if you must self-pay for coverage because you did not work enough hours for a full contribution on your behalf, the cost of coverage may not be "affordable" to you, and you may be eligible for premium tax credits if you choose to enroll in coverage through the Marketplace rather than self-pay.

You do not need to purchase coverage through the Marketplace if you are currently enrolled in the Plan. You will continue to receive Plan coverage for as long as you continue to meet the Plan's eligibility requirements.

(over)

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days, your special enrollment period will end, and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

The Trustees recognize that the ACA is complex and confusing. If you have any questions, or if you would like more information to understand the implications of this Notice or ACA generally, please contact the Fund Office.

Yours truly,

THE BOARD OF TRUSTEES

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WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
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VERY IMPORTANT NOTICE – INITIAL COBRA NOTIFICATION

On April 7, 1986, a Federal Law was enacted (Public Law 99-272, Title X) — The Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") — requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Wisconsin Laborers' Health Fund (the "Plan"). Both you and your spouse should take the time to read this notice carefully.

If you are an employee of a contributing employer and you are covered by the Plan, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose continuation coverage under the Plan for any of the following four reasons:

1. **The death of your spouse;**
2. **A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with a contributing employer;**
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

Dependent children of an employee covered under **the Plan have the right to choose continuation coverage if group health coverage is lost for any of the five following reasons:**

1. **The death of the employee-parent;**
2. **The termination of the employee-parent's employment (for reasons other than gross misconduct) or** a reduction in the employee-parent's hours of employment with a contributing employer;
3. Parent's divorce or legal separation;
4. The employee-parent becomes entitled to Medicare; or
5. The dependent ceases to be a "dependent child" under the **terms of the Plan.**

In addition, there may be a right to continuation coverage for certain eligible retirees and their spouses, surviving spouses, and dependent children if a Title 11 Bankruptcy proceeding is commenced with regard to a contributing employer. If this occurs, you should contact the Plan Administrator concerning your rights.

Effective as of January 1, 1997, the definition of "qualified beneficiary" for COBRA purposes also includes a child born to or **placed for adoption with a covered employee during the period of the employee's continuation coverage. Thus, once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or placement for adoption).**

Under the law, the employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event or **the date on which coverage would end under the Plan because of the event, whichever is later. Your employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement. When the Plan Administrator is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the (i)** date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect continuation coverage to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage, your group **health insurance coverage under the Plan will end.**

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months.

An 18-month period of continuation coverage may be extended for up to 11 months (for a total of up to 29 months of continuation coverage) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the employee's termination or reduction in hours and if the Plan Administrator is timely notified within 60 days of such determination (and within the initial 18-month continuation coverage period). Effective as of January 1, 1997, the 11-month extension also applies if a qualified beneficiary becomes disabled at any time within the first 60 days of the 18-month continuation coverage period, provided that the Plan Administrator is timely notified of the disability, as described above. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18- or 29-month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the initial qualifying event. You should notify the Plan Administrator immediately if a second qualifying event occurs during your continuation coverage period.

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

1. The Plan Sponsor no longer provides any group health coverage;
2. The premium for your continuation coverage is not timely paid (within the applicable grace period);
3. The individual becomes covered under another group health plan (as an employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but does not apply to the individual because he or she has been credited with at least 12 months of creditable health coverage, which ended no more than 62 days before coverage under the new plan began.
4. The individual becomes entitled to Medicare; or
   coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Plan Administrator within 30 days of any such final determination.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Plan reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

Under the law, you may be required to pay up to 102 percent of the applicable premium during the 18- or 36-month period of continuation coverage. However, during the additional 11 months of continuation coverage (for disability), you may be required to pay up to 150 percent of the applicable premium.

This notice is a summary of the law and is therefore general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about the law, please contact the Plan Administrator at 4633 LIUNA Way, Suite 201, DeForest, WI 53532, or by phone (608) 842-9101. Also, if you have changed marital status, or if either you or your spouse has changed addresses, please notify the Plan Administrator immediately.

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

IMPORTANT NOTICE TO PARTICIPANTS

August 2017

To All Employees and Dependents:

UPDATED BPA WEBSITE

Benefit Plan Administration of Wisconsin, Inc. (BPA) would like to introduce you to our website for accessing your benefits. You can access the website by going to www.wilbenefits.com

This website includes the following information related to the Health Fund:

- Enrollment Forms.
- Loss of Time Forms.
- Medical Checklist Form.
- Summary Plan Descriptions for Health, Pension, and HRA
- Participant Notices.
- Summary of Benefits and Coverage (SBC).

Be sure to take advantage of this helpful information readily available to you online. Additional information will be added periodically.

(over)

MemberXG

MemberXG is designed to improve member access to benefit information, including the convenience of access from your mobile device.

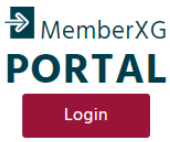
Navigation and user tools make the site easy for you to use. It also uses the latest in website best security practices so you can use it with confidence that your information is safe.

MemberXG contains the following information. Benefit information follows HIPAA regulations and will only display to the appropriate user. Only the member can see information for dependents under the age of 18.

- Dashboard – the landing page which contains navigation to other benefit pages.
- Demographics – displays demographics for a member and/or dependent(s).
- Eligibility – displays past and present eligibility for multiple benefits.
- Deductibles – displays the deductible maximums and the amounts applied to them.
- Health Claims – displays claims processed by the Plan.
- Work History – displays a member's work history for the last five years.

Here are the steps to follow to create your MemberXG account:

1. Go to the BPA website at: www.wilbenefits.com.
2. Click the MemberXG portal link to the right



3. On the initial MemberXG screen, click the Create Account box in the upper right corner of the initial MemberXG screen.
4. Enter the following information into the screen:
    - User Type - either Member or Dependent
    - Email Address
    - Confirm Email Address
    - First Name
    - Last Name
    - Last four digits of your Social Security number (SSN)
    - Date of Birth (MM/DD/YYYY format)
    - Zip Code/Postal Code

- Mobile Phone number (optional)

5. Click Next.
6. Enter a password, confirm the password, answer three Security Questions, and select the Terms of Use and Privacy Policy checkbox.
7. Click Finish. The account is created, and you are returned to the initial MemberXG screen. You also will receive an access code which will be sent to the email address that you entered when you created your MemberXG account. **Note: For security purposes, each time you log in from a new computer/device, you must enter a new access code**.
8. From the initial MemberXG screen, enter the email address you used to set up the MemberXG account and the password, and click Login.
9. Enter the access code you received in your email to access the Dashboard screen.

Write down your MemberXG login information to keep for future access to this site.

Please keep this Notice with your Summary Plan Description (SPD) for future reference. If you have any questions, please feel free to contact the Fund Office.

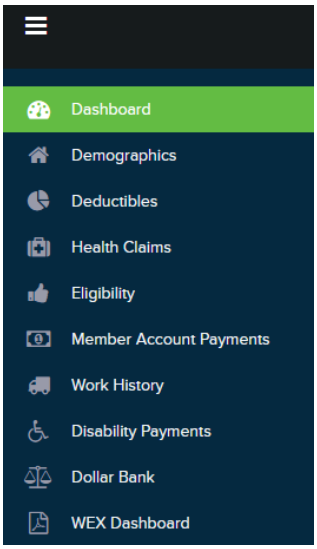
Sincerely,

The Wisconsin Laborers' Health and Pension Fund

Member Online Portal:

We have now made it even easier to view your hours, deductibles, claims, HRA balance etc. When you go to www.wilbenefits.com you can now click on the ***MemberXG Portal Login*** link and it will take you directly to the online website. If you have never signed up, you will need to Create an Account.

Once logged in, you can view a variety of benefits, including your HRA balance. You need to use the scroll arrows or the Menu Bar (3 dashes in upper left corner) to see your options.



Be sure to click on the WEX Dashboard Icon to view your HRA balance. Please also make sure you allow or disable your pop-ups as the WEX icon takes you to another website.

As always, if you have any questions, please call the Fund office at:

Claims.....608-842-9101

Eligibility 608-842-9102

Pension.....608-842-9103

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

December 2015

Health Reimbursement Arrangement Plan (HRA)

Dear Participant and Family:

Enclosed you will find the Wisconsin Laborers' Health Fund's HRA brochure that introduces this new benefit effective with services incurred January 1, 2016 and after. The HRA will help you pay for eligible healthcare expenses for yourself and your eligible dependents.

You may use your HRA for reimbursement of qualified out of pocket expenses such as your deductible, copay, and patient liability coinsurance. Your HRA may also be used for expenses such as self-pays and COBRA premiums. A full description of eligibility and how to use your HRA is included in the enclosed brochure.

You will receive a convenient debit card for your use. Instructions for using the debit card and how to submit paper claims are included in the brochure.

Please read the brochure carefully and share it with your family.

For More Information
If you have any questions about Fund-provided coverage, please call the Fund Office at (608) 842-9102 or toll-free at (800) 397-3373.

Please keep the HRA brochure with your Summary Plan Description (SPD) for easy reference. Receipt of this document does not constitute a determination of your eligibility.

Sincerely,

The Board of Trustees

This cover letter and the enclosed brochure, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

Statement of Grandfathered Status
The Wisconsin Laborers' Health Fund believes this Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding the protections that apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at (608) 846-1742 or toll-free at (800) 397-3373.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

TO ALL ACTIVE AND RETIRED PLAN PARTICIPANTS
WHO HAVE A BALANCE IN THEIR HEALTH REIMBURSEMENT ACCOUNT (HRA)

July 2018

Dear Participants:

The Board of Trustees of the Wisconsin Laborers' Health Fund (the "Fund" or "Plan") is pleased to offer a Health Reimbursement Account (HRA) and HRA debit card to eligible Plan participants. This Notice sets forth the mandatory requirements from the Internal Revenue Service regarding the use of your HRA debit card and the process which will apply beginning August 1, 2018.

When to Use Your HRA

You can use the funds in your HRA to pay for non-reimbursable healthcare expenses you and your eligible dependents incur while you are an active employee, and after you retire (if you are eligible for retiree coverage and have an HRA balance). Such eligible expenses include, but are not limited to, your deductible, copays and coinsurance, and certain healthcare expenses for medical, prescription drug, dental, hearing and vision care. Refer to the "*2019 Health Reimbursement Account (HRA) Brochure*" sent to you for complete details on what qualifies as an eligible expense. An eligible medical expense is further described in Section 213(d) of the Internal Revenue Code. The IRS document is available on the member portal or at www.IRS.gov

How to Use Your HRA Debit Card

To make it easy for you to access the funds in your HRA, you have been provided with a debit card that you can use at the point-of-service or point-of-sale to pay for eligible expenses out of your HRA as you incur them. Note that the debit card has been provided only as a way for you to pay for those expenses that are eligible under the HRA. The HRA debit card ***is not*** a credit card.

Note that the current, active debit card is blue in color. If you still have a red card, throw it out. If you need the newer blue card, contact the Fund Office.

You should maintain copies of receipts for any expenses incurred with the HRA debit card. Beginning August 1, 2018, you will be required to provide the Fund Office with a copy of your receipt for certain types of expenses. When applicable, the Fund Office will send a letter to you requesting that a copy of your receipt be sent to the Fund Office. The quickest and most convenient ways for you to send a copy of your receipt to the Fund Office are through the WEX link on the member portal at www.wilbenefits.com. You can upload your receipt on the member portal by selecting "I Want To" file a claim.

If the Fund Office does not receive a copy of the receipt within 30 days of the date of its letter, you will receive a second notice. If the Fund Office does not receive a copy of the receipt within 20 days of the date of the second notice, use of your debit card will be suspended until a copy of the requested receipt is received. Suspension of your debit card will end within 10 business days of the Fund Office's receipt of the needed document.

If the debit card purchase and receipt do not qualify as an eligible expense, you will need to reimburse the HRA fund. You will then have those monies available to you for a future qualified expense.

Claims and Reimbursement Procedures

If you do not use your debit card to pay for an eligible expense or if your debit card is not accepted (for example, if you use an unapproved vendor), you **must** submit a written claim form to the Fund Office within one year of the date you incurred the expense in order to receive reimbursement. Mail the completed form and any required documentation to the Fund Office at the address shown at the top of this Notice.

To limit administrative expenses, the Fund requires that requests for reimbursement be for a minimum of $100. If you do submit claims for less than $100, the Fund will hold them until the total reimbursement reaches a minimum of $100.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

For more information about how your HRA works, refer to the "*2019 Health Reimbursement Account (HRA) Brochure*." Also, please file this Notice with your copy of the HRA brochure for easy reference.

If you have any questions about your HRA, please contact the Fund Office at the address and telephone number shown at the top of this Notice.

Sincerely,

Board of Trustees

LiUNA!

WISCONSIN LABORERS DISTRICT COUNCIL

Feel the Power

WISCONSIN LABORERS' HEALTH FUND

Health Reimbursement Arrangement (HRA) Brochure

2019

BOARD OF TRUSTEES

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Fund Office
HRA Claims Administrator

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510
Telephone: 608-846-1742 or 800-397-3373
Email: **wlhra@bpalja.com**

Administrative Manager

Benefit Plan Administration of WI, Inc.

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510
608-846-1742 or 800-397-3373
Email: **wlhra@bpalja.com**

Dear Participant:

The Board of Trustees of the Wisconsin Laborers' Health Fund is pleased to provide our participants with comprehensive healthcare coverage. Realizing that no two participants are alike, the Fund provides a Health Reimbursement Arrangement (HRA), which gives you the flexibility to use the Plan in the way that best meets your—and your family's—needs.

The Plan's HRA is designed to provide reimbursement of certain healthcare expenses on a tax-free basis. You can use it to pay for non-reimbursable healthcare expenses you and your dependents incur while you are an active employee and after you retire (if you are eligible for retiree coverage) to help offset your out-of-pocket healthcare costs. This booklet explains how the HRA works for you.

We encourage you to read this brochure carefully to help you understand how your HRA works and how it can benefit you.

If you have any questions about your HRA benefit, please feel free to contact us at 608-846-1742 or 800-397-3373. You can also email us at **wlhra@bpalja.com**.

Sincerely,
Board of Trustees

CONTENTS

HRA HIGHLIGHTS

If you are enrolled in other group health plan coverage and the coverage does not provide minimum value, or if you fail to provide proof of other coverage, your reimbursements will be limited. If you are enrolled in coverage other than the Wisconsin Laborers' Health Fund, and have questions about what items can be reimbursed, please contact the Fund Office at 608-846-1742 or 800-397-3373.

The more you work, the more contributions are made to your HRA account and the more your HRA account grows, tax-free.

Plus, money in your HRA account and amounts reimbursed for eligible expenses are not included in your income, which means you aren't taxed on this money.

How the Fund's Health Reimbursement Arrangement (HRA) works:

- You are eligible for the HRA if you work for an employer that contributes to the Health Fund on your behalf and you are enrolled in coverage through the Health Fund or through other group health plan coverage. If you are enrolled in other group health plan coverage through your spouse or domestic partner, that coverage must provide minimum value and you must provide proof of coverage.
- When you are initially eligible for Plan coverage and employer contributions are received on your behalf, an HRA account is established in your name.
- For each hour of contributions made on your behalf on and after June 1, 2015, a portion of the hourly contribution rate is credited to your HRA account.
- You determine how you want to use the money in your HRA account. You can use it as you incur eligible healthcare expenses or save up and use it in the future.
- A debit card is sent to you that you can use to pay your eligible out-of-pocket expenses as you incur them or you can claim reimbursement for other items such as coinsurance.

Money in your HRA account may be used to pay for eligible healthcare expenses as defined in Section 213(d) of the Internal Revenue Code (refer to page 7). The IRS document is available on the member portal or at **www.IRS.gov.**

A wide range of expenses are eligible for reimbursement if you are enrolled in coverage through the Health Fund, including:

- Payments for coverage, including: self-payment contributions to continue coverage under the Plan when you are not working enough hours, COBRA continuation coverage self-payments, retiree coverage self-payments; and
- Other out-of-pocket costs like deductibles, copayments and coinsurance.

