Cement Masons' Institute Local 502 Welfare Trust Fund

Summary Plan Description
and
Plan Document

2022 Edition

CEMENT MASONS' INSTITUTE LOCAL NO. 502 WELFARE TRUST FUND

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(ADMINISTRATOR AS DEFINED BY LAW)

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Legacy Professionals, LLP

A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this updated booklet describing your health benefits under the Cement Masons' Institute Local 502 Welfare Trust Fund, effective August 1, 2022, unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document, and the Plan's official rules and regulations.

Important terms used throughout this booklet are capitalized and defined. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Fund Office.

This booklet replaces and supersedes any previous written explanation of the Plan.

IMPORTANT REMINDERS

- Tell your family, particularly your spouse, about this booklet and where it is located.
- Please notify the Fund Office promptly if you change your address.
- Only the full Board of Trustees is authorized to interpret the benefits described in this booklet.
- No Employer, the Union, nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan, nor can any such person act as an agent of the Trustees.
- The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. You will be notified in writing of any Plan changes.

NOTICE REGARDING GRANDFATHERED STATUS

The Trustees of the Cement Masons' Institute Local No. 502 Welfare Fund believe 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; one example of this is 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, including, 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 Fund Office, 739 S. 25th Avenue, Bellwood, IL 60104, telephone (708) 544-9105. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (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.

PLAN VENDOR INFORMATION AS OF AUGUST 1, 2022

The **Fund Office** is responsible, under the oversight of the Board, for providing various administrative services for the Plan, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and providing various reports and other services the Plan requires. The Fund Office is available for any questions participants may have regarding Plan benefits. For questions regarding eligibility verification, please call (708) 544-9105.

The **Preferred Provider Organization (PPO or network)** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. ***The Trustees selected Blue Cross Blue Shield of Illinois (BCBSIL) as the Plan's PPO for medical benefits.*** The Blue Cross/Blue Shield ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call the number provided on your ID card, the Fund Office or visit www.bcbsil.com to identify PPO providers.

The **Pharmacy Benefit Manager (PBM)** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs. ***The Trustees selected Sav-Rx to provide the Plan's preferred Prescription Drug coverage.*** Please call Sav-Rx at (800) 228-3108 or visit www.savrx.com for answers to your Prescription Drug questions.

The **Wellness Centers** provide a broad scope of primary care services, annual wellness exams, motion health, urgent care, immunizations, wellness education, lab draws, physical therapy and vision care at no cost to you or your Dependents (if eligible under the Plan). The Wellness Centers are staffed by experienced Physicians and medical assistants. For more information or to set up an appointment for services, please call (312) 421-1016 or visit https://unionwellnesscenters.com.

The **Care Management Organization** helps you and the Fund reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admissions and other medical expenses. ***The Trustees selected Valenz to provide pre-certification, case management and utilization review services to the Plan***. Please contact Valenz for more information at (800) 367-1934.

The **Dental Preferred Provider Organization (PPO)** provides access to dental providers offering discounted fees. ***The Trustees selected Dental Network of America (DNOA) to provide the Plan's Dental PPO.*** Please call DNOA at (800) 522-6758 or visit www.dnoa.com for more information.

The **Life Insurance Benefit and the Accidental Death and Dismemberment (AD&D) Benefit** are provided through an insurance carrier and paid in accordance with the terms of the applicable policy. ***The Trustees selected Dearborn Life Insurance Company to provide the Plan's Life Insurance Benefit and AD&D Benefit***. Please call the Fund Office for further information regarding the terms and limitations of these policies.

The **Hearing Aid Benefit** provides access to hearing aid devices, hearing examinations, hearing screenings and hearing aid fitting fees. ***The Trustees selected Amplifon as the Hearing Aid Benefit provider.*** Please call Amplifon at (877) 298-0653 for more information.

The **Family Supplemental Benefit** helps pay for healthcare expenses that are limited or not covered by the Plan. ***The Trustees selected Zenith American Solutions ("Zenith") as the Family Supplemental Benefit provider.*** Please call Zenith at (800) 757-0071 or visit www.ZenithFlex.com for more information.

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SECTION 1: SCHEDULE OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Fund. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice-versa.

Life Insurance Benefit for Active Employees	
Eligible for 30 or more Pension Credits	$50,000
Eligible for at least 20 but less than 30 Pension Credits	$40,000
Eligible for less than 20 Pension Credits	$30,000
Life Insurance Benefit for Dependents	
Spouse	$15,000
Child (0 – 14 days old)	$0
Child (15 days – 6 months old)	$250
Child (6 months through age 26)	$5,000
Accidental Death & Dismemberment Benefit	
For loss of:	
Life	Principal Sum*
Loss of both hands, both feet or the sight in both eyes	Principal Sum*
Loss of one hand and one foot	Principal Sum*
Loss of one hand, one foot or the sight in one eye	½ Principal Sum*
**The principal sum is equal to your life insurance amount*	
Additional Accident Benefit	
Maximum Benefit	$300 per Accident
Weekly Disability Benefit	
Weekly Benefit Amount	$400 per week for a maximum of 52 weeks

