HEAVY AND GENERAL LABORERS' FUNDS OF NEW JERSEY

Local 472 . Local 172

Joseph P. Madden Building . 700 Raymond Boulevard
Newark, New Jersey 07105
Phone: 973-589-5050 Fax: 973-589-5161

IMPORTANT NOTICE

This is an important notice concerning the health benefits provided by the Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund.

The Notice describes benefit improvements that will be effective April 1, 2017 and a clarification to the 2016 Summary Plan Description. Please take the time to read this Notice carefully, and keep it with your copy of the Fund's Summary Plan Description ("SPD").

GENDER DYSPHORIA COVERAGE

The Fund is always looking for ways to improve the benefits provided to you and your eligible dependents. To that end, we are pleased to announce the following benefit improvement, which is effective April 1, 2017.

The following General Exclusion found in the 2016 SPD on page 63 as an exclusion and not covered by the Plan will be deleted:

N. Treatment leading to or in connection with transsexual surgery.

The Fund will now cover services and supplies related to gender dysphoria including, but not limited to, medically services and supplies for counseling, surgery, durable medical equipment and prescription drugs, in the same way as other medical or surgical services and supplies subject to the Plan's general medical management guidelines.

ADDITION OF ANTI-ASSIGNMENT CLAUSE

The Fund has added the following language to page 140 of the SPD:

PROHIBITION AGAINST ASSIGNMENTS

You are expressly prohibited from assigning the benefits to which you are entitled under this Plan. Therefore, **you may not assign your benefits to any provider and the Plan will not honor any assignment you make to a provider, for any reason.** However, the Plan may choose, in its sole and exclusive discretion, to pay a provider from whom you obtain services directly. The Plan also has discretion to negotiate with an out-of-network provider to reduce their billed charges as set forth in the definition of Fund's ***Fee Schedule/Allowable Amount/Allowed Charge or Maximum Allowable Fee*** found on pages 139-140 of the SPD. If payment is made directly to you as opposed to the provider, it will be your responsibility to pay the provider.

In accordance with the Plan's claims and appeals procedures, the Plan will allow a personal representative authorized by a participant or beneficiary to act on the participant or beneficiary's behalf for claims and appeals purposes only. The Plan's recognition of a personal representative for this purpose shall not be construed as a waiver of the Plan's prohibition against assignments described above.

CLARIFICATION TO SUMMARY PLAN DESCRIPTION

The definition of "Fund's Fee Schedule/Allowable Amount/Allowed Charge or Maximum Allowable Fee" found on pages 138-139 of the SPD misstated the amount that the Plan pays for out-of-network claims. Therefore, the language currently found in the SPD is deleted and replaced with the following amended language:

Fund's Fee Schedule/Allowable Amount/Allowed Charge or Maximum Allowable Fee: means the amount this Plan allows for eligible Medically Necessary services or supplies and will be determined by the Plan Administrator or its designee to be the **lowest** of:

- ✧ With respect to a PPO or participating network health care or dental care provider/facility, the fee set forth in the agreement between the PPO or participating network health care or dental care provider/facility and the PPO network or the Plan.

- ✧ For out-of-network/non-PPO Provider charges, the Fund's Fee Schedule is the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers. This Plan has adopted a Medicare based reimbursement strategy for Non-Network providers, where the maximum amount payable by this Plan is 125% of the amount that would have been payable in accordance with national Medicare allowable amounts.

- ✧ The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim, including instances where there is no allowable amount established by Medicare for the submitted claim.

- ✧ For an in-network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed amount under this Plan is the discounted fee that would have been payable by the plan had the claim been processed as an in-network claim.

- ✧ The health care or dental care provider's/facility's actual billed charge.

In the case where the PPO allowed amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed amount versus the actual billed charges.

The Plan adheres to the National Correct Coding Initiative (NCCI) edits. Claims will be processed according to NCCI guidelines regardless of how a provider submits a claim. For example, when a provider bills separately for several individual services and NCCI guidelines indicate that these services should be billed under a single CPT-code, the Plan will follow the NCCI edits and pay the claim as a single, bundled claim.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim-repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the Plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

If you have any questions regarding the information in this Notice or the enclosed pages, please contact the Fund Office.

Notice of Grandfathered Health Plan Status

The Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund believes this 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 (973) 589-5050. 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.

This Notice is intended to provide you with an easy-to-understand description of certain important changes, updates and clarifications to the Fund's plan of benefits and rules. While every effort has been made to make this description as complete and accurate as possible, this Notice, of course, cannot contain a full restatement of the terms and provisions of the plan. For a full description of your rights under the Fund, please refer to the plan documents (including the SPD).

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the amendment procedures established under the plan and the trust agreement establishing the plan. The formal plan documents and trust agreement are available at the Fund Office and may be inspected by you during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the plan, or to change any provision of the plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the plan and decide all matters arising under the plan.