You can also use the funds in your HRA account to pay for non-reimbursable healthcare expenses you and your eligible dependents incur while you are an active employee, and after you retire (if you are eligible for retiree coverage and have an HRA account balance).

HRA ELIGIBILITY

You are eligible for the HRA if you work for an employer that contributes to the Health Fund on your behalf and you are enrolled in coverage through the Health Fund or other group health plan through your spouse or domestic partner. If you are enrolled in other group health plan coverage, it must provide minimum value and you must provide the Fund Office with proof of such coverage. Alternatively, if you enroll in other group health plan coverage and that coverage does not provide minimum value, then reimbursements under the HRA Plan benefit will be limited. Those reimbursements include the reimbursement of copayments, coinsurance, deductibles and premiums for the other group health plan coverage, to the extent such premiums are paid on an after-tax basis, as well as medical care as defined under Internal Revenue Code Section 213(d) that does not constitute an essential health benefit.

Once you are eligible for coverage under the Health Fund, HRA contributions are credited to an HRA account established in your name and you can begin to access your HRA account balance. Only HRA contributions earned during the 12-month eligibility period are credited to your HRA account.

You are eligible for reimbursement of covered expenses incurred by you and any of your eligible dependents whom you can claim as a dependent on your tax return.

If you become ineligible or are never eligible for coverage under the Health Fund, your HRA contributions will be frozen and possibly forfeited.

While contributions are only made on your behalf while you are working for a contributing employer in a bargaining unit position or through a participation agreement, you do not have to be an active participant to use your HRA account. Your HRA account balance is available as long as you have money in your HRA account and are eligible for active or retiree health coverage, provided you have not waived coverage under the HRA. In addition, your HRA account balance is available to your surviving spouse and/or eligible dependents for reimbursement in the event of your death.

Continued Eligibility

Your eligibility for HRA contributions is based on your continued eligibility for the Health Fund. Once you are eligible, your eligibility will continue as described in the *Eligibility* section of your SPD (Summary Plan Description), provided the required contributions are made on your behalf. You will continue to receive HRA contributions as long as you are actively working. Once you retire or terminate employment, no contributions are made into your HRA account.

Refer to information in the *Life Events* section of this brochure regarding what occurs if you refuse to work or stop working.

When Eligibility Ends

Your eligibility to use your HRA account ends on the earliest date of the following occurrences:

The Trustees reserve the right to discontinue contributions to your HRA at any time.

- The date you waive coverage under the HRA; or
- The date your balance in your HRA account equals $0; or
- The date you are no longer eligible for the Health Fund.

In addition, your HRA funds may also be frozen if you refuse to work or stop working, as described in the *Life Events* section of this brochure.

After Eligibility Ends

You should file a claim for reimbursement online or with the Fund Office as soon as possible. If your claim is not filed within one year of the date of the expense, your claim will be denied.

After you are no longer eligible for the Health Fund, you may continue to submit eligible expenses for reimbursement from your HRA account for expenses you incurred while eligible, unless your account is frozen. However, contributions into your HRA account will stop.

If you lose eligibility due to a lack of hours, and then become eligible again, the contributions for some portion of the hours you worked during the period of ineligibility will be deposited into your HRA once you regain eligibility for Health Fund coverage. If you re-establish eligibility prior to a two-year break, then any HRA credits that you earned during the ineligibility period will be credited to your HRA account balance. If your break is longer than two years, then only those HRA contributions you earned in the two-year period immediately prior to your re-established eligibility date will be credited to your HRA account balance.

Opting Out of HRA Coverage

Annually on January 1, you are allowed to permanently opt out of HRA coverage and waive future reimbursements from your HRA account.

For instance, you may wish to opt if you cannot have access to an HRA because you are receiving a subsidy for the premiums of an individual insurance plan purchased from a state or federal Health Insurance Marketplace.

If you opt out, you will not receive any contributions toward your HRA account and the balance in your HRA account will be frozen. Note that when your account is frozen, it may be reinstated (refer to the *Life Events* section).

If you terminate employment, you may elect to forfeit your HRA account balance at any time, unless an opt-out was elected in which case, your HRA account will be frozen.

YOUR HRA ACCOUNT

Establishing the Account

When you are initially eligible for the Health Fund and employer contributions are received on your behalf, an HRA account is established in your name and a portion of the employer contributions made on your behalf is credited to that account.

The Plan establishes and maintains an HRA account for each eligible participant to track contributions, reimbursements and available balances.

The more you work for a contributing employer, the more contributions are made to your HRA, which means your HRA continues to grow.

Contributions

Your HRA account is funded ***exclusively*** through contributions made by your employer on your behalf in accordance with the collective bargaining agreement applicable to you. All contributions credited to your HRA account are assets of the Health Fund; you are not vested in contributions made on your behalf and you may use your HRA account only for the purposes stated in the governing Plan document.

The HRA account will be funded at an hourly rate determined by the Trustees. Only amounts contributed above the Health Fund rate set by the Board of Trustees will be credited to your HRA account.

If you work under a reciprocity agreement, reciprocal contributions will first be allocated to your HRA account and then the balance will be applied toward the monthly cost to maintain Health Fund coverage. If your HRA account balance falls under the amount needed to maintain eligibility, you will need to pay the amount necessary to maintain coverage under this Plan.

If money remains in your HRA at the end of a year, it rolls over into the next year, allowing you to save for future healthcare expenses.

Your HRA Account Balance

Your HRA account balance is the total of employer contributions made on your behalf to the HRA account minus any reimbursements you receive from your HRA account.

The amount available for reimbursement of eligible expenses is the amount credited to your HRA account, less prior reimbursements and any administrative fees. Contributions made on your behalf will be credited to your HRA account within 30 days of receipt by the Health Fund. Therefore, there may be a lag between the time contributions are required on your behalf and when they are available for you to use.

If you lose your HRA debit card, you will have to pay an administrative charge of $10 for the cost of sending you a new one. This amount will be deducted from your HRA balance.

Tax Status

Contributions credited to your HRA account are not taxable income when made and generally are not taxable when paid out as eligible benefits. However, certain actions may cause your HRA account to be taxable. For instance:

- You receive reimbursement from your HRA account for contributions for health coverage that are paid or could have been paid pre-tax from an IRC Section 125 plan;
- Reimbursements are made for individuals that are not "dependents," as defined under IRC Section 152; and
- Your dependents may still receive reimbursements from the HRA account balance for eligible expenses in the event of your death.

Contact your tax expert to ensure that expenses reimbursed from your HRA are non-taxable under the Internal Revenue Code (IRC).

If you submit an expense for reimbursement under the Plan's HRA, you cannot deduct that expense on your tax return.

If You Do Not Work Enough Hours

When you, your spouse, and/or your dependents are eligible for COBRA continuation coverage, your HRA balance may be used for self-payments to continue this coverage.

If you do not work enough hours to continue eligibility for the Health Fund, you may use your HRA to make self-payments to continue your coverage (if eligible). You must contact the Fund Office and complete any necessary paperwork to use your HRA balance towards any required self-payment amounts, including COBRA continuation coverage. You do not receive employer contributions to your HRA for hours for which you are making self-payments; however, you will receive contributions for hours you work.

If You Refuse or Stop Working

If you refuse to work or stop working, your HRA account will be frozen beginning on the first day of the first month following the date that you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions and then you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is not with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Your frozen HRA account will be forfeited (in other words, closed and forever unavailable to you) as of the first day of the 12th month following the month you are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area. If, however, prior to forfeiture, you return to work for an employer that is required to make contributions to the Health Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, your account will not be forfeited. **(Note: If your frozen account is not forfeited, it may be reinstated on the first day of the month following the month in which you satisfy the Plan's initial eligibility requirements.)**

EXAMPLE:

John was called to work on August 1, 2018 but refused to work or stopped working under a collective bargaining agreement with the District Council or its affiliated Local Unions. He subsequently started working in the construction industry in a non-laborers trade, or in a laborers' trade or sub-trade in the restricted area, so his HRA account was frozen on September 1, 2018.

If John's HRA account remains frozen for 12 months, his account will be forfeited on August 1, 2019. But, if John returns to work prior to the forfeiture, let's say on June 1, 2019, and he works consecutively 600 hours between June 1, 2019 through May 31, 2020, and the Fund receives contributions from his employer for 600 hours on June 1, 2020, John's account could be reinstated when the eligibility requirements are met.

When You Retire

In order to receive retiree benefits through the Health Fund, you must be eligible for retiree coverage and make self-payments for that coverage.

While contributions are only made to your HRA account while you are an active employee, you can use your HRA account for reimbursement of expenses in retirement. When you retire, your HRA account balance is carried forward until no balance remains or until you are no longer eligible for coverage under the Health Fund.

You may use the balance in your HRA towards your self-payments for retiree coverage. In addition, you may also use your HRA account to pay for any eligible expenses you incur during retirement.

No contributions are put into your HRA account once you retire, unless you return to work for which contributions are required to be made on your behalf. If you enroll for Medicare Part D (prescription drug coverage), you will not be eligible for prescription drug reimbursements from your HRA account.

In the Event of Your Death

Your HRA will continue to be available to provide reimbursement for your surviving dependents' eligible expenses in the event of your death. In other words, your HRA account balance is available to your surviving spouse and/or eligible dependents after your death. Your spouse and/or dependents may use your HRA account to pay for eligible expenses (including expenses you incurred before your death) or to make self-payments to continue coverage until the earliest of when your HRA account balance is zero or the Plan ends. However, in no event will amounts be paid in cash to any person for other than reimbursement of an eligible expense (for example, there are no lump sum distributions of the HRA account balance as a death benefit).

If you have no surviving spouse and/or other eligible dependents at the time of your death, any balance in your HRA will be forfeited and become a part of the Plan's general assets.

While your surviving spouse and/or dependents may continue to use your HRA account, no further employer contributions will be made to the HRA account.

If You Take an FMLA or USERRA Leave of Absence

If you take a leave of absence that qualifies under the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), the HRA account will be treated as if you were still an active employee. You must notify the Fund of your leave. However, if your leave is not subject to FMLA or USERRA, such leave will be treated as a termination of participation.

WHAT IS OR IS NOT AN ELIGIBLE EXPENSE

Expenses Eligible for Reimbursement

You determine how you want to use the money in your HRA account. As you, your spouse and/or your covered dependents incur eligible healthcare expenses, you can use the money in your HRA account to pay for those expenses. You can also save up and use the money in your HRA account in the future.

Examples of eligible expenses, as defined by the Plan include:

- Coverage costs, including self-payment contributions or premiums:
  - To continue Health Fund coverage when you are not working enough hours;
  - For COBRA continuation coverage;
  - For retiree coverage, if eligible; and
  - Amounts you and your spouse pay for group health coverage through your spouse's employer only if the premiums are paid on an after-tax basis and could not have been paid under an IRC Section 125 Plan. Please contact the Fund Office for additional information.
- Healthcare expenses, including:
  - Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance; and
  - Expenses not covered, or only partially covered, under the Plan, such as expenses that exceed benefit maximums.

Healthcare expenses may include medical, prescription drug, dental, hearing and vision expenses.

In general, expenses eligible for reimbursement only include those that:

- Are incurred while you are eligible for coverage under the Plan's HRA;
- You, your spouse, and/or your eligible dependents are required to pay;
- Are not reimbursed by insurance or any other source; and
- You, your spouse, and/or your dependents have not taken (or will not take) as a tax deduction.

An eligible medical expense is defined as an expense paid for care as described in Section 105 and Section 213(d) of the Internal Revenue Code.

Again, if you are enrolled in other group health plan coverage and the coverage does not provide minimum value, or if you fail to provide proof of other coverage, your reimbursements will be limited. If you are enrolled in coverage other than the Wisconsin Laborers' Health Fund, and have questions about what items can be reimbursed, please contact the Fund Office.

Please note that federal and state tax regulations are subject to change. **The above eligible expenses are only examples; it is not a complete list and does not include the provisions relating to each individual expense.**

Expenses Not Eligible for Reimbursement

Expenses not eligible for reimbursement from the HRA account include any item that does not constitute "medical care" as defined in Internal Revenue Code Section 105 or Section 213(d), such as:

- Individual health insurance premiums for active participants.
- Funeral and burial expenses.
- Health club or fitness program dues or equipment for general well-being, paid to improve your general health or to relieve physical or mental discomfort even if the program is necessary to alleviate a specific medical condition, such as obesity, unless you have a physician's letter stating a specific diagnosis and prescribing the membership or equipment.

- Personal use items such as cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements taken to maintain your own good health.
- Uniforms and special clothing, such as maternity clothing.
- Over-the-counter medications and other medical supplies without a prescription (except insulin).
- Long-term care services.
- Cosmetic or Reconstructive Surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic or Reconstructive Surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Sickness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Household and domestic help (even though recommended by a qualified physician due to a participant's or dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a child with discipline issues to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Premiums paid through salary reduction contributions under the terms of a Code Section 125 plan.
- Premiums for individual market coverage or insurance plans purchased from a state or federal Health Insurance Marketplace. Individual Medicare Supplement, Medicare Prescription Drug Plan, or Medicare Advantage policies are also not reimbursable; however, Medicare Part B, Medicare Part D and Medicare supplemental plan premiums (for those not enrolled in Fund coverage) are reimbursable for terminated employees, including retired employees or dependents of deceased employees who are spending down the HRA account balance.
- Prescriptions for retirees who have enrolled in a Medicare Part D plan.
- Any expense reimbursed or reimbursable from another source.

For more information, refer to IRS Publication 502 titled, "Medical and Dental Expenses." Go to **https://www.irs.gov/forms-pubs/about-publication-502**.

YOUR DEBIT CARD

How to Use Your HRA Debit Card

The HRA debit card is not a credit card.

To make it easy for you to access the funds in your HRA account, you are provided with a debit card that you can use at the point-of-service or point-of-sale to pay for eligible expenses out of your HRA account as you incur them. Note that the debit card is only being provided as a way for you to pay for those expenses that are eligible under the HRA.

You may use the debit card at the point of service or point of sale for eligible medical expenses at medical care providers or at approved merchants who provide health-related services and products and who accept the Plan's card. For example, you may use the card for medical office visit copayments, deductibles and coinsurance or for prescription drugs.

Check your debit card balance at any time by logging onto **www.bpalja.com**.

You should retain copies of receipts for any expenses incurred with the HRA debit card. You are required to provide the Fund Office with a copy of your receipt for certain types of expenses. When applicable, the Fund Office will send a letter to you requesting that a copy of your receipt be sent to the Fund Office.

Send a copy of your receipt to the Fund Office through the WEX link on the member portal at **www.bpalja.com**.

You can upload your receipt on the member portal by selecting "Dashboard" and then "I Want To" file a claim.

If the Fund Office does not receive a copy of the receipt within 30 days of the date of its letter, you will receive a second notice. If the Fund Office does not receive a copy of the receipt following the second notice, use of your debit card will be suspended until a copy of the requested receipt is received. Suspension of your debit card will end within 10 business days of the Fund Office's receipt of the needed document. If the receipt is not received, the expense may be reported as taxable income.

If the debit card purchase and receipt do not qualify as an eligible expense, you will need to reimburse the HRA account. You will then have those monies available to you for a future qualified expense. If the monies are not reimbursed, the expense may be reported as taxable income.

Debit Card Misuse

Refer to the next section for more information on claims and reimbursement procedures.

You must only use the card to pay for Medical Expenses as defined in section 213(d) of the Internal Revenue Code. In addition, you must not seek reimbursement under any other source (such as a health savings account or individual insurance plan) for any expense paid for with the card and you must retain sufficient documentation (including invoices and receipts) for any expenses paid with the card. The Plan will automatically deactivate your card when you become ineligible for the Plan (for active employees) and when you opt out of the HRA.