Medical Benefit		
Plan Deductibles for Covered Medical Expenses	***PPO Charges***	***Non-PPO Charges***
Calendar Year Deductible (Does not apply towards Co-Payments and Wellness Benefit)	$175 per person	
Out-of-Pocket Maximum per Calendar Year	***PPO Charges***	***Non-PPO Charges***
Once you reach the out-of-pocket maximum, the Plan pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the remainder of the calendar year. The maximum does not include Deductibles, Prescription Drug Co-Payments and Non-PPO payments (except for certain Non-PPO payments as required by federal law).	$2,000 per person	Not Applicable
Covered Medical Expenses Subject to Maximums		
Chiropractic Care	24 visits per person per calendar year	
Bariatric Surgery (Morbid Obesity)	One occurrence per lifetime	
Covered Medical Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Physician Office Visit	80%	80%
Specialist Office Visit	80%	80%
Diagnostic Tests	80%	80%
Hospital/Facility (Inpatient or Outpatient)	90%	80%
Emergency Services for an Emergency Medical Condition	90%	90% of the lesser of the amount billed or the QPA (PPO out-of-pocket maximum applies)
Air Ambulance	80%	80% of the lesser of the amount billed or the QPA (PPO out-of-pocket maximum applies)
Ground Ambulance	80%	80%
Outpatient Surgical Centers	80%	Not Covered

Medical Benefit		
Covered Medical Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Skilled Nursing Care	80%	80%
Home Health Care	80%	80%
Durable Medical Equipment	80%	80%
All Other Covered Medical Expenses	80%	80%
Prescription Drug Benefit		
Out-of-Pocket Maximum per Calendar Year	$10,000 per person	
Your Co-Payment Amount	***Retail (30-day supply)***	***Mail (90-day supply)***
Generic	10%	10%
Formulary Brand	15%	15%
Non-formulary Brand	20%	20%
Specialty	Mail Order Co-Payments Apply	
Dental Benefit		
Covered Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Calendar Year Deductible (Does not apply to Diagnostic and Preventive Services)	$50	
Calendar Year Maximum Benefit (Does not apply to Dependent children under age 19)	$3,000 per person	
Diagnostic and Preventive Services	80%	
Basis Services	80%	
Major Services	80%	

Orthodontia Care under the Dental Benefit		
Covered Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Maximum Benefit per Lifetime	$4,000 per person (Dependent children up to age 26 only)	
Covered Services	80%	
Vision Benefit		
Covered Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Calendar Year Maximum Benefit (Does not apply to Dependent children under age 19)	$400 per person	
Wellness Benefit		
Covered Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Physical Exam Benefit (Participant and Spouse Only)	100%	Not Covered
Well Child Care Benefit	100%	Not Covered
Hearing Aid Benefit		
Covered Expenses Paid by the Fund up to the R&C Charges	***PPO Charges***	***Non-PPO Charges***
Maximum Benefit (Participant and Spouse Only)	100% up to $1,500 per ear	
Frequency Limit	One per ear for any three (3) year period	
Family Supplemental Benefit		
Calendar Year Maximum Benefit	$3,500 per family	

SECTION 2: ELIGIBILITY

2.01 Active Employee Benefits

A. Work Quarters and Benefit Quarters

A Work Quarter is a period of three consecutive calendar months during which you accumulate credited hours to qualify for Active Employee Benefits under the Plan. A Benefit Quarter is a period of three consecutive calendar months during which you are eligible for Active Employee Benefits under the Plan. Work Quarters and Benefit Quarters consist of the following calendar months as follows:

Work Quarter *Work performed during…*	**Benefit Quarter** *Determines eligibility for…*
May, June, July	September, October, November
August, September, October	December, January, February
November, December, January	March, April, May
February, March, April	June, July, August

B. Initial Eligibility Requirements

1. New Active Employees

If you have never been a Participant in this Plan, you will become eligible for benefits on the first day of the Benefit Quarter following any two consecutive Work Quarters in which you accumulate at least 200 credited hours from working in Covered Employment, or at least 250 credited hours in one Work Quarter from working in Covered Employment.

2. Returning Active Employees

If you have previously been a Participant in this Plan but have since lost coverage, you will become eligible for benefits again on the first day of the Benefit Quarter following the Work Quarter in which you accumulate at least 250 credited hours from working in Covered Employment.

C. Continuing Eligibility Requirements and Hours Bank

Once you meet the Initial Eligibility Requirements, you will continue to be eligible for subsequent Benefit Quarters if you accumulate 250 or more credited hours in the corresponding Work Quarter.

When you work for an Employer, the Contributions that you earn in excess of 250 hours for a Work Quarter will be credited to your Hours Bank. You can accumulate up to a maximum of 1,200 hours in your Hours Bank at any one time.

If you have a Work Quarter with less than 250 credited hours, the number of hours you are short will automatically be withdrawn from your Hours Bank and used to continue your eligibility.

D. Continuing Eligibility Through Self-Payments

If you work during a Work Quarter but fail to earn 250 credited hours and have insufficient hours in your Hours Bank, you may make a Self-Payment to continue your eligibility under the Plan provided you are available to work and were eligible during the prior Benefit Quarter. The amount of the Self-Payment is the difference between 250 and your hours (credited hours from Employer Contributions plus banked hours) multiplied by the current Employer Hourly Contribution Rate.

You may continue to make Self-Payments for up to a maximum of four Benefit Quarters. If you again earn eligibility for a Benefit Quarter because you have at least 250 credited hours, you will be entitled to a new four Benefit Quarter maximum period. If you exhaust the four Benefit Quarter maximum, you must either meet the Initial Eligibility Requirements or make COBRA payments to continue coverage under the Plan.

Your Self-Payment is due before the fifth day of the Benefit Quarter and must be received by the Fund Office (not postmarked) on or before that date. It is your responsibility to make any required Self-Payment on time regardless of whether you receive a notice from the Fund Office. If you fail to submit a timely Self-Payment, your coverage will terminate, and you must meet the Initial Eligibility Requirements or make COBRA payments to continue coverage under the Plan.

E. Coverage During Your Disability

If you cannot work in Covered Employment because of a qualifying disability, you will be credited with disability hours to maintain your eligibility. For purposes of this Section, a qualifying disability is one for which you are either receiving Weekly Disability Benefits from this Plan or receiving workers' compensation benefits (even though you cannot get Weekly Disability Benefits under this Plan for your occupational disability). If you are receiving workers' compensation benefits, you must submit proof of your receipt of those benefits to the Fund Office. You will be credited with 20 disability hours for each full week of your qualifying disability.

The maximum hours you can receive for any one period of disability is 1,040 hours (52 weeks multiplied by 20 hours per week) for a non-occupational disability, and 1,000 hours if you are receiving workers' compensation benefits.

If your qualifying disability lasts longer than 52 weeks and you are eligible for a disability pension from the Cement Masons' Local 502 Pension Plan, your coverage may be continued under the Cement Masons' Local No. 502 Retiree Welfare Plan until you reach normal retirement age (as defined by the Cement Masons' Local 502 Pension Plan).

F. When Coverage Ends

Your coverage for Active Employee Benefits under the Plan will end upon the earliest of the following events:

1. The last day of the Benefit Quarter in which you fail to qualify for eligibility under any of the Plan's eligibility rules;

2. The last day of the Benefit Quarter in which you fail to make a timely Self-Payment;

3. The date on which you enter the armed forces of any country on a full-time basis;

4. Your death; or

5. The Trustees discontinue the Plan.

If you lose coverage under the Plan, the only methods of coverage available to you are to meet the Initial Eligibility Requirements or elect COBRA Continuation Coverage.

G. Reinstatement of Eligibility

If you lose eligibility under the Plan because your Employer failed to submit Contributions on your behalf or you failed to make a timely Self-Payment, you must meet the Initial Eligibility Requirements to regain coverage.

H. Effect of Military Service on Eligibility

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into active service, your eligibility will be frozen during your period of active duty. You can, if you wish, make self-payments to continue your own coverage for up to 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are similar to COBRA continuation coverage. This Plan will pay primary benefits before the military/government pays except for service-related disabilities.

The Plan offers "free" continuation coverage for your Dependents while you are serving in active military duty. The free coverage lasts during your active service, for up to one tour of duty. If your tour of duty lasts for more than four years (48 months), your Hours Bank can be used to continue your Dependents' coverage at a rate of 100 hours per quarter (or they can self-pay at that rate). Running out your Hours Bank or making self-payments can extend their eligibility for an additional three (3) years (banked hours and self-payments combined).

For more information about your rights during military service, contact the Fund Office.

I. Coverage under the Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. Your Employer will submit a copy of the approved application to the Trustees so that your rights to health care coverage are protected during your leave.

During your absence, you will continue to receive coverage under the Plan. If you return to work for an Employer within the FMLA guidelines, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

If your coverage terminates, you will then be eligible for COBRA Continuation Coverage. Contact the Fund Office for additional information about your coverage during FMLA leave or continuing your coverage under COBRA.

You have the right to take unpaid leave if you meet the following criteria:

1. You worked for the same Employer for at least 12 months;

2. You worked at least 1,250 hours during the previous 12 months; and

3. You work at a location where at least 50 employees are employed by your Employer within a 75-mile radius.

The duration of leave available to you will depend upon the reasons for which you are taking the leave, and you should confirm details with your Employer.

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called into active military duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities defined under the FMLA in 29 CFR Part 825.

2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26-week leave is the maximum time period allowed and is not in addition to the 12-week leave provided above.

2.02 Dependent Eligibility

A. Dependents' Initial Eligibility

Your Dependents will become eligible for benefits on the later of the date:

1. You are eligible for coverage; or

2. He or she meets the definition of Dependent under the Plan.

B. When Dependent Coverage Ends

Your Dependents' coverage will terminate on the earliest of the following to occur:

1. The date your eligibility ends for reasons other than your death;

2. The date your spouse or child no longer meets the definition of Dependent under the Plan;

3. The date the Trustees terminate Dependent benefits under the Plan; or

4. The date the Trustees terminate the Plan.

C. Dependent Eligibility in the Event of Your Death

After your death, your surviving Dependents may be able to run out your eligibility under the Plan and exhaust your Hours Bank. Once those benefits are exhausted, they may be eligible to elect COBRA Continuation Coverage.

D. Dependent Eligibility under a Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan for the purposes of the Plan's coordination of benefits rules.

The Fund Office will notify you if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

2.03 COBRA Continuation Coverage

A. General Provisions

When you lose coverage because of a Qualifying Event, coverage for you or your eligible Dependents can be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying events include death of the participant, a reduction of hours, loss of employment (except due to gross misconduct), the participant's entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan and divorce from the participant.

The Plan provides two options for COBRA Continuation Coverage: (1) medical only; and (2) medical, vision and dental. Both options include Prescription Drugs. COBRA Continuation Coverage does not include the following benefits: Life Insurance Benefit, Accidental Death and Dismemberment Benefit, Weekly Disability Benefit and Family Supplemental Benefit.