If the Plan seeks to verify a purchase and you do not respond to the request for additional information or if the Plan determines there is an improper payment, the Plan must follow certain correction procedures under IRS rules. For instance, the Plan may deactivate your card until you submit the requested documentation or repay the improper amount. In addition, the amount may be deducted from your other claim reimbursements or the amount may be treated as a bad debt. The amount may also be reported as taxable income.

CLAIMS AND REIMBURSEMENT PROCEDURES

An eligible expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, charged for, or pays for the medical care. Expenses incurred before an employee, retired employee or eligible dependent first becomes covered by the HRA are not eligible for reimbursement from the HRA account. This section explains the Plan's claims and reimbursement procedures.

When to Submit a Claim

If you do not use your debit card at the time of service to pay for expenses or your debit card is not accepted (for example, if you used an unapproved vendor), you must submit a written claim form to the Fund Office to receive a reimbursement check. Checks that are not cashed for 12 months after the end of the calendar year in which the expense was incurred will be forfeited to the Fund. Checks for approved claims will be sent within 30 days of the receipt of the claim.

Written claim forms for reimbursement of any eligible expense must be submitted to the Fund Office within one year of the date you incurred the expense in order for you to receive reimbursement.

While requests for reimbursement can be made at any time, to limit administrative expenses, the Plan requires that requests for reimbursement be for a minimum of $100. Therefore, you generally have to hold your requests for reimbursement until you have at least $100 in eligible expenses. If you do submit claims for less than $100, the Fund will hold them until the total reimbursement reaches a minimum of $100. In addition, the amount reimbursed for any eligible expense will not exceed your HRA account balance at the time reimbursement is requested. In the event your Plan coverage ends, you may submit eligible expenses totaling less than $100 to close out your HRA account.

Reimbursement is paid directly to you; you are responsible for paying any providers. To limit administrative expenses, the Plan requires that requests for reimbursement be for a minimum of $100. Hold your requests for reimbursement until you have a total of at least $100 in eligible expenses.

All expenses must be incurred prior to being considered for reimbursement except for certain advance payments for orthodontia services.

How to Submit a Claim

Reimbursement requests must be accompanied by a properly completed form, which can be obtained on the online Consumer Portal or from the Fund Office. The form will include a statement that you must sign verifying that the eligible expenses:

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source;
- For premiums paid for other coverage have not been paid or are not eligible for payment on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with the form, you must provide any of the following, as applicable:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge;
- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment;
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 plan;
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs); and
- Any additional documentation requested by the Plan.

If you need an HRA reimbursement form, please contact the Fund Office or download the form by logging onto **www.bpalja.com**.

It's a good idea to make a copy for your records of all materials you submit.

Materials you submit will not be returned to you. You may also submit claims directly through the online link.

Again, if you, your spouse, and/or your dependents are eligible for other coverage, you must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB(s), will be considered eligible for reimbursement. In completing the claim, you will need to provide the following information:

- The person or persons who incurred the medical care expenses;
- The date and nature of the incurred expense;
- The amount of the requested reimbursement; and
- A statement that these expenses have not been reimbursed and are not reimbursable through any other source including a Health Flexible Spending Account (FSA). If you have a FSA, such as through a spouse's employer, you must have expenses paid through the FSA first, before you request a reimbursement through the HRA account.

Where to File a Claim

You must file a claim for reimbursement with the Plan within one year of the date of the expense or your claim will be denied.

The quickest and most convenient way to file a claim is through the online Consumer Portal located at **www.bpalja.com**. However, you can mail a completed form and any required documentation to:

Wisconsin Laborers' Health Fund
4633 LIUNA Way, Suite 201
DeForest, Wisconsin 53532-2510

Claim Decisions

A request for reimbursement of an eligible expense is considered a claim. Claim decisions are subject to the Plan's claims procedures for healthcare claims listed in your SPD. If your request for reimbursement is denied, you may appeal the decision. Review the *Claim Filing and Appeal Information* section of your Summary Plan Description (SPD) document for more information on how to appeal a denied claim.

Coordination of Benefits

Reimbursements available under the HRA account are intended to be solely for eligible expenses not previously reimbursed or reimbursable elsewhere. To the extent an eligible expense is payable or reimbursable from another source, that other source must pay or reimburse before reimbursement from the HRA account. If there is any question as to what source should pay benefits first, please refer to the *Coordination of Benefits* section of your SPD for specific information on the Plan's coordination of benefits provisions.

If you, your spouse, and/or your dependents have other coverage, you must first submit any claim for reimbursement of eligible healthcare expenses to the other plan before submitting it for reimbursement from your HRA account. Any portion of your eligible expenses that is not reimbursed after submission to the other plan can be submitted for reimbursement from the HRA account.

If eligible healthcare expenses are covered by both the HRA Plan and by a Health FSA, then the HRA Plan is not available for reimbursement of such medical care expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Tax Consequences

The Plan makes no guarantee that any amounts reimbursed to you, your spouse, or your dependents under the HRA will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA are excludable, and to notify the Plan if you have any reason to believe that such payment is not excludable. If payments made to you are not excludable, you may be liable for any harm your action causes to the Plan.

The Plan may be disqualified if reimbursement under the HRA is made on a tax-free basis when the payment does not qualify for tax-free treatment under the Internal Revenue Code. In this situation, you will be required to indemnify and reimburse the Plan for any liability incurred for failure to withhold federal income taxes, Social Security taxes, or other taxes.

A FINAL NOTE

The HRA was created to help you to use the Health Fund in the way that best meets your needs. This brochure is a summary of the Health Fund's HRA as of January 1, 2019, and is intended to serve as an addition to your Summary Plan Description (SPD)/Plan Document; however, it is not meant to interpret or change provisions of the SPD/Plan Document. Your SPD/Plan Document describe the Plan's eligibility requirements, benefits and related terms and conditions of the Plan in more detail. Please keep this brochure with your SPD/Plan Document. If you have any questions, please contact the Fund Office.

The HRA is a part of the Health Fund and as such is subject to the Plan's provisions relating to all applicable provisions as listed in the Plan's SPD/Plan Document. Benefits will be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other laws applicable to group health plan to the extent required by such laws.

The HRA is intended to qualify as a medical reimbursement plan under §105 and §106 of the Internal Revenue Code of 1986, as amended, and related regulations, and as a health reimbursement arrangement, as defined under IRS Notice 2002-45. Eligible HRA Expenses reimbursed under the HRA are intended to be eligible for exclusion from your gross income under §105(b) of the Internal Revenue Code of 1986, as amended.

The Plan will establish and maintain a Health Reimbursement Arrangement with respect to each eligible participant but will not create a separate fund or otherwise segregate assets for this purpose. These Health Reimbursement Arrangement accounts are recordkeeping accounts with the purpose of keeping track of contributions and available reimbursement amounts.

In the event of any inconsistencies between this brochure and actual HRA Plan Document provisions, the terms of the Plan Document will govern. The Board of Trustees reserves the right to amend, modify, or terminate the HRA Plan at any time.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the healthcare reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at 608-846-1742 or 800-397-3373. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or via **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

LiUNA!

WISCONSIN LABORERS DISTRICT COUNCIL

Feel the Power

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

January 2016

Dear Participant & Family:

As Trustees of the Wisconsin Laborers' Health Fund, we are pleased to announce some changes to the Plan, Anthem has expanded its network of providers and has added identity protection services and dental coverage has been expanded for dental services related to cancer. This letter provides details of these changes.

Anthem Changes Effective January 1

Anthem Network Expands

Anthem Blue Cross Blue Shield has contracted with Dean Health System, St. Mary's Madison Hospital, St. Mary's Janesville Hospital, and St. Clare Hospital effective January 1, 2016. This means that the Health Fund will now only have one network in Wisconsin, Anthem Blue Preferred Plus POS. The Anthem networks associated with this Plan are listed below with their contact information. There are no changes to benefits.

PPO Providers		
In Wisconsin	Anthem Blue Preferred Plus POS	800-810-2583 www.anthem.com
Outside Wisconsin	Anthem National BlueCard PPO	800-810-2583 www.anthem.com

Anthem Identity Protection Services Added

Anthem Blue Cross Blue Shield identity protection services are included for free with your medical coverage. Coverage is automatic as long as you are eligible for coverage under the Fund; however, you must enroll for monitoring. Identity protection services are provided through AllClear. If you would like to enroll for credit monitoring, identity theft monitoring, identity repair, identity theft insurance, or *ChildScan* for minors, call AllClear at 1-855-227-9830. Enclosed is an overview of Anthem Identity Protection Services.

Expanded Dental Services Effective April 1, 2015

We have expanded coverage for dental services related to cancer to include the following services as long as the service is Medically Necessary:

- Any dental services, including dental surgery, provided by a Physician or Surgeon that are for the treatment of cancer or as a result of related cancer treatment (without the 24-month limit) will be covered at the coinsurance for Comprehensive Major Medical Benefits.
- For Standard Plan participants: If the service is performed by a Dentist in the Delta Dental network, the Plan's coinsurance will be 75%; if performed by an out-of-network dentist, the out-of network coinsurance rate of 60% will apply. The Bare Bones Plan does not provide dental coverage. Dental coverage for retirees is optional.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Please keep this announcement with your Summary Plan Description benefit booklet. If you have any questions about these changes, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

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Anthem BlueCross BlueShield

Identity Protection Services

Overview

Why are identity protection services being provided?
We believe your personal information should stay that way—personal. That's why we're taking industry-leading steps to help you keep your information safe. Identity protection is now available with our eligible health plans beginning January 1, 2016 and for as long as you have active medical coverage with us.

Why AllClear ID?
AllClear ID is a leader in customer security and identity protection. They give you easy access to identity protection services.

Is it safe to share my information with AllClear ID?
AllClear ID takes lots of steps to keep your information safe. All information you provide – including passwords and PINs – is stored securely.

Will AllClear ID sell or share my personal information with third parties?
No. AllClear ID takes your privacy very seriously. They do not sell, rent, or share your personal information with any third party for marketing purposes. Please see their Privacy Policy to learn more https://allclearid.com/legal/privacy-policy.

Eligibility

Who's eligible for these new services?
Subscribers (the person who holds the eligible medical health plan policy) and dependents on their policy are eligible for identity protection services. As long as you have active medical coverage with us as of January 1, 2016, you'll be eligible for identity protection services.

Who's not eligible for these new services?
Members in Federal programs, such as Medicare, are not currently eligible; if this changes we'll let you know. Individuals who only have specialty products, such as dental insurance, or non-health products are not eligible.

What services are being offered to protect my child's identity?
Any eligible member under the age of 18 on your active medical health plan is covered by *AllClear Identity Repair* services (no enrollment required) and *AllClear ID ChildScan* (if you enroll them in this coverage). *AllClear ID Child Scan* is only available to children under the age of 18 because adult credit monitoring services are not available to minors. *AllClear ID ChildScan* actively scans databases to see if your child's Social Security number is being used illegally. If fraud is found, an investigator will help to repair your child's identity.

Who will receive the notification about these services?
Only the subscriber (the person who holds the eligible medical health plan policy) will receive the notice. Children and adult dependents will not. However, all members are eligible for identity protection services as long as they have an active medical health policy.

AllClear ID services

Identity Repair Services

What is AllClear Identity Repair?
AllClear Identity Repair provides identity repair assistance to help fix identity theft issues and return your information to its proper condition. If there's a potential problem with your credit or you're concerned about identity theft, just contact AllClear ID at any point while you're an active health plan member at 1-855-227-9830. The investigator will help you determine if there is a problem and help you recover financial losses, restore your credit, and make sure your identity is returned to its proper condition.

Do I need to do anything to sign up for AllClear Identity Repair?
No, *AllClear Identity Repair* is automatically available with no enrollment required. Simply call AllClear ID at 1-855-227-9830 at any point while you're an active medical health plan member if you need help.

Credit and Identity Theft Monitoring Services

What are AllClear Credit and Identity Theft monitoring?
This service includes credit monitoring, identity theft monitoring, identity repair, identity theft insurance, and *ChildScan* for minors.

How does AllClear ID Credit Monitoring work?
AllClear Credit Monitoring looks at your credit activity and sends alerts when banks and creditors use your identity to open new accounts.

How does AllClear Identity Theft Monitoring work?
AllClear Identity Theft Monitoring alerts you if personal information is reported to AllClear ID by industry security professionals such as the FBI. This can include Social Security numbers, credit card numbers, PIN numbers, bank account logins, and other online logins (emails & passwords). You'll be alerted when your information is reported and an investigator can look into the situation.

Do I need to do anything to sign up for AllClear Credit and Identity Theft monitoring?
Yes. You must enroll in order to take advantage of any of these services. If you're interested in signing up, go to anthemcares.allclearid.com. Once you reach the secure site you'll be asked for your name and e-mail address. Next, you'll get an email with a redemption code and instructions on creating an online account. When enrolling, you'll need to provide your name, contact information, Social Security number and the unique redemption code. You can also sign up by calling 1-855-227-9830, Monday – Saturday from 8:00 AM to 8:00 PM CST.

What is the identity theft insurance policy and how does it work?
Identity theft insurance is a zero-deductible policy included in the *AllClear Credit and Identity Theft Monitoring* service. It will reimburse you for certain fees, lost wages, and fraud losses in the event of fraud. The full policy terms can be found here: https://allclearid.com/legal/insurance.

Will I be billed for this service?
There is no separate charge for these services described above. Identity protection is now available with our eligible health plans beginning January 1, 2016 and for as long as you have active medical coverage with us.

Will AllClear ID bill me for these services?
No, unless you specifically ask them to. AllClear ID purposely does not collect a method of payment when you enroll in this service, and therefore cannot automatically bill you. If you enroll in the *AllClear Credit and Identity Theft monitoring*, you'll receive an email at the end of the coverage period letting you know coverage is expiring. These notices will include two options:

1) An option to renew coverage if you still have active medical coverage with us; and
2) An option to continue the services, at a discounted rate, if you no longer have active medical coverage with us, but want to continue the services with AllClear ID. A form of payment will be requested only if you elect to continue the services at your own expense.

Information about enrolling

May I use my email address to enroll a family member?
Every adult must have a unique email address to enroll. That's because your email address is the user name for your account. We also use your email address to send you updates. A parent or guardian may use their email address to enroll their children in AllClear ID service.

Can I use my redemption code to enroll my family members, too?
No, each redemption code may only be used once. You should request a unique redemption code for each eligible family member at: https://anthemcares.allclearid.com

Why isn't my redemption code working?
If you have trouble with your redemption code, please:

1. Check that you have typed the right URL in your browser. Be sure to use the "https://" when typing in the URL (not "www").
2. Make sure you've typed in the redemption code exactly as it appears in your email notice. Copy and paste the code into the redemption box to reduce the chance of an error.

I'm hearing impaired. How do I talk to someone?
Toll free services for hearing impaired are available 24 hours a day, 365 days a year by using a Telecommunications Relay Service (TRS). The relay service will take text messages from the caller and relay them to the AllClear ID representative and send the information back to the caller via the TTY service. Remember that AllClear ID's service support hours are Monday – Saturday from 8:00 AM to 8:00 PM CST.

Do I need to provide my personal information or SSN to AllClear ID?
You only need to provide AllClear ID with personal information if you enroll in *AllClear Credit and Identity Theft Monitoring* or if it's needed by AllClear ID to help you with an identity repair service. This personal information allows AllClear ID to monitor, investigate, and/or repair your identity.

Information about timing

When does this new protection start and when does it end?
Identity protection services will be provided to all eligible members with medical health plan coverage as of January 1, 2016. They'll be made available for as long as you have an active medical health plan.

Do I need to enroll in the monitoring services when I get the notice to qualify for the service?
No enrollment is required to take advantage of *AllClear Identity Repair Services.* Enrollment is required to take advantage of *AllClear Credit and Identity Theft Monitoring.* Eligible members can enroll at any time during the calendar year. Services are available as of January 1, 2016.