If you elect COBRA Continuation Coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA coverage is conditioned on timely and uninterrupted payment of premiums.

If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement to have this child added to your coverage. Children born, adopted or placed for adoption

as described above have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage.

B. Marketplace Coverage

There may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

C. Eligibility

1. 18-Month COBRA Continuation Coverage

You and your eligible Dependents may elect up to 18 months of COBRA coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. An eligible beneficiary generally is an individual covered by the Plan on the day before the Qualifying Event occurs. This includes your spouse and your Dependent child. Any child born to or placed for adoption with you during the period of COBRA coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage based on when you no longer have sufficient hours in your Hours Bank to meet the Continued Eligibility Requirements.

2. Disability Extension of 18-Month COBRA Continuation Coverage

If you or an eligible Dependent is determined by the Social Security Administration to be disabled, you and all family members previously covered under COBRA may be entitled to receive an additional 11 months of COBRA coverage. This means that COBRA Continuation Coverage will continue for a total of 29 months if the required premium is paid. Coverage for the additional 11 months may be at a higher cost.

You must notify the Fund Office of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the first 18 months of continued coverage. Otherwise, you will not be eligible for the additional 11 months of coverage.

3. 36-Month COBRA Continuation Coverage

Certain Qualifying Events allow your eligible Dependents to purchase a total of 36 months of COBRA Continuation Coverage. A total of 36 months is allowed if one of the following events occurs:

a. Your death;

b. Your divorce; or

c. Your Dependent child no longer qualifies as a Dependent under the terms of the Plan.

Coverage terminates at the end of the month in which the event occurs. You or your Dependent must notify the Fund Office in writing in the event of a divorce or a child losing Dependent status within 60 days of the date coverage terminates. If you do not provide the notice to the Fund Office within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA Continuation Coverage.

4. Second Qualifying Event

If your eligible Dependent experiences a second Qualifying Event (as listed above) while receiving COBRA Continuation Coverage during the first 18 months of coverage, he or she may be entitled to receive an additional 18 months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly provided to the Fund Office. This extension is available only if the second Qualifying Event would have caused your Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

D. COBRA Premium, Payments and Due Dates

The COBRA premium is determined by the Trustees and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan.

COBRA payments must be made monthly to the Fund Office. The initial COBRA payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA payment is not received by the Fund Office within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the last day of the month in which a timely COBRA premium payment was made. Once this coverage is terminated due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

E. The Notification Responsibilities of the Fund Office

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the

Qualifying Event. The Fund Office will send the notice within 45 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

To protect your rights and your Dependents' rights, you should keep the Fund Office informed of any change in your address or your Dependents' addresses.

F. Electing COBRA Continuation Coverage

You or your Dependents must complete the COBRA Election Form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.

2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.

3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any minor children who were covered by the Plan on the date of the Qualifying Event.

4. The person electing COBRA Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of COBRA Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.

5. If the COBRA Election Form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

G. When the COBRA Coverage Period Begins

If you properly elect COBRA Continuation Coverage, the applicable period of COBRA coverage (18, 29, or 36 months) begins on the date your eligibility or your Dependents' eligibility for coverage otherwise terminated under the Plan.

H. When COBRA Coverage Ends

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group health plan. However, coverage will continue if you or an eligible Dependent was covered under another group

health plan prior to the COBRA election, or if you or the eligible Dependent has a health problem for which coverage is excluded or limited under the other group health plan;

2. The required COBRA premium is not timely paid;

3. The Trustees terminate the Plan;

4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA Continuation Coverage period;

5. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or

6. Your Dependents become entitled to Medicare after their coverage under the Plan ends.

SECTION 3: LIFE INSURANCE BENEFIT

3.01 Eligibility for Life Insurance Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Life Insurance Benefit. The amounts of the Life Insurance Benefit are provided in the Schedule of Benefits. The Life Insurance Benefit will be paid to your beneficiary in the event of your death regardless of the cause of death. Your beneficiary must submit a claim form for benefits and proof of your death.

The Trustees contracted with an insurance carrier to provide this Life Insurance Benefit and the benefit will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

3.02 Designating Your Beneficiary

To designate your beneficiary, you must complete a form supplied by the Fund Office. You may name more than one beneficiary and indicate the percentage of the Life Insurance Benefit you want each beneficiary to receive. If you do not specify the percentage for each beneficiary, your beneficiaries will share the benefit equally. If one of your beneficiaries dies before you, the benefit will be split equally among your remaining beneficiaries. You can change your beneficiary at any time by submitting a new form. Beneficiary designations are effective on the date you sign the form.

If there is no named beneficiary still surviving at the time of your death or if you have not designated a beneficiary, your Life Insurance Benefit will be divided equally among the living members of the first surviving class listed below:

A. Your spouse;

B. Your children;

C. Your parents;

D. Your brothers and sisters; or

E. Your estate.

3.03 Coverage During Total Disability

If you become Totally Disabled while eligible for the Life Insurance Benefit and before age 60, you will remain eligible for the Life Insurance Benefit during your period of disability. You must submit proof of your disability to the Fund Office within twelve months after the date your coverage ends (and after you have been disabled for at least six months). You must submit proof of your continued disability periodically thereafter.

3.04 Dependent Life Insurance Benefit

If your Dependent dies from any cause, the Fund will pay you a Life Insurance Benefit in the amount shown in the Schedule of Benefits. You must submit a claim form for benefits and proof of your Dependent's death.