What happens if I am no longer a member? Will my identity protection coverage end?
If your medical health plan coverage ends or you cancel your medical health plan coverage, you will no longer be eligible for Identity protection services. If you re-enroll in one of our eligible health plans later, you would again be eligible for these services.
Will AllClear ID continue to honor my services if I end or cancel my medical health plan coverage during the year?
AllClear ID services will continue through the end of the calendar year.

Information about AllClear ID

When and how will I get alerts?
If you're enrolled in *AllClear Credit and Identity Theft Monitoring* and suspicious use of your personal information is detected, you'll be notified directly by phone or e-mail.

Does AllClear ID monitor my existing bank accounts for fraudulent activity?
No, AllClear ID doesn't monitor daily activity of your bank or credit card accounts. You can monitor your bank accounts by setting up account alerts, which are provided, free of charge to customers by most banks and credit unions. AllClear ID can assist eligible individuals in setting up these alerts for your credit card and bank accounts. It's also recommended to review your monthly statements for unusual activity.

Information about suspected fraud

What do I do if I suspect insurance coverage or medical fraud?
If you believe someone has stolen your medical health insurance or medical information, or you notice a change in your medical records, please contact your health plan right away by calling the Member Services number on your ID card.

What if someone steals my identity?
If you become a victim of identity theft, you can take advantage of the *AllClear Identity Repair* services. The incident will be fully investigated, creditors, law enforcement and other parties will be contacted, and you will be informed throughout the entire process. Simply call AllClear ID at 1-855-227-9830 and an investigator will work to help fully repair and restore your identity.

I think someone is using my identity. What should I do?
If you think someone is using your personal information, please contact AllClear ID to open an investigation. If you need help, simply call AllClear ID at 1-855-227-9830 at any point while you're an active medical health plan member.

What happens if I have a fraud problem and I already cancelled my medical health plan coverage?
Your *AllClear Identity Repair* services will be honored through the end of the calendar year. If there's a potential problem with your credit or you're worried about identity theft, just contact AllClear ID at 1-855-227-9830 to speak with an investigator.

Information about the Anthem cyber-attack

I already have identity protection through Anthem, Inc. Do I need to do anything now?
No. If you enrolled with AllClear ID after the Anthem, Inc. cyber-attack in 2015, you don't need to do anything. However, when that protection coverage ends after two years, you can enroll in the new offering if you're still an active medical health plan member.

What if I'm eligible for services as part of the 2015 cyber-attack but never enrolled?
You can still enroll by accessing AnthemFacts.com. Information on how to enroll can be found on the AnthemFacts.com website.

LiveHealth Online, 24/7 NurseLine, and Future Moms Programs

Provided by Wisconsin Laborers

LiveHealth Online

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.* The program is available 365 days a year, 24 hours a day, seven days a week (including holidays) anywhere you have an internet connection.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at a cost that is same as your office visit copay or $49 per visit, subject to deductible and coinsurance, depending on your health plan benefits.
- Private, secure and convenient online visits.

Common treatments include:

- Cold/fever/flu
- Allergies
- Pink eye
- Sinus pain
- Sore throat
- Headache
- Vomiting
- Diarrhea
- Bronchitis
- Cold Sores
- Minor rashes
- Hives
- Trouble sleeping
- Ear pain

To access this program:

1. Log on to **LiveHealthOnline.com**.
2. Click **Sign Up** in the top right corner of the screen.
3. Complete the form to create your account and click **Finish**.
4. Review the physician profiles to select the one that's right for you and begin your consultation.

You will need your ID number from your ID card when creating your account in order for Anthem to identify you as a Plan participant.

LiveHealth Online is not intended for medical emergencies. If you experience an emergency, always call 911.

24/7 NurseLine – Call **1-866-670-1565**

Anthem's 24/7 NurseLine provides access to a registered, trained nurse over the phone anytime, anywhere. Registered nurses can help you understand your symptoms and medical condition or prescribed course of treatment. Nurses are trained to address common health care concerns, provide medical information, health education and assist you in accessing health care. The most frequent reasons for calls are:

- Pediatrics concerns
- Digestive system disorders
- Bone/muscle/joint concerns
- General health education
- Dermatology

Future Moms

Future Moms provides support to help achieve healthier pregnancies, deliveries and babies. The program is designed to help expectant mothers focus on early prenatal interventions, risk assessments and education by using a comprehensive, systematic and personalized management approach. Key features include:

- Registered nurses with obstetrics experience
- 24/7 toll-free telephone access to nurses and coaches
- Education on pregnancy care and topics
- Lifestyle management and behavioral change counseling
- Pharmacy and nutritional counseling
- Coordination of services and referrals
- Screening for pre-delivery and postpartum depression
- A thorough assessment and risk analysis for each participant

Call 1-877-351-8389 to join this program at no cost!

Anthem BlueCross BlueShield

*As legally permitted in certain states.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

< Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. >

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

January 2015

Dear Participant & Family:

As Trustees of the Wisconsin Laborers' Health Fund, we are pleased to announce an enhancement to the Plan's coverage of diagnostic services and dental emergencies, effective with dates of service on or after January 1, 2015.

Diagnostic Services

Effective January 1, 2015, the Plan will cover initial diagnostic services, even if the treatment for the diagnosis is not covered. The medical services will include office visits, outpatient laboratory or x-ray examinations, and related fees charged by a radiologist or pathologist for diagnosis of an injury or sickness that are ordered by a physician and are performed in a physician's office, clinic, or hospital outpatient department. Diagnostic genetic testing is not included in this Plan change. Applicable copays, deductibles and coinsurances apply. All other Plan exclusions, limitations, maximums and exclusions apply. However, if the condition is excluded under the Plan then treatment of the condition or services to monitor the condition will not be covered.

General Exclusion 12 is modified to read as follows: Inpatient or outpatient charges resulting from behavioral problems, conduct disorders, learning disabilities, and developmental delays. Treatment of these conditions is excluded.

General Exclusion 22 is modified to remove fertility tests from the exclusion.

Dental Emergencies

Effective January 1, 2015, the Plan will cover dental emergencies that require you to go to the Emergency Room on weeknights, weekends, and holidays under the Comprehensive Major Medical Benefit. You will still have to pay the ER Deductible of $100, major medical deductible, and the coinsurance. Like any other medical emergency, a dental emergency must meet the following definition:
An emergency is the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, that are severe enough that the lack of immediate medical attention could reasonably be expected to result in: (1) the patient's health being placed in serious jeopardy; (2) bodily function being seriously impaired; or (3) serious dysfunction of a bodily organ or part.

Example: Martin had a toothache that started on Tuesday, but it was only a slight toothache and he ignored it for a few days. By Saturday evening, the toothache was unbearable and his jaw was swollen. Martin went to the ER where they determined that he had an abscess. The ER staff provided medications to stabilize his symptoms, so that he could go a dental provider to have his dental problem treated.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Please keep this announcement with your Summary Plan Description benefit booklet. If you have any questions about these changes, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

SAV-RX PRESCRIPTION BENEFIT PROGRAM

Should you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please contact Sav-Rx. Their website is www.savrx.com or call toll free at 1-800-228-3108.

How to Use the Benefit — Present your ID card and your prescription to the pharmacist. The pharmacist will dispense your medication, submit the claim to Sav-Rx electronically, and notify you of the amount which you are required to pay.

The prescription benefit allows for a 30-day supply or 100 units, whichever is greater, with a limit of two refills at the local pharmacy. **MAINTENANCE MEDICATIONS MUST COME FROM THE MAIL ORDER PROGRAM.**

The plan covers all federal legend drugs, state restricted drugs, compounded medications, insulin, injectable medications, needles & syringes, immune altering drugs, retin a (diagnosis required over age 25), dexedrine (diagnosis required over age 25), imitrex vials, imitrex auto injector, diabetic medication, diabetic supplies, ulcer medication, mental health drugs, non-steroidal anti-inflammatory drugs, accutane (diagnosis required over age 25), diabetic lancets, glucometer and cox inhibitors in quantities of a 30 day supply or 100 units, whichever is greater, not to exceed one year.

The plan will exclude over the counter items and devices, injectable fertility medication, federal legend vitamins, blood products, serums, rhogam, rogaine, genetically engineered drugs, oral fertility medication, anorexiants (diet medication), anabolic steroids, children's vitamins, bee sting kits, yohimbine, male sexual dysfunction medication, ostomy products, growth hormones and allergy serums.

Retail Co-payment — The co-payment for generic medications will be $8
The co-payment for brand name medications will be $25
The co-payment for non-formulary brand name medications will be $40

Save money using the Sav-Rx Mail Order Program — The Mail Order Program was designed to allow members to receive a 90-day supply of maintenance medication (e.g. heart medication, blood pressure medication, diabetic medication etc). Whenever you start a new maintenance medication, the initial fill and two refills can be obtained with applicable co-pays through your local pharmacy. Any subsequent refills must be obtained through the Sav-Rx Mail Order Program. Step-by-step instructions on how to use the Sav-Rx Mail Order Program are provided in the Mail Order Brochure.

Mail Order Co-Payment — The co-payment for generic medications is $16
The co-payment for formulary brand name medications is $50
The co-payment for non-formulary brand name medications is $80

MAIL ORDER FORM

PLEASE PRINT CLEARLY. Enclose this form with your prescription(s) and payment.

MEMBER INFORMATION

CARDHOLDER NAME

CARDHOLDER ID #	DOB (MO/DAY/YR)	☐ MALE ☐ FEMALE

ADDRESS

CITY	STATE	ZIP

DAYTIME PHONE	EVENING PHONE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)

DOB (MO/DAY/YR)	☐ MALE ☐ FEMALE

IMPORTANT

You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise.

☐ By checking this box, I elect to receive brand drugs for all prescriptions in this order. By making this choice, I understand that I will be responsible for the **applicable copay PLUS the difference in cost.**

Please do not send cash.

☐ Check or money order enclosed

☐ Charge to my credit card

CARDHOLDER NAME

CREDIT CARD NUMBER	EXPIRATION DATE

CARDHOLDER SIGNATURE

Make checks payable to:

Sav-Rx Pharmacy

P.O. Box 8 Fremont, NE 68026

If mailing address for patient is different than cardholder address, please contact Sav-Rx.

HOW TO USE YOUR SAV-RX CARD

Our network of more than 65,000 pharmacies provides prescription services at convenient locations across the country. In addition to more than 3,000 independent pharmacies, Sav-Rx cards are also accepted at every major chain pharmacy. To locate a network pharmacy near you, call Sav-Rx or you may visit www.savrx.com.

RETAIL PHARMACY

You may present your card at any of over 65,000 retail network pharmacies nationwide to purchase your prescription medication. Your pharmacist may call Sav-Rx with any questions 1-800-228-3108.

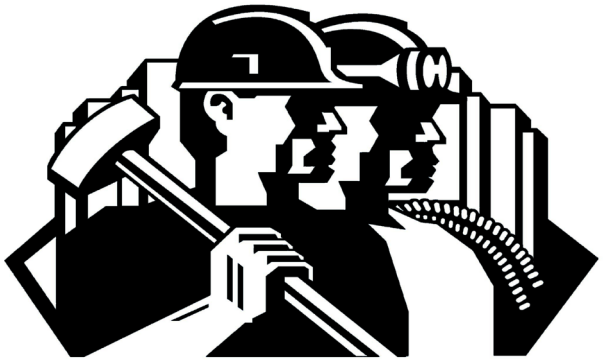
MAIL ORDER

You may also order prescription medication from the Sav-Rx Mail Order Pharmacy. The mail order should be used for your long-term maintenance medications. Using the Sav-Rx mail order may offer some cost savings to you. Regular orders are processed within 24 hours of receipt and mailed First-Class for convenient home delivery.

Your doctor may E-scribe new prescriptions to Sav-Rx or call in a new prescription to Sav-Rx at 1-800-228-3108. You may also mail your prescription to Sav-Rx PO Box 8 Fremont, NE 68026. **Please note that your payment is required with every order.** Be sure to reference your Sav-Rx identification number with each prescription. Additional mail order forms are available at www.savrx.com.

Refills may be called in 24 hours a day, 7 days a week to 1-800-228-3108. You may also request a refill online at www.savrx.com or download the Sav-Rx App from the App Store or Google Play.

Wisconsin Laborers' Health Fund



PRESCRIPTION DRUG PLAN ADMINISTERED BY:

SAV-RX *Prescription Services*

1-800-228-3108

Sav-Rx Prescription Services

Frequently Asked Questions

1. How much do I pay for my prescriptions?

RETAIL PHARMACY (UP TO 30 DAYS SUPPLY)	
Generic	$8.00
Formulary	$25.00
Non Formulary	$40.00
Brand w/ Generic	$40.00 + Difference in cost
MAIL ORDER (UP TO 90 DAYS SUPPLY)	
Generic	$16.00
Formulary	$50.00
Non Formulary	$80.00
Brand w/ Generic	$80 + Difference in cost
SPECIALTY (UP TO 30 DAYS SUPPLY)	
Generic	$8.00
Formulary	$25.00
Non-Formulary	$40.00
Brand w/ Generic	$40.00 + Difference in cost

2. When do I use the mail service?

You may order any prescribed medication, but the mail order service should be used for medications that you will be taking for more than 30 days. This will save you and your Fund money. All regular orders are processed within 24 hours of receipt, and mailed First-Class.

3. How do I get the best value in my pharmacy benefit?

The best way to ensure that you are getting the best value in your pharmacy benefits is to use generics whenever they are available.

Many brand name drugs do not have a generic equivalent; however, a generic drug is available within the same therapeutic class, which is designed to treat the same symptoms. It is recommended that whenever you visit with your physician, you discuss the importance of using generics whenever they are available because it will save you money at the pharmacy.

4. What is a formulary?

A formulary is a list of preferred products. The formulary considers treatment options on a therapeutics basis first, then based upon cost effectiveness. Generic medications, when they are available and considered equivalent to their brand counterpart, are always preferred over brand name products. When similar brand name medications are available to treat a condition, the formulary helps physicians and patients consider treatment options in order of cost effectiveness.

Please visit our website at:

www.savrx.com

5. What medications are covered?

Most maintenance medications are covered by your plan. These include, but are not limited to: insulin, diabetic testing supplies and more. Please refer to your Summary Plan Description for specific coverage rules.

Certain classes are excluded from coverage such as: fertility, weight loss products, cosmetic products, over the counter medications and drugs used for experimental purposes.

Some medications may require prior approval such as injectables and specialty medications. Some medications may be subject to quantity limits and/or step therapy.

Please contact Sav-Rx Prescription Services with any questions regarding your medications.

SAV-RX *Prescription Services*

Call to find out more about your prescription copays, network locations and clinical programs. An agent will be ready to provide you with personalized, professional assistance 24/7.

1-800-228-3108

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

Announcing Access to a NEW Hearing Service Program for Participants Enrolled in the Regular Plan or the Retiree Plan

July 2018

Dear Active and Retired Plan Participants:

As the Board of Trustees of the Wisconsin Laborers' Health Fund ("Fund" or "Plan"), we are pleased to announce that effective August 1, 2018, you will have access to a hearing service program offered through Amplifon Hearing Health Care ("Amplifon").

Amplifon's program will complement the hearing aid benefits available to you and your eligible dependents by providing you with access to credentialed audiologists and hearing aid dispensers who offer discounts off the manufacturers' suggested retail price on major brands of hearing aids.

You can still contact Anthem at 800-810-2583 to locate and/or schedule your initial hearing exam with an Anthem in-network ear, nose and throat (ENT) physician. Once you complete your initial hearing exam, you can call Amplifon's call center at 866-674-3979 and speak with a Patient Care Advocate who will schedule an appointment for you with an Amplifon provider for hearing aid selection and fitting. Amplifon's call center is open 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday.

For further information on Amplifon's services, visit www.amplifonusa.com/wilaborers or call 866-674-3979.

THE PLAN'S HEARING AID BENEFIT IS NOT CHANGING

If you are enrolled in the Regular Plan or the Retiree Plan (and not the Bare Bones Plan), you and your eligible dependents are still eligible to receive the hearing aid benefits offered by the Fund. This means that the Plan will continue to cover 100% of your hearing aid expenses, up to $2,000 per person in any consecutive five-year period.

Covered hearing aid expenses include the allowable charge for a necessary hearing aid instrument, as determined by a licensed otologist or an otolaryngologist (ENT). A hearing aid device replaced without obtaining a new prescription is a covered expense, provided the original device was covered by the Plan and a valid prescription for the original device (from a qualified otologist or otolaryngologist) is on file with the Fund Office.

Epic's Hearing Service Program Reminder
You will also continue to have access to the hearing service program provided by EPIC Hearing Healthcare as another complement to the Fund's hearing aid benefits. This hearing service program provides you with access to EPIC's national network of independent and credentialed audiologists and ENT physicians who perform hearing evaluations and offer discounts off the manufacturers' suggested retail price on all major brands of hearing aids. You can call EPIC at 866-956-5400 to set up a hearing evaluation with an EPIC network provider. The call center is open 8:00 a.m. to 8:00 p.m. Central Time, Monday through Friday.

STATEMENT OF GRANDFATHERED STATUS

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

FOR MORE INFORMATION

Please refer to your Summary Plan Description (SPD) booklet for complete Hearing Aid Benefit information and keep this announcement with your SPD booklet for easy reference.
If you have any questions about your hearing aid benefits or any other Plan benefit, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

Your hearing health care program - for life

Brought to you by Wisconsin Laborers' Health Fund

We offer...

Custom hearing solutions - we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

Continuous Care - one year free follow-up care, two years free batteries, and a three-year warranty.

Risk-free 60-day trial - 100% money-back guarantee.

Hearing aid low price guarantee - if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

Accessing your discount is as easy as...

1. Call Amplifon at 866-674-3979 and we'll find a provider near you.
2. We'll explain the Amplifon process and help you schedule an appointment.
3. We'll send information to you and the provider, ensuring your discount is activated.

www.amplifonusa.com/wilaborers

amplifon Hearing Health Care

Discount Card

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your discount, call 866-674-3979 today!

amplifon Hearing Health Care

Additional money-saving offer!

$50 off one hearing aid* -or- $125 off two hearing aids*

Call 866-674-3979 today!

Act now!

*Savings on top of our already discounted pricing. Please bring this offer with you to your appointment.

EPIC HEARING HEALTHCARE

MEMBER | SAVINGS

EPIC HSP members save up to 60% off of retail on brand name hearing aids from major manufacturers through the EPIC Hearing Service Plan.

- Phonak
- Unitron
- Hansaton
- Resound
- Starkey
- Signia
- Widex
- Oticon

Technology Levels	Typical MSRP	EPIC HSP Price	Member Savings
Entry	$1,400	$495	**$905**
Essential	$1,650	$999 / $1,199	**$550**
Standard	$2,250	$1,299 / $1,499	**$850**
Advanced	$2,700	$1,899 / $2,099	**$700**
Premium	$3,500	$2,399 / $2,499	**$1,050**

WELLNESS REWARDS | PROGRAM

ListenHear • LiveWell

Participants who complete the four fun, educational hearing health related activities in the Listen Hear, Live Well hearing wellness program receive *Wellness Reward Coupons* for additional savings on their hearing purchase! Go to **www.listenhearlivewell.com** on your desktop computer or mobile device to participate.

- **$200 off** Premium Level Devices*
- **$100 off** Advanced Level Devices*
- **$50 off** Standard Level Devices*

Wellness Reward Coupons are applied to each device that is purchased!

*applies to all Standard, Advanced, and Premium level hearing aid makes/models; cannot be combined with any other offers or promotions

Call EPIC today to start the process to better hearing.

1 866.956.5400

www.epichearing.com/registration

EPIC HEARING HEALTHCARE

Hear Better • Live Well

Welcome

EPIC HSP members have access to the largest hearing care provider network in the country and substantial savings on top tier manufacturer brand devices and related professional services through the **EPIC Hearing Service Plan**.

Provider Network

The EPIC network is comprised of professional Audiologists and ENT physicians and represents the largest accredited network of its kind in the nation, with provider locations in all 50 states.

Hearing Aid Technology

The EPIC Hearing Service Plan gives you access to all name brand hearing aid technology by the top tier hearing aid manufacturers at reduced prices, 30%-60% below MSRP; maximizing your value and savings.

How it Works

Contact an EPIC hearing counselor today. The hearing counselor can answer any questions you may have about the plan and coordinate your referral to a nearby participating provider. If the provider recommends you obtain hearing aids, an EPIC counselor will contact you to coordinate your coverage and payment. You will receive a 45 day trial period.

Warranty & Batteries

All hearing aids, with the exclusion of the Entry Level, come with the EPIC guaranteed warranty which covers repair, damage, and one time loss for three years. (Entry level is one year). Each hearing aid purchase includes a one year to lifetime supply of hearing aid batteries at no additional cost. *excludes Entry Level Products; Premium hearing devices include a lifetime battery supply

Wisconsin Laborers' Health Fund

Notice of Creditable Coverage
For Distributions Prior to October 15, 2018

Prepared by
Segal Consulting
October 2018

Notice of Prescription Drug Creditable Coverage
Wisconsin Laborers' Health Fund

Important Information about Your Prescription Drug Benefits and Medicare Prescription Drug Coverage

This Notice has information about:

- Medicare Prescription Drug Coverage that is available to everyone with Medicare.
- How the Wisconsin Laborers' Health Fund's existing prescription drug benefits are, on average for all active and retired Plan participants and their dependents, at least as good as standard Medicare Prescription Drug Coverage.
- What your choices are and what happens to your coverage under the Wisconsin Laborers' Health Fund if you elect Medicare Prescription Drug Coverage.
- Where to find more information to help you make decisions about your prescription drug coverage.

The Wisconsin Laborers' Health Fund provides prescription drug coverage for all participants. You do **not** need to enroll for Medicare Prescription Drug Coverage since you have creditable coverage available under the Wisconsin Laborers' Health Fund.

This Notice explains the options you have under Medicare Prescription Drug Coverage and can help you decide if you want to enroll. Please read this Notice carefully and keep it in a safe place for future reference.

Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage is available to anyone with Medicare. Most people must pay a monthly premium for Medicare Prescription Drug Coverage. For people with limited resources, extra help paying for Medicare Prescription Drug Coverage is available. Medicare Prescription Drug Coverage is insurance provided by private companies that have been approved by Medicare. Medicare Prescription Drug Coverage is available through Medicare Advantage (like an HMO or PPO) and Medicare Prescription Drug Plans.

All Medicare plans provide at least a standard level of coverage as set by Medicare. Some Medicare plans offer better coverage for a higher monthly premium.

Individuals entitled to Medicare Part A or enrolled in Medicare Part B can enroll for Medicare Prescription Drug Coverage when they first become eligible for Medicare and each year from October 15th through December 7th. If a Medicare eligible individual loses or drops prescription drug coverage under the Wisconsin Laborers' Health Fund, the individual may be eligible for a two (2) month Special Enrollment Period to sign up for Medicare Prescription Drug Coverage. More detailed information about Special Enrollment Periods can be found in the *Medicare & You* booklet sent to Medicare eligible individuals each fall.

Existing Coverage as Good as Standard Medicare Prescription Drug Coverage

The Wisconsin Laborers' Health Fund has determined that the Plan's existing prescription drug benefits are "creditable coverage," which means coverage under the Wisconsin Laborers' Health Fund is, on average, expected to pay as much (or more in some cases) in claims for all participants as standard Medicare Prescription Drug Coverage.

Keep this Notice. If you enroll for Medicare Prescription Drug Coverage, you will need a copy of this Notice when you enroll. This Notice verifies that you have creditable coverage and that you are not required to pay the higher premium penalty.

Because your current prescription drug benefits under the Wisconsin Laborers' Health Fund are, on average, as good as Medicare standard coverage, you can choose to stay covered under the Wisconsin Laborers' Health Fund and join a Medicare plan later and not be subject to higher premiums.

Your Choices and the Consequences

You should compare your current coverage, including which medications are covered, with the coverage and cost of the Medicare plans in your area.

If you do not enroll for Medicare Prescription Drug Coverage, you will continue to receive prescription drug benefits under the Wisconsin Laborers' Health Fund (as long as you are otherwise eligible to continue Plan coverage). Remember that the

Wisconsin Laborers' Health Fund also provides medical and other benefits, in addition to prescription drug benefits. You will continue to receive all current benefits for which you are eligible.

- **Active Participants and Their Dependents:** If you are an active participant or the dependent of an active participant and enroll for Medicare Prescription Drug Coverage, you will continue to be eligible for the Fund's prescription drug benefits. However, your prescription drug benefits will be coordinated with Medicare if you enroll.
- **Retirees and Their Dependents:** If you are a retiree or dependent of a retiree and are eligible and enroll for Medicare Prescription Drug Coverage, you will no longer receive prescription drug benefits under the Wisconsin Laborers' Health Fund. You will continue to be eligible to receive medical benefits under the Wisconsin Laborers' Health Fund. However, your monthly self-payments for coverage under the Wisconsin Laborers' Health Fund will not change as a result of not receiving prescription drug benefits under the Fund. Also, remember that for most people there is a monthly premium for Medicare Prescription Drug Coverage.

  If you or your dependents enroll for Medicare Prescription Drug Coverage, lose Wisconsin Laborers' Health Fund prescription drug benefits, and later decide to drop Medicare Prescription Drug Coverage, you will be given a one-time opportunity to re-enroll for the Fund's prescription drug benefits. Contact the Fund Office for more information.

  If you drop *all* coverage under the Fund, enroll for Medicare Prescription Drug Coverage, and later drop Medicare coverage, retiree coverage under the Wisconsin Laborers' Health Fund cannot be reinstated because once retiree coverage ends, it may not be reinstated unless you return to work and satisfy the eligibility requirements for active coverage.

Note to Medicare-Eligible Individuals: If you drop or lose your coverage under the Wisconsin Laborers' Health Fund and do not enroll for Medicare Prescription Drug Coverage after your current coverage ends, you may pay more for Medicare Prescription Drug Coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Prescription Drug Coverage, your monthly premium for Medicare Prescription Drug Coverage will increase. The increase will be at least 1% per month for every month that you were eligible but did not have coverage. For example, if you go 19 months without coverage, your monthly premium penalty will always be at least 19% higher than what most other people pay. You will have to pay this higher premium penalty as long as you have Medicare Prescription Drug Coverage. In addition, you may have to wait until the next open enrollment period (October 15th through December 7th each year) to enroll.

For More Information about Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug Coverage is available in the *Medicare & You* handbook that Medicare publishes each fall and sends to Medicare beneficiaries. You may also be contacted directly by Medicare Prescription Drug Plans. You can also get more information about Medicare Prescription Drug Coverage from the following resources:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number is included in the *Medicare & You* handbook).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited resources, extra help paying for Medicare Prescription Drug Coverage is available. Additional information is available from the Social Security Administration by:

- Visiting www.socialsecurity.gov.
- Calling 1-800-772-1213 (TTY users should call 1-800-325-0778).

For More Information About this Notice or the Health Fund's Prescription Drug Benefits

If you have any questions about this Notice or would like more information about your prescription drug benefits under the Wisconsin Laborers' Health Fund, please call the Fund Office.

In the future, the Wisconsin Laborers' Health Fund will periodically send you an updated copy of this Notice for your records. You also may request a copy of this Notice at any time by contacting the Fund Office.

Date: October 2018
Contact: Fund Office

Entity/Sender: Wisconsin Laborers' Health Fund
Address: 4633 Liuna Way, Suite 201, DeForest, Wisconsin 53532-2514
Telephone Number: 1-608-846-1742 or 1-800-397-3373

Benefits under the Wisconsin Laborers' Health Fund are not vested or guaranteed. Full details of the Wisconsin Laborers' Health Fund are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.

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WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

ANNOUNCING PLAN CHANGES

Date: May 2019

To: Active and Non-Medicare-Eligible Retired Employees and Their Eligible Dependents Participating in the Wisconsin Laborers' Health Fund

From: The Board of Trustees

As your Board of Trustees of the Wisconsin Laborers' Health Fund (the "Fund" or "Plan"), we are pleased to announce the implementation of a new Employee Assistance Program (EAP), maternity care benefit and biometric screening services for you and your eligible dependents. Please read this Summary of Material Modifications (SMM) in its entirety as it provides details about these new benefits.

New Employee Assistance Program (EAP) Through Anthem BlueCross BlueShield—Effective June 1, 2019

Everybody has problems and issues they deal with from time to time. And while you may talk to family, friends, spiritual advisors and/or coworkers about your troubles, that may not be all you need. That's why the Fund is contracting with Anthem BlueCross BlueShield to provide you with access to Anthem's Employee Assistance Program (EAP).

Anthem has a national network of over 22,000 EAP professionals, including psychologists, social workers, marriage and family therapists, counselors and psychiatric nurses, who can help you deal with life challenges like:

- Stress and/or anxiety
- Depression
- Suicidal thoughts
- Personal and/or emotional challenges
- Grief or loss
- Marital, relationship and family issues
- Alcoholism, drug use and addiction

You will never receive a busy signal, which means that you will have direct access to a customer care representative or clinician 24 hours a day, seven days a week. **All discussions with an EAP counselor will be kept confidential** (except those that pose a threat to someone's safety, such as a child abuse situation; such calls will be an exception to the counseling confidentiality rule).

93% of Anthem's EAP professionals also participate in the BlueCard® PPO mental health/substance abuse provider network.

The EAP will also provide you and your eligible dependents with:

- ***Face-to-face counseling sessions or online video counseling sessions via LiveHealth Online (three sessions per covered individual per issue)***. If there are any issues that cannot be effectively addressed within the three counseling sessions, you may be able to discuss them further with a clinician if they are covered services under the Plan's mental health or substance abuse benefits.
- ***Work-life services*** (including child and elder care resources).
- ***One legal consultation (up to 30 minutes per issue per benefit year)*** for issues such as divorce/custody, criminal matters, estate planning/wills/trusts, real estate, landlord/tenant matters, bankruptcy, personal injury/malpractice cases, small claims, adoption and will preparation. The EAP also has a library of legal forms that you can access online and use for a variety of consumer, medical and family situations.
- ***Telephonic financial consultations*** for issues like bankruptcy, budgeting (to cope with reduction in household earnings, reduce debt, or save money, for example), buying a home for the first time, major life-event planning (wedding, adoption, divorce), college fund planning, credit card debt (lowering rates, consolidating debt), retirement planning and foreclosure prevention.
- ***Access to "myStrength."*** This is an online and mobile "health club for the mind" app you can use to help you manage stress, depression or other matters that you're having difficulty coping with.
- ***Unlimited access to the EAP's website (www.AnthemEAP.com)***. Access the website when you need to locate an EAP provider. The site also offers information on several subjects, including aging, work/life balance, parenting, child and elder care, and more. Just log on at any time using the login ID: Wisconsin Laborers.

We highly recommend that you contact the EAP if and when you ever need assistance coping with a difficult matter. It will be worth your while. To reach an EAP specialist, call Anthem at 800-865-1044.

Note: Certain services available under the EAP may not be covered under the Plan. For example, the Plan does not provide benefits for marriage counseling or other non-referenced legal services. However, these services are offered by the EAP.

New Maternity Benefit—Effective March 1, 2019

The Plan now offers an $800 weekly benefit in connection with a live birth for active eligible female employees. The benefit is payable for six (6) weeks per live birth, for a traditional delivery, and eight (8) weeks for a cesarean section delivery.

> The Plan will continue to provide benefits for a mother and/or newborn child for hospital confinement in connection with childbirth of at least 48 hours following a normal vaginal delivery or at least 96 hours following a cesarean section.