SECTION 4: ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

4.01 Eligibility for AD&D Benefit

If you are eligible for Active Employee Benefits, your coverage includes the AD&D Benefit. Those covered under COBRA Continuation Coverage are not eligible for this benefit.

The Trustees contracted with an insurance carrier to provide the AD&D Benefit and benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the Fund Office.

AD&D Benefits are payable if you sustain one of the losses listed in the Schedule of Benefits as a result of an accident. The loss must have resulted from an accident that occurred while you were eligible for the AD&D Benefit and the loss must have occurred within 365 days of the date of the accident. For purposes of this Section, "loss" with respect to hands and feet means complete severance through or above the wrist or ankle joint. "Loss" with regard to eyes means entire and irrecoverable loss of sight.

The full amounts of the AD&D Benefit are provided in the Schedule of Benefits. The amount payable for all losses resulting from any one accident cannot exceed this full amount. If you suffer any combination of losses as the result of any one accident, benefits are paid only for the loss that pays the greatest amount.

The amount payable for your accidental death (loss of life) is in addition to your Life Insurance Benefit and is payable to your beneficiary as described in Section 3.02.

4.02 Limitations on AD&D Benefit

The AD&D Benefit does not cover any loss that results from:

A. War or any act of war, whether declared or undeclared;

B. Suicide or attempted suicide, or intentionally self-inflicted injury, while sane or insane;

C. Commission of, or an attempt to commit, a felony, or being engaged in any illegal occupation;

D. Injury resulting from travel in any type of aircraft, except as a fare paying passenger in a commercial aircraft;

E. Bodily or mental infirmity, disease, or bacterial infections (except bacterial infections which occur as a result of an injury), any infections; or

F. Any of the circumstances listed under the General Plan Exclusions listed in Section 15.

SECTION 5: ADDITIONAL ACCIDENT BENEFIT

5.01 Eligibility for Additional Accident Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Additional Accident Benefit. Dependents or those covered under COBRA Continuation Coverage are not eligible for this benefit.

5.02 Additional Accident Benefit

Payments are made under this benefit as a supplement to the other benefit payments made by this Plan for charges incurred for treatment of non-occupational accidental injuries. The treatment must be rendered within 90 days of the date of the accident.

The Plan will pay 100% of the expenses not paid by any other Plan benefit up to $300 per accident. Covered expenses include the Reasonable and Customary charges incurred for hospital and physician services, diagnostic examinations and services provided by a registered nurse.

SECTION 6: WEEKLY DISABILITY BENEFIT

6.01 Eligibility for Weekly Disability Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Weekly Disability Benefit. Dependents or those covered under COBRA Continuation Coverage are not eligible for this benefit.

To be eligible to receive the Weekly Disability Benefit, you must be Totally Disabled as the result of a non-occupational Accident or Sickness and you must be under the regular care of a Physician. You must also be eligible for Plan benefits when the disability begins.

6.02 Payment of Weekly Disability Benefit

The amount of the Weekly Disability Benefit payable is provided in the Schedule of Benefits. If you are disabled for part of a week, you will receive 1/5 of the weekly benefit for each day of Total Disability. The Plan will withhold your share of FICA tax from each weekly payment made to you and will send it to the government. You must include weekly benefits you receive in your gross income and pay Federal Income Tax on them at the end of the tax year. If you have questions about how this works, you should consult a competent tax advisor or legal counsel.

Benefits will start on the first day of disability due to a non-occupational Accident or on the eighth day of disability due to a non-occupational Sickness. This benefit is payable for up to 52 weeks for any one continuous period of disability.

If you have successive periods of disability that are the result from the same or related causes and the successive periods are separated by less than two weeks of full-time work in Covered Employment, they will be considered one continuous period of disability. Alternatively, if the second period of disability is due to an Accident or Sickness entirely unrelated to the cause of the first disability and the second disability begins after you have returned to work in Covered Employment for at least one full day, then the second disability will be considered as a new period of disability and you will be eligible for a new 52-week period of Weekly Disability Benefits.

6.03 Limitations on Your Weekly Disability Benefits

No Weekly Disability Benefits will be paid:

A. For any disability resulting from a Sickness or Accident for which you are not under the direct care of a Physician;

B. For any work-related disability, or any disability for which you are receiving, in whole or in part, unemployment compensation benefits under any workers' compensation law, employers' liability law or similar laws;

C. For any disability that began while you were continuing coverage under the Plan through COBRA payments;

D. After you become covered under another group health plan; or

E. For any loss caused by the circumstances listed under the General Plan Exclusions in Section 15.

SECTION 7: MEDICAL BENEFIT

7.01 Eligibility for Medical Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Medical Benefit.

7.02 Deductible

The Deductible is the amount of Covered Medical Expenses that you and each of your eligible Dependents pay each calendar year before Plan benefits are paid. The amount of the individual Deductible is listed in the Schedule of Benefits. The amounts you pay out-of-pocket to satisfy the Deductible do not apply to your out-of-pocket maximum.

If a covered person's Deductible is entirely met by Covered Medical Expenses incurred during October, November and December of a calendar year, that covered person's Deductible for the following calendar year will be waived.

7.03 Percentage of Benefits Payable

Once you pay the calendar year Deductible, the Fund will pay the percentage of your Covered Medical Expenses listed in the Schedule of Benefits up to the Reasonable and Customary (R&C) charges and up to any Plan maximums.

7.04 Out-of-Pocket Maximum

After paying your Deductible, the maximum amount you pay for Covered Medical Expenses each calendar year is the out-of-pocket maximum listed in the Schedule of Benefits. Once you reach the applicable out-of-pocket maximum, the Fund pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the remainder of the calendar year. The Out-of-Pocket Maximum applies to each covered person in your family separately.

The following out-of-pocket payments do not count toward satisfying the out-of-pocket maximum:

A. Deductibles;

B. Prescription Drug Co-Payments;

C. Payments made for Non-PPO expenses (except for certain Non-PPO payments as required by federal law);

D. Payments made for expenses that are not considered Covered Medical Expenses;

E. Payments made for any charge or any portion of a charge that is considered not to be Reasonable and Customary, including any charges in excess of the R&C amounts; and

F. Charges incurred in excess of any applicable maximum benefit.

7.05 Preferred Provider Organization (PPO)

The Fund contracts with Preferred Provider Organizations (PPO) to help control medical costs. A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower as a result of the Fund's participation in the PPO.

To minimize your out-of-pocket costs, contact the Fund Office for information about which Hospitals and providers are in the Plan's PPO network. Although you are not required to use PPO Hospitals and providers, when you use PPO Hospitals and providers rather than Non-PPO Hospitals and providers, you can reduce costs for both you and the Fund.

Covered Non-PPO Hospital charges will be paid as if incurred at a PPO Hospital if the patient resides more than 50 miles from a PPO Hospital, or if the treatment is due to an Emergency.

7.06 Pre-Certification, Case Management and Utilization Review

The Fund has contracted with a provider to perform pre-certification, case management and utilization review.

A. Pre-Certification.

Pre-certification is the process of obtaining approval from the Fund before you have certain procedures performed. Pre-certification is mandatory for the following expenses:

1. Inpatient Hospitalizations
2. Inpatient Mental/Nervous Disorders and/or Chemical Dependency/Substance Abuse Treatment
3. Outpatient Surgery
4. Home Health Care
5. Durable Medical Equipment
6. Physical Therapy
7. Bariatric Surgery (Morbid Obesity)
8. Maternity Services
9. Infertility Services
10. Skilled Nursing Care
11. Hospice Care
12. Speech Therapy
13. Applied Behavioral Analysis

If you are expecting to incur expenses for these types of treatment, you, someone on your behalf, or your Physician must contact the care management organization to obtain pre-certification prior to incurring the expense.

Other selected procedures, medical supplies, and/or therapy may require pre-certification to ensure that the service is Medically Necessary and meets standard guidelines for care. Before you receive treatment recommended by your Physician, you or your Physician should view the pre-certification list of selected procedures, medical supplies, or therapies by contacting the Fund's care management

organization. Once you have provided the necessary information, the care management organization will evaluate the proposed services based on your individual treatment needs and the standards of the community.

Please remember that pre-certification does not verify eligibility for benefits or guarantee benefit payments under the Plan. Pre-certification also does not constitute a guarantee or warranty of the quality of treatment you receive.

B. Case Management and Utilization Review

Case management is a process in which you as the patient, your family, Physician and/or other health care providers and the Fund work together under the guidance of the Fund's care management organization to coordinate a quality, timely and cost-effective treatment plan that provides Medically Necessary services. Participation in the case management program is voluntary, but the Fund encourages you to explore how this benefit can help you manage your disease or injury. Utilization review is the evaluation of the necessity, appropriateness and efficiency of medical services, procedures and facilities.

7.07 Covered Medical Expenses and Exclusions

A. Covered Medical Expenses

The Plan covers the Reasonable and Customary (R&C) Charges, subject to the Plan maximums and limitations provided in the Schedule of Benefits for the following services and supplies (Covered Medical Expenses) provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:

    a. Room and board fees up to:

        i. The Hospital's regular daily semi-private rate; or

        ii. The Hospital's regular daily rate for a private room, when required.

    b. Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services while hospitalized.

    c. Outpatient Hospital services including fees incurred for:

        i. Outpatient surgical procedures; and

        ii. Emergency treatment for an Accident or Sickness.

    Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the

mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Fund or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

2. Medical care and treatment (including surgery) that is listed as a covered expense under the Plan and is provided by a legally qualified Physician.

3. Second surgical opinions.

4. Services and supplies provided in an Outpatient Surgical Center. Services and supplies provided by Non-PPO Outpatient Surgical Centers are not covered.

5. Nursing care by an R.N. or an L.P.N. provided the attending Physician furnishes written certification that the nursing care is Medically Necessary. The nursing care must be rendered by a nurse who is not a relative, either by blood or through marriage, of the patient, does not ordinarily live in the patient's home, and is not an employee of the Hospital where the patient is confined.

6. Transfer by local ambulance from the place where an Accident occurs or a Sickness begins to the nearest Hospital where suitable treatment is available.

7. Anesthetics and their administration.

8. X-ray treatment, x-ray examinations, radioactive therapy, magnetic resonance imaging (MRI), positron emission tomography (PET) and computed tomography (CT/CAT) scans.

9. Physical therapy administered by a registered physical therapist under the direction of a Physician.

10. Occupational therapy provided by a registered occupational therapist under the direction of a Physician. Covered Medical Expenses do not include supplies relating to occupational therapy.

11. Speech therapy provided by a qualified registered speech therapist to restore speech loss, or to correct an impairment, due to a congenital defect for which corrective surgery has been performed, or due to an Accident or Sickness. The treatment may be rendered in or out of a Hospital and must be recommended by the attending Physician. Prior approval must also be obtained in advanced by the care management organization.