Enhanced Biometric Screening Coverage Through BPA—Effective July 1, 2019

Effective July 1, 2019, biometric screening services will be provided through our Fund Administrator, Benefit Plan Administration of WI, Inc. (BPA), instead of HMC HealthWorks. You will not be required to undergo a biometric screening in order to be covered by the Plan. *Your participation in the program is voluntary.* However, we recommend that you take advantage of this benefit. It will be available at **NO COST** to you. Additionally, when you (and your spouse or eligible domestic partner, if applicable) get a biometric screening performed, you will be rewarded. Here's how it will work:

For Active Plan Employees:

- If you undergo a biometric screening during the period ***July 1, 2019 through June 30, 2020***, you will have the choice of either waiving the annual medical deductible that will apply in 2020 and 2021 ***OR*** receiving a $150 gift card (your spouse and/or your eligible domestic partner, if applicable, will receive a $150 gift card, as well). Note that if you are married or have an eligible domestic partner and you choose to waive the annual medical deductibles, your spouse or eligible domestic partner must agree to waive the deductibles, as well.

  In addition, regardless of whether you choose to have the annual medical deductibles waived or to receive a $150 gift card, if the results of your screening test are considered out of range, $100 will be contributed to your Health Reimbursement Arrangement (HRA) if and when you complete a mandatory ***coaching*** program. Information about the mandatory coaching program is provided later in this document.

- If you undergo biometric screening during the period ***July 1, 2020 through June 30, 2021***, you (and your spouse or eligible domestic partner, if applicable) may choose to either have your 2022 annual medical deductible waived or receive a gift card. If you choose the gift card, one in the amount of $225 will be awarded to you, but only if you pass the screening tests. If the screening tests are not passed, you (and your spouse and/or your eligible domestic partner, if applicable) will receive the following:

  - an initial gift card in the amount of $75; and
  - a second gift card in the amount of $150 once you complete a mandatory ***coaching*** program.

  In addition, if you (and your spouse or domestic partner, if applicable) elect to have the 2021 annual medical deductible waived and the results of your screening test are considered out of range, $100 will be contributed to your HRA, but only upon completion of the mandatory ***coaching*** program.

For Non-Medicare-Eligible Retired Employees:

- If you undergo a biometric screening during the period ***July 1, 2019 through June 30, 2020***, you will receive a $150 gift card.
- If you undergo biometric screening during the period ***July 1, 2020 through June 30, 2021*** and you ***pass*** all of the screening tests, a $225 gift card will be awarded to you. However, if you ***do not pass*** all of the screening tests, the following will occur:

  - you will initially receive a $75 gift card instead; and
  - then you will receive a second gift card for $150 once you complete a mandatory coaching* program through Case Management Specialists, Inc. (CMS).

You Will Receive a Health Report—After you complete the screening, your test results will be sent to you. The health report will be kept confidential and will not be shared with your employer.

About the Coaching Program—The coaching program will be administered by Case Management Specialists, Inc. (CMS). We believe the CMS coaching program is a valuable complement to your biometric screening benefit. If the results of your screening show that you are considered out-of-range for certain health-related conditions (like BMI, diabetes, back pain, coronary heart failure, high blood pressure or high cholesterol), a wellness coach will contact you and help you set the necessary goals to improve your health and live a healthier lifestyle.

More to Come—Be on the lookout for additional information in the mail about the biometric screening program, well before the program's implementation date.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform.The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

Note that additional information will be sent to you in the mail soon about the biometric screening benefit. In the meantime, if you would like more information about the benefit and/or the new EAP program and maternity benefit, contact the Fund Office at the address and telephone number shown at the top of this Notice.

In addition, please file this SMM with your Plan-related documents for easy reference.

This announcement, which serves as a Summary of Material Modifications, contains only highlights of recent changes to the Wisconsin Laborers' Health Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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Important Instructions

It is REQUIRED to complete the 1st page of the Health Screening Program Consent and Authorization form, which includes two signatures. The next 2 pages of the Health Risk Questionnaire is optional. However, it is preferred that you complete the Questionnaire as well.

Provide the above completed forms to your Primary Care Physician "PCP", along with the PCP form at the time of your appointment. Your physician will need to complete and provide ALL your biometrics on this form. ALL forms must be faxed together to Healics. You will find Healics' contact information on the PCP form.

Please keep in mind, it is your responsibility to provide ALL forms to Healics for processing.

Thank you

Healics
With you for life

Health Screening Program
Consent and Authorization

Barcode

The purpose of this voluntary health screening program offered through the sponsor employer is to gather sufficient information, so you can receive an informative confidential Healics™ Health Risk Report from Healics Inc. ("Healics").

Employer: **Wisconsin Laborers Health Fund**

Have you completed a Healics health risk assessment before? ❒ Yes ❒ No

Please print name:_____ Date of birth:_____
(Last Name) (First) (MI) (mm/dd/yyyy)

Mailing address:_____ City:_____ State:_____ Zip:_____

Best contact number:(_____)_____ Work phone number:(_____)_____ Gender: ❒ Male ❒ Female

Regarding the sponsor employer, are you the: ❒ Employee ❒ Spouse of employee

If you are a spouse, what is the employee's name? _____Employee Date of Birth:_____

If you are the employee and the sponsor employer has multiple shifts, which shift do you work? ❒ 1st shift ❒ 2nd shift ❒ 3rd shift

I wish to participate in this voluntary health screening/health risk assessment (HRA) offered by the sponsor employer and conducted by Healics. I understand that Healics is the program vendor and it subcontracts with others, such as examiners (to take measurements and to draw blood via venipuncture, oral swab, or fingerstick methods) and Clinical Reference Laboratory (to analyze the blood sample).

I understand the health screening program, including any possible consultation or follow-up, is not a substitute for a full examination by my own physician. I will arrange any appropriate follow-up examinations. The health coaching process that may be included is a support system, which utilizes goal setting, identification of obstacles and action planning to improve physical health. All information provided in the coaching sessions are suggestions. All suggestions should be cleared with a medical doctor before implementing. I understand that there are possible risks associated with venipuncture or fingerstick methods including, but not limited to, risk of infection, discomfort, bruising and, in unusual situations, more serious risks (including death). I agree that Healics is not liable for such risks when Healics is acting properly, and that I will assume the risk of injuries, including death, damages or loss, which I may sustain as a result of my participation in the assessment. I consent to the taking of blood from me by a qualified examiner. **I understand that I may refuse to sign this Consent, but if I do so, I will not be processed as a participant in the health-screening/HRA program.** I understand that Healics and its vendors generally are required by law to maintain the confidentiality of the medical information I provide through the HRA. The medical information includes my biometric results and other information about the manifestation of a disease or disorder. Healics uses this information to provide services to me and / or my spouse, such as an analysis of certain health risk factors. Healics is restricted by privacy law in how my or my spouse's medical information can be used or disclosed. For example, the Genetic Information Nondiscrimination Act generally prohibits Healics from disclosing to my employer my spouse's genetic information (which generally includes his or her health status). Such spousal information generally cannot be made available to managers, supervisors or others at the employer who make employment decisions, or anyone else in the workplace. Healics has established privacy and security policies and procedures that discuss how my medical information will be properly held, used and disclosed. I knowingly and voluntarily provide my Consent.

Signature (required to process results): _____ **Date**: _____

If this Consent is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual:_____

I authorize Healics to release my name as a participant, my participation status in the program, and certain other limited health "information" (i.e., my nicotine results and scores) to sponsor employer for the purposes of administering the wellness program. In the event sponsor employer offers a bonus or incentive related to the program, I authorize Healics to release Information to sponsor employer — as well as companies engaged by sponsor employer and/or Healics — for purposes of administering the bonus or incentive related to the program and/or providing me with follow-up coaching, counseling or related services. All other health information resulting from the health risk assessments will be held confidentially and not shared with sponsor employer. I understand the following:

- **I may refuse to sign this Authorization, but if I do so, I will not be processed as a participant in the health screening/HRA program.**
- Sponsor employer may condition my enrollment in a health plan or eligibility for benefits upon my executing this Authorization.
- This Authorization is effective until the earlier of: (1) the date it is revoked or superseded; or (2) one year after the date I signed it.
- I may revoke this Authorization at any time, in writing provided to Healics, Attn: Privacy Officer at 8919 W. Heather Ave., Milwaukee, WI 53224. My revocation will not be effective until received by Healics and will not be effective: (1) regarding any disclosure that Healics has made prior to receipt of my revocation; or (2) if this Authorization was obtained as a condition of obtaining insurance coverage.
- I have the right to request access to health information I have authorized to be used or disclosed pursuant to this Authorization. I may arrange to inspect my health information or obtain copies of my health information by contacting the Healics Privacy Officer at 1-800-HEALICS.
- Information disclosed pursuant to this Authorization may be subject to redisclosure and no longer protected by federal privacy standards.
- A photocopy will be as valid as the original.
- If a disclosure is required by law (e.g., pursuant to a judge's written order), Healics or its representative may be required to make the disclosure.
- I may request a copy of this Authorization.

Signature (required to process results): _____ **Date**: _____

If this Authorization is signed by a minor or personal representative on behalf of the individual, complete the following:
Personal representative's name and relationship to Individual: _____

This constitutes stand-alone documents that are separately: (1) a consent form; and (2) an authorization to disclose health information. Any other documents which are attached to this document are done so for your convenience, in order to ensure that the documents are not misplaced. Please proceed to the attached or following documents and complete the questions. If your doctor has prescribed any medication, you must stay on that medication for the health screen.

Medical History

1 Have you ever been diagnosed or treated for any of the following conditions? (check box if yes)

Allergies ❒	
Arthritis ❒	
Asthma ❒	
Back or neck pain ❒	
Cancer ❒	
Depression/anxiety ❒	
Diabetes (Type 1) ❒	
Diabetes (Type 2) ❒	
Fibromyalgia ❒	
Heart attack ❒	
Heart conditions ❒	
Heartburn/acid reflux ❒	
High cholesterol ❒	
High blood pressure ❒	
Irritable Bowel Syndrome/Crohn's ❒	
Kidney disease ❒	
Liver disease ❒	
Lung disease ❒	
Lymes disease ❒	
Migraine headache ❒	
Obesity ❒	
Sleep disorder/trouble sleeping ❒	
Stroke ❒	
Thyroid disease ❒	
Other condition(s) ❒	
None of the above ❒	

Are you taking prescription medication for any of the following conditions? (check box if yes)

Allergies ❒
Arthritis ❒
Asthma ❒
Back or neck pain ❒
Cancer ❒
Depression/anxiety ❒
Diabetes (Type 1) ❒
Diabetes (Type 2) ❒
Fibromyalgia ❒
Heart attack ❒
Heart conditions ❒
Heartburn/acid reflux ❒
High cholesterol ❒
High blood pressure ❒
Irritable Bowel Syndrome/Crohn's ❒
Kidney disease ❒
Liver disease ❒
Lung disease ❒
Lymes disease ❒
Migraine headache ❒
Obesity ❒
Sleep disorder/trouble sleeping ❒
Stroke ❒
Thyroid disease ❒
Other condition(s) ❒
No prescription medications used ❒

2 Pregnancy (Females only)

Are you pregnant? No ❒ Yes ❒ | Trimester 1st ❒ 2nd ❒ 3rd ❒ | Pre-pregnancy weight _____

Are you postpartum (0-12 months)? No ❒ Yes ❒ | Delivery date (mm|dd|yyyy) | | | | | | | | |

Lower of pre-pregnancy or postpartum weight _____

3 Weekly Exercise On average, how many minutes per week do you exercise (excluding work activity), in which your rate of breathing and heart rate increases for a total of 10 minutes or longer?	150 mins or greater ❒	75-149 mins ❒	74 mins or less ❒

4 Ergonomics On average, how many hours per day do you spend:	9+ hrs	7-9 hrs	3-6 hrs	Less than 3 hrs
Sitting	❒	❒	❒	❒
Standing	❒	❒	❒	❒
Performing repetitive motions	❒	❒	❒	❒

5 Sleep On average, how many hours a day do you sleep?	9+ hrs ❒	7-9 hrs ❒	3-6 hrs ❒	Less than 3 hrs ❒

Do you experience interrupted sleep, sleep apnea, difficulty with quality sleep? No ❒ Yes ❒

6 Nicotine

Have you ever used products containing nicotine?

No ❒

I did, but I quit ❒ Quit date (mm|dd|yyyy) | | | | | | | | |

Current nicotine user ❒

I currently use nicotine in the following way(s):

Cigarettes ❒	Chew/dip/pouches ❒
Cigars ❒	Nicotine Replacement Therapy (gum/patch/lozenge) ❒
Pipe ❒	Electronic cigarettes (vaping) ❒

7 Alcohol

How often do you have a drink containing alcohol?

Never ❒ One time per month or less ❒ 2-4 times a month ❒ 2-3 times a week ❒ 4 or more times a week ❒

How many drinks containing alcohol do you have on a typical day?

0 ❒ 1-2 ❒ 3-4 ❒ 5-6 ❒ 7+ ❒

How often do you have six or more drinks on one occasion?

Never ❒ Less than once per month ❒ Monthly ❒
Weekly ❒ Daily or almost daily ❒

8 Safety

In the last 30 days, how often have you read/written texts or emails, viewed/responded to social media or watched videos on a phone or electronic device while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

In the last 30 days, how often have you been drowsy, dozed while driving or fallen asleep while driving?

Every time I drive ❒ Most of the times I drive ❒ Some of the times I drive ❒ Rarely ❒ Never ❒

9 Stress

Indicate how often the following apply to you:	Always	Usually	Sometimes	Never
I feel stress from work issues	❒	❒	❒	❒
I feel stress from family/personal relationships	❒	❒	❒	❒
I feel stress from financial concerns/issues	❒	❒	❒	❒
I feel stress from health concerns/issues	❒	❒	❒	❒

10 Worksite Productivity

In the past four weeks, how often did the following keep you from working all or most of the day?	Always	Usually	Sometimes	Never
Illness	❒	❒	❒	❒
Injury	❒	❒	❒	❒
Emotional well-being	❒	❒	❒	❒

11 Readiness to Change

How would you like to enhance or improve your quality of life? Please rate your readiness to change using the key below:

Nicotine use	1	2	3	4	5	NA
Alcohol use	1	2	3	4	5	NA
Exercise habits	1	2	3	4	5	
Eating habits	1	2	3	4	5	
Stress management	1	2	3	4	5	
Weight management	1	2	3	4	5	
Sleep habits	1	2	3	4	5	
Financial management	1	2	3	4	5	

Readiness to Change key:

1 = I don't have a concern, I'm doing well in this area.
2 = I've begun making a positive change in the area, but need to maintain.
3 = I'm ready to start and want more information (used for program planning by your employer).
4 = I would like to start, but concerns are holding me back.
5 = I have a problem but I am not ready to make a positive change.
NA = Not Applicable

12 Interest Survey

Identify wellness topics of interest to you (used for program planning by your employer).

Personal health coaching ❒	Back/neck health ❒	Blood pressure ❒
Stretching ❒	Fitness ❒	Cholesterol ❒
Financial wellness ❒	First aid/CPR ❒	Workplace programs/seminars ❒
Sleep health information❒	Men's health ❒	Nutrition ❒
Nicotine cessation ❒	Stress management ❒	Weight management❒
Women's health ❒	Emotional well-being program ❒	Employee Assistance Programs ❒

13 Primary Care Provider

Do you have a Primary Care Provider? No ❒ Yes ❒

Have you had an annual physical with your Primary Care Provider in the last 12 months? No ❒ Yes ❒

Do you share your health screening results with your Primary Care Provider? No ❒ Yes ❒

14 Perceived Health

In general, how would you rate your physical health? Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor ❒

15 Self-Reported Health Measurements

Height: ☐☐ feet ☐☐ inches Weight: ☐☐☐ pounds

Thank you for completing the Health Assessment!

Primary Care Provider (PCP) Form - Biometric Screening

Wisconsin Laborers Health Fund is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance.

The following information is needed to meet the requirements of participation in the screening:

Date of Biometric Results: _____

Participant Information and Biometrics (to be completed by PCP)

Name	
Date of Birth	
Best Contact Number	
Height	
Weight	
Blood Pressure	
Inches around waist at belly button to nearest ¼"	
Participant uses nicotine products (Yes or No)	

Blood Tests (to be completed by PCP - <u>provide result for ALL tests listed</u>)

Total Cholesterol	
LDL Cholesterol	
HDL Cholesterol	
Chol/HDL Ratio	
Triglycerides	
Glucose	

PRIMARY CARE PROVIDER (PCP) - contact Healics, Inc. at the number listed below if you have any questions regarding the blood test requirements.

_____ _____

PCP Name (Printed) PCP Signature and Date

PARTICIPANT - mail this form <u>along with the</u> health assessment questionnaire to:

Healics, Inc., ATTN: HRA Processing Dept
8919 W. Heather Avenue
Milwaukee, WI 53224

OR fax to 414-375-1639

Contact Healics with questions at 414-375-1600 or 800-432-5427

Wellness Year 1 (July 1, 2019 – June 30, 2020)

Acceptable Ranges

- Body mass index (BMI) ≤ 27.5kg/m2
- Total cholesterol < 200mg/dL
- Blood pressure ≤ 140/90mmHg
- Non-fasting glucose ≤ 200mg/dL

If you fail the BMI target, you now have the option to substitute your body fat measurement instead. The following shows the normal recommended body fat percentages by gender. You must fall within the applicable range to satisfy the marker.

Males	**Females**
24.9	35.9

If you fail the Total Cholesterol target, you now have the option to substitute your Total Cholesterol: HDL ratio. The following shows the recommended Total Cholesterol: HDL Ratio by gender.

	Males	**Females**
Average Risk	5.0	4.4

*All telephonic coaching for this period **must begin no later than July 30, 2020**, as the coaching must be completed no later than September 30, 2020. It is your responsibility to plan your coaching sessions ahead of the completion date.*

WISCONSIN LABORERS' HEALTH FUND

What Do I Do After Reading My Health Report?

If you did not meet the Fund's acceptable biometric ranges you may participate in health coaching. If you participate and complete health coaching, you would be entitled to a one-time $100 Health Reimbursement Account (HRA) credit. The $100 credit will be posted to your HRA after the Health Fund receives confirmation that you have completed your coaching. (NOTE: the HRA credit does not apply to Early Retirees).

Your Healics Risk Level/Score is presented here with corresponding coaching sessions. Your individualized scorecard is based on national standards. We encourage you to speak with your Health Coach and decide how you would like to plan your health goals.

If you meet the acceptable biometric ranges, you are NOT required to do any coaching sessions.

Risk Level/Score	Coaching Sessions	Total Sessions
Minimal (86-100)	Report Consultation	1
Moderate (71-85)	Report Consultation +1	2
Medium (61-70)	Report Consultation +2	3
High (51-60)	Report Consultation +3	4
Extreme (50 or less)	Report Consultation +3	4

***Health coaching is available to all risk levels; maximum limit of four sessions.**

You should expect to receive a call from a CMS Health Coach within one month of receiving your health report. **If you have significant concerns regarding your health, or one month has passed and you have not heard from a Health Coach, please contact CMS at 262-563-6460.** All coaching sessions must begin no later than July 30, 2020.

Remember that health and wellness changes are behaviors that occur over time. To achieve the best overall results, take advantage of your health coaching. Not rushing through health and wellness has been shown to be a good recipe for success!

CMS CASE MANAGEMENT SPECIALISTS, INC.

Healics With you for life

BPA Benefit Plan Administration of Wisconsin, Inc.

WISCONSIN LABORERS' HEALTH FUND
PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

This Privacy Practices Notice is from the Wisconsin Laborers' Health Fund (referred to further on as the "Fund", "health plan", "we" or "our"). It is being sent on behalf of the Board of Trustees of the Fund (the "Board"), which is the sponsor of the Fund.

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to the Board whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to the Board for certain limited purposes. We may disclose your medical information to the Board to administer your group health plan if the Board explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Contact Person:	Mark Traino
Telephone:	608-278-9500
Fax:	608-278-9505
Address:	2901 W. Beltline Highway, Suite 100 Madison, WI 53703

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal

duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2013 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Board of Trustees: We may disclose to the Board, as the sponsor of the Fund, whether you are enrolled or disenrolled in the Fund.

We may disclose summary health information to the Board to use to obtain premium bids for the health insurance coverage offered under the Fund in which you participate or to decide whether to modify, amend or terminate the Fund (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in the Fund to the Board to administer the Fund. Before we may do that, the Board must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see the Fund's plan document for a full explanation of those limitations.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations; to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically.If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agreed upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the beginning of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the beginning of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the beginning of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the beginning of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that

notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

State Law: As a condition of Plan participation, the Board requires that the privacy rights of you, your spouse and dependents be governed only by HIPAA and the laws of the State of Wisconsin (but only to the extent such laws are not preempted by the Employee Retirement Income Security Act of 1974, as amended), without regard to whether HIPAA incorporates privacy rights granted under the laws of other states and without regard to Wisconsin's choice of law provisions.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

QB\22712727.1

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

Notice of Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Wisconsin Laborers' Health Fund's Medical Benefits, as required by the WHCRA of 1998, provide coverage in connection with a mastectomy.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Fund Office at 1-608-842-9101 or toll free at 1-800-397-3373.

WISCONSIN LABORERS' HEALTH FUND
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4633 LIUNA WAY SUITE 201
DE FOREST, WI 53532-2510
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TOLL FREE: 800-397-3373

Patient Protection and Affordable Care Act
Grandfathered Health Plan

The Wisconsin Laborers' Health Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Wisconsin Laborers' Health Fund at 1-608-842-9101 or toll free at 1-800-397-3373.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

Notice of Nondiscrimination and Accessibility Services under Section 1557 of the Affordable Care Act

The Wisconsin Laborers Health Fund (the "Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund provides the following services free of charge to qualifying individuals:

- Aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Fund Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Wisconsin Top 15 Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-846-1742.
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-846-1742.
Cushite	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-608-846-1742.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-846-1742.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-846-1742.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-846-1742.
Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-846-1742.
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-608-846-1742.
Karen	ymol.ymo;= erh>uwdRAunD AusdmtCd<AerRM>Ausdmtw>rRpXRvXAwvXmbl.vXmphRAeDwrHRb.ohM. vDRIAud; 1-608-846-1742.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-846-1742.
Cambodian	ុរបយ័តៈ េបើសិនអ្កនិយ ាយ ែខ្មរ, េសវាជំនួ យេផ្នកភាសា េ ើយមិនគិតឈ ួល គឺមានសំប់បំេរីអ្កេ ើ ទូរស័ព 1-608-846-1742
Arabic	تنك تدحتت ركذا ةغلل، نإف تامدخ ةدعاسملا ةيوغلا رفاوتت كل ناجملاب. لصتا مقرب1742 - 846-608-1مقر ظوحلم: اذإ
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-846-1742.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-846-1742.번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-608-846-1742.

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2514
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

July 2018

Dear Active Plan Participants:

As the Board of Trustees of the Wisconsin Laborers' Health Fund ("Fund" or "Plan"), we recognize how important it is for you to have a clear understanding of the Plan's provisions. This Summary of Material Modifications (SMM) provides details about new Plan rules regarding termination and reinstatement of employee eligibility and your Health Reimbursement Arrangement (HRA) account, which go into effect on August 1, 2018. Please read this SMM in its entirety and store it with your other important Plan documents.

Termination of Employee Eligibility

Effective August 1, 2018, your eligibility for Plan benefits can terminate on the last day of any month in which you are called to work but you refuse to, or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is **not** with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

Example:

Let's say you are called to work on August 1, 2018, and you refuse or you stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area, your eligibility for benefits will end on August 31, 2018.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Reinstatement of Employee Eligibility

Effective August 1, 2018, if your Plan eligibility ends because you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area,, you may again become eligible upon meeting the Plan's "Initial Employee Eligibility" requirements. This means that you can again become eligible for benefits on the first day of the first calendar month that follows any 12 consecutive calendar months in which you are credited with at least 600 hours of covered work.

Example:

Let's say your Plan eligibility ends on August 31, 2018, for either of the reasons described above. If the Fund receives more than 600 hours of contributions from your employer on your behalf between December 1, 2018 and November 30, 2019, you will be eligible for coverage on December 1, 2019.

If you are credited with at least 600 hours of covered work in less than 12 consecutive calendar months, you will become eligible for benefits again on the first day of the first calendar month that follows the date on which the 600 hours are credited to you.

Example:

Let's say your Plan eligibility ends on August 31, 2018, for either of the reasons described above. If the Fund receives more than 600 hours of contributions from your employer on your behalf between January 1, 2019 and July 31, 2019 (in less than 12 consecutive months), you will be eligible for coverage on August 1, 2019.

Health Reimbursement Arrangement (HRA)—Freezing and Forfeiture of the Account

As long as you are eligible for Plan coverage (including when you are eligible to continue coverage by making self-payments), the Fund maintains a Health Reimbursement Arrangement (HRA) account for you, through which you can receive reimbursement for eligible medical expenses that you and your dependents incur, which are not covered by the Plan.

Effective August 1, 2018, your HRA account will be frozen beginning on the first day of the first month following the date that you either are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and then you subsequently start working:

- In the construction industry in a non-laborers trade; or
- In a laborers' trade or sub-trade in the geographic area of Wisconsin under a collective bargaining agreement that is **not** with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union.

This Plan rule applies if your employer has entered into a collective bargaining agreement with the Wisconsin Laborers' District Council or its affiliated Local Unions.

Your frozen HRA account will be forfeited (in other words, closed and forever unavailable to you) as of the first day of the 12th month following the month you are called to work and refuse or stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and subsequently start working in the construction industry in a non-laborers trade or in a laborers' trade or sub-trade in the restricted geographic area If, however, prior to forfeiture, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, your account will not be forfeited. [**Note**: If your frozen account is not forfeited, it may be reinstated on the first day of the month following the month in which you satisfy the Plan's initial eligibility requirements.]

Example:

Let's say you are called to work on August 1, 2018, and you refuse or you stop working under a collective bargaining agreement with the Wisconsin Laborers District Council or its affiliated Local Unions and you subsequently start working in the construction industry in a non-laborers trade, or in a laborers' trade or sub-trade in the restricted area, your HRA account will be frozen on September 1, 2018. If your HRA account remains frozen for 12 months, your account will be forfeited on August 1, 2019. If prior to forfeiture, let's say June 1, 2019, you return to work for an employer that is required to make contributions to the Fund under a collective bargaining agreement with the Wisconsin Laborers' District Council, its affiliated Local Unions or the International Laborers' Union, and you work consecutively each month from June 1, 2019 through May 31, 2020, and the Fund receives contributions from your employer for 600 hours on June 1, 2020, your account could be reinstated on July 1, 2020.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximums). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

For More Information

If you have any questions regarding the Plan's eligibility provisions or your Plan benefits in general, please contact the Fund Office at the address and telephone number shown at the top of this announcement.

Sincerely,

Board of Trustees

This announcement notice, which serves as a Summary of Material Modifications, contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

5754519v3/01577.032

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

December 2018

To All Active Employees and Dependents:

The health insurance marketplaces (previously referred to as "exchanges") were created as part of the Patient Protection and Affordable Care Act ("ACA" or "Health Care Reform"). The Fund previously provided a Notice which described how the marketplaces work and noted the eligibility potential for premium tax credits to help pay for coverage.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace, you also will learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

The Trustees feel that is it important to provide you with this Notice to give you additional information on the marketplaces and how your participation in the Plan impacts these new options. **Most importantly, the Trustees want to assure you that your eligibility for coverage under the Plan is not affected by the existence of such marketplaces. As long as you continue to meet the Plan's eligibility requirements, you will remain eligible for coverage under the Plan.**

Your eligibility for Plan coverage generally makes you ineligible for premium tax credits through the Marketplace. The coverage provided by the Plan is considered "affordable" and provides "minimum value" under the federal government's guidelines. Because the Plan's coverage is affordable to you and provides minimum value, you will not be eligible to receive any premium tax credits. However, if you must self-pay for coverage because you did not work enough hours for a full contribution on your behalf, the cost of coverage may not be "affordable" to you, and you may be eligible for premium tax credits if you choose to enroll in coverage through the Marketplace rather than self-pay.

You do not need to purchase coverage through the Marketplace if you are currently enrolled in the Plan. You will continue to receive Plan coverage for as long as you continue to meet the Plan's eligibility requirements.

(over)

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days, your special enrollment period will end, and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

The Trustees recognize that the ACA is complex and confusing. If you have any questions, or if you would like more information to understand the implications of this Notice or ACA generally, please contact the Fund Office.

Yours truly,

THE BOARD OF TRUSTEES

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BUILDING AND PUBLIC WORKS LABORERS VACATION TRUST FUND

Summary Plan Description
March 1, 2014

TO ALL PARTICIPANTS

The Trustees of the Building and Public Works Laborers Vacation Trust Fund are pleased to present this booklet to Plan participants. Please read it carefully. It explains in non-technical language the essential features of the Fund.

The purpose of the Fund is to provide participants with vacation, jury duty and witness duty benefits. This Fund is registered with the Department of Labor as a welfare plan. The Fund is financed through a payroll deduction arrangement from the wages of employees of participating employers. The amounts withheld and remitted to this Fund are in accordance with the collective bargaining agreements of participating employers.

The Fund is administered by a Board of Trustees consisting of an equal number of union and employer representatives.

If there are any questions regarding the Fund that are not answered in this booklet, please feel free to contact the Fund Office. The material in this booklet is arranged as follows:

Sincerely,

THE BOARD OF TRUSTEES

PART 1 – PLAN INFORMATION

THE TRUSTEES ARE:

Union Trustees

Richard Pusa
Secretary-Treasurer
Laborer's Union Local No. 113
6310 W Appleton Avenue
Milwaukee, WI 53210

Tony Neira
Business Manager
Laborer's Union Local No. 113
6310 W Appleton Avenue
Milwaukee, WI 53210

Mike Emordeno
Business Representative
Laborer's Union Local No. 113
6310 W Appleton Avenue
Milwaukee, WI 53210

John Swan III
Business Representative
Laborer's Union Local No. 113
6310 W Appleton Avenue
Milwaukee, WI 53210

Management Trustees

John Topp
Chief Executive Officer
Allied Construction Employers Association, Inc.
17100 W Bluemound Rd, # 102
Brookfield, WI 53008

Kathleen Froode
President
Masonry Specialists II
4330 Conifer Court
Union Grove, WI 53182

Robert Olson
Globe Contractors, Inc.
N50 W23076 Betker Road
Pewaukee, WI 53072

Mike Dretzka
UPI, LLC
2180 S Springdale Road
New Berlin, WI 53146

Plan Administrator:

The Board of Trustees of the Building and Public Works Laborers Vacation Trust Fund
4633 LIUNA Way, Suite 201
De Forest, Wisconsin 53532-2510
Telephone: 608-846-1742
Toll-Free: 800-397-3373

Labor Organizations, the Members of Which Are Covered by the Plan

Laborer's International Union of North America Local No. 113

Employer Associations:

Allied Construction Employers Association, Inc.
17100 W Bluemound Rd, # 102
Brookfield, Wisconsin 53008

Wisconsin Underground Contractors Association, Inc.
2835 N Mayfair Road
Milwaukee, Wisconsin 53222

Plan Year:

The Plan's fiscal year ends on May 31.