12. Developmental speech language therapy for Dependent children up to age 19, provided the therapy is provided by a licensed speech and language pathologist.

13. Radiation therapy.

14. Chemotherapy for malignancies.

15. Oxygen and the rental of equipment for its administration.

16. Whole blood and blood plasma and its administration.

17. Bandages and surgical dressings, casts, splints, trusses, braces and crutches.

18. Surgical supplies, including appliances to replace lost physical organs or parts, and surgical supplies required to aid any impaired physical organ or part in its natural body function.

19. Prosthetics such as artificial limbs and eyes. Only the initial charge for such an appliance is a Covered Medical Expense.

20. Purchase and/or rental of Durable Medical Equipment. The Fund reserves the right to purchase the equipment instead of paying for rental if purchase would cost less than the reasonable and customary rental amount.

    Durable Medical Equipment means equipment, recognized as such by Medicare Part B, that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose related to the person's physical disorder, (c) generally is not useful in the absence of illness or injury and (d) is appropriate for use in the home.

    Examples of Durable Medical Equipment include: wheelchairs, Hospital-type beds and equipment for giving oxygen.

    Coverage for Durable Medical Equipment is not provided for (a) equipment that serves as a comfort or convenience item or (b) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

    Examples of equipment that are not covered include, but are not limited to, the following: exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, whirlpool tubs and portable jacuzzi pumps.

21. Reconstruction surgery for repairs following surgery, repairs of a congenital defect of a newborn child and the nonaffected breast to achieve symmetrical appearance.

22. Certain dental services as follows:

    a. Treatment of injuries to sound natural teeth (including initial replacement) when rendered within 90 days following the Accident that caused the injury;

    b. Setting of a fractured jaw; and

    c. Other surgical procedures on the gums and oral tissues when not performed in connection with the removal or repair of teeth, including but not limited to, the removal of alveolar abscesses and tumors, apicoectomies, removal of cysts of the jaws, removal of tumors of the gums, and surgical treatment of the gums necessary to treat periodontal (gum) disease.

23. Chiropractic treatment provided by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine or a Registered Physical Therapist (under direction of a Physician) for treatment of the back, neck, spine and vertebra for conditions due to subluxation, strains, sprains and nerve root problems, subject to the maximums listed in the Schedule of Benefits.

Covered Medical Expenses do not include diet or hair analysis, massage therapy, booklets, pamphlets or other education materials and acupuncture.

24. Home birth deliveries by a Physician.

25. Vasectomies and tubal ligations for Employees and spouses only.

26. Inpatient and outpatient treatment of a covered Mental or Nervous Disorder, including individual or group therapy rendered by a psychiatrist, psychologist, Physician (M.D. or D.O.), Hospital, accredited treatment facility, or a master's level mental health clinician.

27. Inpatient and outpatient treatment of Chemical Dependency/Substance Abuse, including individual or group therapy rendered by a psychiatrist, psychologist, Physician (M.D. or D.O.), Hospital, accredited treatment facility, or a master's level mental health clinician.

28. Charges incurred for the diagnosis and treatment of infertility, including but not limited to the following procedures: in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer.

    In vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures are covered only if the following conditions are met:

    a. You or your spouse has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under this Plan.

    b. You or your spouse has not undergone four completed oocyte retrievals, except that of a live birth follows a complete oocyte retrieval, then two more completed oocyte retrievals will be covered.

29. Organ and tissue transplants provided the procedure meets the coverage criteria established by Medicare (regardless of whether you are covered by Medicare). Benefits are payable for both the recipient and the transplant donor. Covered Medical Expenses do not include expenses that are payable by a governmental or charitable program or grant.

30. Room and board, services and supplies provided during an approved confinement in a Skilled Nursing Facility.

31. Home health care services and supplies provided in accordance with the following rules and requirements:

    a. The plan of home nursing care must be established and approved in writing by the patient's Physician;

    b. The Physician must certify that the home health care is for the same or related condition(s) for which the patient was hospitalized and that proper treatment of the patient's condition would require hospital confinement in the absence of the service and supplies provided as part of the home place of care;

c. Prior approval is obtained in advanced by the care management organization; and

d. The home health care services must be provided by or through an organization which meets the Plan's definition of Home Health Agency.

Covered Medical Expenses for home health care services include charges incurred for the following services and supplies:

a. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

b. Part-time or intermittent home health aide services;

c. Medical social services provided under the direction of a Physician; and

d. Medical supplies (other than prescription drugs and biologicals) and surgical supplies.

Covered Medical Expenses do not include homemaker services, food or home delivered meals, and custodial care.

32. Hospice care services and supplies provided in accordance with the following rules and requirements:

a. The attending Physician must certify that the patient's life expectancy does not exceed six (6) months;

b. Services must be approved in advance by the care management organization; and

c. Services must be provided by a facility which meets the Plan's definition of Hospice Organization.

Covered Medical Expenses do not include services or supplies not provided as "core services" by the Hospice Organization, bereavement counseling, administrative services, child care, housekeeping services or services and supplies rendered by family members.