Plan Number:

The Plan Identification Numbers are:
EIN 23-7027174, PN 501

The Administrative Manager Is:

Benefit Plan Administration of WI, Inc.
4633 LIUNA Way, Suite 201
De Forest, Wisconsin 53532-2510
Telephone: 608-846-1742
Toll-Free: 800-397-3373

The Certified Public Accountants Are:

Freyberg Hinkle Ashland Powers & Stowell, S.C.
15420 West Capitol Dr.
Brookfield, Wisconsin 53005

The Legal Counsel Is:

The Previant Law Firm, S.C.
1555 North Rivercenter Drive, Suite 202
Milwaukee, Wisconsin 53212

Plan Administrator

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Type of Administration:

The Plan is administered directly by the Plan Administrator with certain bookkeeping functions performed under contract by the Administrative Manager at the request of the Plan Administrator.

Benefit Request Procedures:

a. Benefit Request Presentation. See Part 2 for requirement as to notice.

b. Benefit Request Forms should be obtained from the Administrative Manager.

c. Opportunity for review of denied benefits. If a request for benefits is denied, participants will be notified in writing as to the specific reasons for the denial. Notification shall include the name and address of the person to whom written request may be made for review of the denial.

Service of Legal Process:

Service of legal process can be made upon the Plan Administrative Manager or any one of the Trustees.

Plan Termination:

The right is reserved in the Plan for the Plan Administrator to terminate, amend or modify, the Plan in whole or in part at any time.

Source of Contributions to the Plan:

Employer contributions are made pursuant to collective bargaining agreements which require contributions to be paid to the Vacation Fund at a specified rate for each hour of covered employment. These agreements are provided through negotiations between the unions listed previously and, respectively, the Allied Construction Employers Association, Inc., and the Wisconsin Underground Contractors Association, Inc., other multi-employer bargaining groups, and certain independent employers.

The Fund Office will provide you information as to whether a particular employer is contributing to this Fund on behalf of participants working under a collective bargaining agreement. The Fund Office will also provide you with a copy of the collective bargaining agreement under which the Plan is maintained upon written request.

Trust Fund:

Benefits are provided from the Fund's assets that are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Information About Your Plan:

The following documents and reports are available for review in the Fund Office during regular business hours by Plan participants and their eligible beneficiaries:

- The Plan Description
- The latest Annual Report
- The Trust Agreement, applicable provisions from the collective bargaining agreements, a complete list of employers who participate in the plan, and other operating instruments.
- The latest Summary Plan Description.

These documents may be examined in the office on any business day, Monday through Friday, between the hours of 8:30 a.m. and 4:30 p.m. at the following location:

Office of Administrative Manager and Fund Office:

Benefit Plan Administration of WI, Inc.
4633 Liuna Way #201
De Forest, WI 53532-2510
(608) 846-1742
(800) 397-3373

Copies of these documents will be sent to the participants within 30 days of written request. If there is a charge for photocopying any of these documents, a notice will be sent.

PART 2 – VACATION BENEFITS

Vacation Benefit Eligibility Rules

All employees may be eligible for Vacation Benefits from the Building and Public Works Laborers Vacation Trust Fund subject to the following rules and any amendments thereto, which the Trustees may adopt from time to time.

An employee shall have worked for an employer required to make contributions on his behalf to the Building and Public Works Laborers Vacation Trust Fund.

Statement of Vacation Benefits

All employees eligible for Vacation Benefits in accordance with the eligibility rules adopted by the Trustees will receive the following benefits:

1. Vacation contributions received by the Fund from participating employers will be distributed twice each fiscal year. Benefit payments will be made to participants in June and December. The June benefit payment will include employer contributions received the immediately preceding months of November through May, for hours worked during October through April. The December benefit payment will include employer contributions received in the immediately preceding months of June through October, for hours worked during May through September.

2. An application for vacation benefit payments is not required. A benefit payment will automatically be issued to all participants on whose behalf employer contributions were received. In order to receive any benefit payments, it is the responsibility of the participant to furnish the Fund Office with a current address.

3. The amount of vacation benefit payment due each employee is the amount received on his behalf from participating employers during the applicable period. This amount may be increased by a pro rata share of trust earnings and any surplus of jury and witness duty contributions, reduced by trust expenses, as determined by the Trustees.

   If an employer is delinquent in making contributions owed under the collective bargaining agreement, such delinquent amounts will not be included in the participant's vacation benefit payment. If such delinquent employer contributions are subsequently received by the Fund, a supplemental vacation benefit payment will be issued.

4. Benefits payable to a deceased participant shall be paid to the beneficiary designated in writing on file at the Fund Office.

5. Emergency vacation benefit payments will be considered not more often than one time per year and a service charge will be assessed any employee vacation payout approved by the Trustees.

6. After issuance of vacation benefit checks, the Fund will access a Laborers International Union data base in order to obtain information on the current whereabouts of any individual who fails to cash a Fund benefit check within six (6) months of the date of issuance. The Fund will re-issue benefit checks to Participants located via the Laborers International Union data base and submit the names of those who are not located to a private locator service commonly used by employee benefit plans to locate missing participants. The names of Participants located through the Laborers International Union data base that fail to cash re-issued benefits checks within three (3) months of re-issuance will also have their names submitted to the private locator service. The Fund will again re-issue benefit checks to those located through the private locator service. If after utilizing the International Union data base and a private locator service the benefit check of a Participant remains un-cashed for a period of one year, said vacation benefit shall be deemed to be forfeited, subject to reinstatement in the event the Participant or a Beneficiary of the Participant as defined herein appears and demonstrates entitlement to the benefit. In the event that the Trustees receive

adequate proof which in their discretion demonstrates that the Participant has passed away and that there are no Beneficiaries as defined therein, then the vacation benefit will be permanently forfeited.

PART 3 – JURY DUTY BENEFITS

Jury Duty Eligibility Rules

All employees shall be eligible for Jury Duty Benefits from the Building and Public Works Laborers Vacation Trust Fund subject to the following rules and any amendments thereto, which the Trustees may adopt from time to time:

1. An employee shall be working and have worked for an employer required to make contributions, on the employee's behalf, to the Building and Public Works Laborers Vacation Trust Fund, including one cent per hour for Jury Duty and Witness Duty Benefits.

2. The effective date of eligibility for Jury Duty Benefits shall be June 1, 1972, provided the employee:

    a) Has been credited with employer contributions for Jury Duty Benefits for at least 100 contribution hours in the first three months of the four months immediately preceding the month in which the claim arises, or at least 200 contribution hours in the first six months of the seven months immediately preceding the month in which the claim arises, or

    b) Is active employed within the jurisdiction of Laborers' Local 113, or is actively employed in the construction industry outside of the geographical jurisdiction of Laborers' Local 113 by a contribution employer, or

    c) Is available for work but unemployed through no fault of his own.

Statement of Jury Duty Benefits

All employees eligible for Jury Duty Benefits in accordance with the eligibility rules adopted by the Trustees shall receive the following benefits while serving on a jury or on a jury panel:

1. Jury Duty Benefit payments will be made for lost wages on a daily basis, Monday thru Friday inclusive. Saturday, Sunday and Holidays are not included. The daily rate shall be an amount equal to eight (8) times the straight time hourly rate of a General Laborer plus eight (8) times the Employer's hourly contribution rate to the Health and Pension funds, as provided in the Laborers' Collective Bargaining Agreement in effect at the time in which the claim was incurred, less any amounts paid by the Court and any wages earned from an Employer in the construction industry between 8:00 a.m. and 4:30 p.m., Monday thru Friday, on which day jury duty has been rendered.

2. Jury Duty Benefit payments shall not be paid for more than 40 days in any calendar year, except in extraordinary cases as determined exclusively by the Trustees.

3. If an employee is eligible for Jury Duty Benefits from this Fund and any other fund, this Fund will pay one-half of the benefit otherwise normally payable.

Request for Benefit Payment

Forms and complete instructions for filing a claim for Jury Duty Benefits will be provided at the Fund Office. All forms and supporting materials must be returned to the Fund Office. Failure to return the forms and supporting materials will cause forfeiture of Jury Duty Benefits to which the employee may be entitled.

PART 4 – WITNESS DUTY BENEFITS

Witness Duty Eligibility Rules

All employees shall be eligible for Witness Duty Benefits from the Building and Public Works Laborers Vacation Trust Fund subject to the following rules, and any amendments thereto, which the Trustees may adopt from time to time:

1. An employee shall be working and have worked for an employer required to make contributions on the employee's behalf, to the Building and Public Works Laborers Vacation Trust Fund, including one cent per hour for Jury Duty and Witness Duty Benefits.

2. The effective date of eligibility for Witness Duty Benefits shall be June 1, 1981, provided the employee:

a) Has been credited with employer contributions for Witness Duty Benefits for at least 100 contribution hours in the first three months of the four months immediately preceding the month in which the claim arises, or at least 200 contribution hours in the first six months of the seven months immediately preceding the month in which the claim arises, and

b) Is actively employed within the jurisdiction of Laborers' Local 113, or is actively employed in the construction industry outside of the geographical jurisdiction of Laborers' Local 113 by a contributing employer.

c) Is available for work but unemployed through no fault of his own.

Statement of Witness Duty Benefits

All employees eligible for Witness Duty Benefits in accordance with the eligibility rules adopted by the Trustees shall receive the following benefits while serving as a witness in a criminal proceeding before State Circuit Courts or before United States District Courts:

1. Witness Duty Benefit payments will be made for lost wages on a daily basis, Monday thru Friday inclusive. Saturday, Sunday and Holidays are not included. The daily rate shall be an amount equal to eight (8) times the straight time hourly rate of a General Laborer plus eight (8) times the Employer's hourly contribution rate to the Health and Pension funds, as provided in the Laborers' Collective Bargaining Agreement in effect at the time in which the claim was incurred, less any amounts paid by the Court and any wages earned from an employer in the construction industry between 8:00 a.m. and 4:30 p.m., Monday thru Friday, on which day witness duty has been rendered.

2. Witness Duty Benefit payments shall not be paid for more than 40 days in any calendar year, except in extraordinary cases as determined exclusively the by the Trustees.

3. If an employee is eligible for Witness Duty Benefits from this Fund and any other fund, this Fund will pay one-half of the benefits otherwise normally payable.

Request for Benefit Payment

Forms and complete instructions for filing a claim for Witness Duty Benefits will be provided at the Fund Office. All forms and supporting materials must be returned to the Fund Office. Failure to return the forms and supporting materials will cause forfeiture of Witness Duty Benefits to which the employee may be entitled.

PART 5 – CLAIM REVIEW PROCEDURES

Section 1. Notice of Denial of Claim

The Administrative Manager or Trustees shall give written notice within 90 days of receipt of the initial claim to a Participant, or to his beneficiaries, dependents or authorized or legal representatives, as may be appropriate, (collectively referred to in these Claim Review procedures as "Participant") whenever there has been denied in whole or in part such Participant's claim with respect to eligibility for, or amount of the benefit(s). Such notice shall include the following:

a) The specific reason or reasons for the denial;

b) Reference to pertinent provisions of the Plan (such as eligibility rules, etc.) on which the denial is based.

c) A Description of any additional material or information, if any, necessary for the Participant to perfect the claim, and, where appropriate, an explanation of why such material or information is necessary;

d) An explanation of the Funds' Claim Review Procedure.

Special circumstances may require more time to review a claim. If so, written notice will be given to the participant explaining the reason for the delay along with an estimate of a decision date. An additional 90 days will be allowed to review the claim if the participant is so notified.

If the participant receives no word at all within 90 days after filing (or 180 days, if extended) the claim is considered to be denied and the participant may proceed to the review process.

Section 2. Request for Review

a) Within sixty (60) days after the receipt, by the Participant, of the notice described in and required to be given pursuant to Section 1, wherein the Participant's claim for benefits is denied in whole or in part, or if the Participant is otherwise dissatisfied with a determination of the Administrative Manager of the Trustees (or of a committee of the Trustees) with respect to his eligibility for, or amount of the benefit(s), the participant may in writing:

    1. Request a review of such denial of such a claim;

    2. Request an inspection of designated, pertinent documents or files;

    3. Submit issues and comments, as well as any additional or supplemental material or information which may have been requested in the notice of denial referred to in Section 1 or which the Participant may consider desirable or necessary.

b) As part of such written request for review, a Participant may request a hearing and, in such event, the Participant (or duly authorized representative of his choice) shall be afforded an opportunity to appear before the Trustees or, in the Trustees' discretion, before a committee thereof. No verbatim record of any such hearing or appearance need be made, but the Administrative Manager shall prepare a summary of the Participant's presentation and preserve the same, along with any documents which the Trustees, or any committee thereof, deem pertinent or which the Participant requests to have included in the file.

c) With respect to any matter as to which a Participant requests review in accordance with this Section 2, the Trustees, or a committee thereof, respectively; shall act by the vote of a majority of its members present and shall notify the Participant of its decision.

1. Within sixty (60) days after receipt, by the Office of the Administrative Manager of the Fund, of the written request for review of the denial of the claim in accordance with Section 2(a) and if no hearing is requested in accordance with Section 2(b); or

2. Within one hundred twenty (120) days after receipt, by the Office of the Administrative Manager of the Fund, of the written request for review of the denial of the claim in accordance with Section 2(a) and if a hearing is requested in accordance with Section 2(b).

d) The decision of the Trustees, or of a committee thereof, respectively, on review, shall be in writing and shall include (1) specific reasons for the decision and (2) references to pertinent provisions of the Plan on which the decision is based.

Section 3. Exhaustion of Administrative Remedies

The procedures prescribed by Sections 1 and 2 must be followed and exhausted before any Participant my institute any legal action (including actions or proceedings before administrative agencies) with respect to a claim concerning eligibility for, or amount of the benefit(s) from and under the Fund or Plan. No legal action (including actions or proceedings before administrative agencies) regarding your application or claim concerning your eligibility for, or amount of, your benefits from and under the Fund or Plan may be commenced later than two years from the date the application or claim was initially filed on which the legal action was commenced.

PART 6 – STATEMENT OF ERISA RIGHTS

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and

- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report form the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe 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 federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA at:

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington DC 20210
866-444-3272

Nearest Regional Office:

Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago IL 60606
312-353-0900

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the Web site of the EBSA at www.dol.gov/ebsa. Brochures or publications about your rights and responsibilities under ERISA can also be obtained by calling EBSA publications hotline at (866) 444-3272.

BUILDING & PUBLIC WORKS LABORERS' VACATION TRUST FUND

4633 LIUNA WAY, SUITE 201
DE FOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

The Trustees of the Building & Public Works Laborers' Vacation Trust Fund are providing the enclosed Summary Plan Description (SPD) to give you an understanding of the Plan benefits. This edition, which includes all Plan changes adopted since the previous edition, replaces and supersedes any previous SPD.

The Fund Office would like to remind you of some important issues:

- **Vacation checks are mailed twice a year**; around **mid-June** and the **first week of December**. The exact date of the mailing is dependent on the financial review by the Board of Trustees to determine the amount of earnings, if any, to be paid. The amount of your check is not known until the checks are created and mailed so please do not call the Fund Office to request the check amount.

- **It is the responsibility of the member to contact the Fund Office to report a change of address.** To ensure that you receive your check on time, all address changes should be updated at the Fund Office by May 31st and November 30th. The Fund Office maintains one main address for member's medical and vacation correspondence, therefore we are not able to mail vacation checks to an alternate address.

- **Vacation checks are <u>not</u> forwarded by the Post Office**. All undeliverable checks are returned to the Fund Office. Please allow **10 days** for the Post Office to deliver the checks before calling the Fund Office. Lost or undeliverable checks will not be reissued until 10 business days after the check mailing date.

- **IMPORTANT — Please keep your vacation check stubs. Information on the check stubs will be needed to file your income tax return at the end of the year. The check stubs will contain the total of your working dues withheld as well as the total interest paid on your check, if it was approved by the Trustees.**

- If your total interest received on all vacation checks paid in the calendar year exceeds $10, you will receive a Form 1099-INT. All tax forms are mailed by January 31st. All interest must be reported to the Internal Revenue Service.

If you have any questions, please contact the Fund Office at **608-842-9102** or toll free,800-397-3373 between the hours of 8:00 am and 4:30 pm Central Time.