33. Treatment or surgery for <u>one</u> occurrence of morbid obesity if the covered person:

a. Has a body mass index (BMI) of 40 or greater, or a BMI of 35 or greater with an obesity-related co-morbid condition including, but not limited to the following:

i. Diabetes mellitus;

ii. Cardiovascular disease;

iii. Hypertension; or

iv. Life threatening cardio pulmonary problems;

b. The person has a documented history of unsuccessful attempts to reduce weight by more conservative measures;

c. The surgery is performed at a PPO Hospital;

d. Is at least twenty-one (21) years of age.

Treatment must be ordered by a Physician and services must be approved in advance by the care management organization. Covered Medical Expenses do not include post-surgical removal of excess skin following successful weight loss.

34. Prophylactic surgery, including but not limited to, unilateral or bilateral mastectomies, to prevent or treat a disease or condition identified by genetic testing.

35. Medical and surgical benefits for mastectomies as required by federal law under the Women's Health and Cancer Rights Act of 1998 (WHCRA), including the following, when requested by the patient in consultation with her Physician:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications of all stages of mastectomy including lymphedemas.

36. Applied behavioral analysis services for the treatment of autism.

B. Medical Expenses Not Covered by the Plan

No benefits shall be payable under the Medical Benefit for charges incurred which are in excess of any maximum benefit or limitation specified in the Schedule of Benefits or this Section. No benefits will be payable which are not specifically included under the terms of the Plan, or which are specifically excluded from coverage. Specifically, the Medical Benefit does not cover the following:

1. Treatment, care, services, supplies or procedures which are not recommended or approved by a Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.

2. Services or supplies that are not Medically Necessary, as determined by the Plan Administrator.

3. Treatment, care, services, supplies or procedures received from a physician, hospital, home health agency, outpatient surgical center or skilled nursing facility which does not meet the Plan's definition of such person, facility or organization.

4. Charges for Non-PPO Outpatient Surgical Centers.

5. Charges for personal comfort items incurred at a Hospital or otherwise, including but not limited to: personal laundry, guest trays, beds or cots for guests or family members, the purchase or rental of a radio, television or telephone, or telephone charges.

6. Treatment, care, services, supplies or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational Accident or Sickness, unless specifically identified as being covered under the Plan.

7. Charges incurred for any type of custodial care (milieu therapy). Custodial care means the type of care, wherever furnished and by whatever name called, including room and board or any other type of care, which is designed primarily to assist a person in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called.

8. Physical therapy, speech therapy or any other type of corrective therapy if the prognosis or history of the individual receiving the treatment or therapy does not indicate that there is a reasonable chance of improvement.

9. Physical examinations for employment, school, marriage or other reasons that are not necessary for treatment of a Sickness, except as specifically identified as being covered under the Plan.

10. Inoculations and treatments, including flu shots, to prevent the contraction of a disease, unless specifically identified as being covered under the Plan.

11. Charges incurred for travel or transportation, except as specifically provided in the Plan.

12. Contraceptive devices or any other method of contraception, except as specifically provided in the Plan.

13. Treatment of an overweight condition or obesity, except as provided in the Plan for surgical treatment of morbid obesity.

14. Hearing devices, or their fitting or repair, including but not limited to hearing aids and cochlear implants.

15. Charges for eye refractions, eye examinations, contact lenses, eyeglasses, or the fitting of eyeglasses, unless specifically provided in the Plan or the charges incurred for eye refractions and/or eye examinations are rendered as a result of an Accident and within 12 months of the date of the Accident. This exclusion does not apply to the first pair of contact lenses or eyeglasses required following cataract surgery.

16. Charges incurred for dental surgery, dental x-rays or other dental services and supplies provided for or in conjunction with treatment of the teeth, the gums (other than for tumors) and other associated structures primarily in connection with the treatment or replacement of teeth, except as specifically provided for by the Plan.

17. Charges incurred for any care, treatment or surgical procedure that is of an elective nature or for any non-Emergency plastic or cosmetic surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts and abdominal tissue, except for the following:

a. Correction of defects resulting from accidental bodily injury;

b. Correction of congenital defects;

c. Corrective surgical procedures on organs of the body which perform or function improperly; or

d. Surgical reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to achieve a symmetrical appearance.

18. Reversal or attempted reversal of any voluntary vasectomy or sterilization procedure.

19. Any expenses or charges for sex transformation.

20. Any expenses or charges for penile implants.

21. Acupuncture or acupressure.

22. Smoking cessation products or programs.

23. Charges incurred for any abortion which is not a therapeutic abortion (one that is essential to the health of the mother).

24. Vasectomies or other sterilization procedures performed on a Dependent child.

25. Any charges for treatment or consultation with a marriage counselor, naprapath, naturopath, pastor, rabbi or priest.

26. Surgical or laser procedures to correct nearsightedness, farsightedness or astigmatism, including Laser Assisted In-Situ Keratomileusis (Lasik) surgery.

27. Any of the following items of a similar nature or purpose, regardless of intended use: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, dehumidifiers, pillows (including allergy-free pillows), blankets or mattress covers, commodes, electric heating units, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, chiropractic braces, wigs (unless required due to hair loss following chemotherapy or disease), devices or surgical implantations for simulating natural body contours, breast pumps or health club memberships.

28. Charges incurred for treatment of injuries caused by suicide, attempted suicide or self-inflicted injury, unless the injuries resulted from a medical condition (including both physical and mental health conditions).

29. Charges incurred for special education provided to any person, regardless of the type or purpose of the education, the recommendation of the attending Physician or the qualifications of the individuals providing the education.

30. Charges incurred for a confinement in an institution which is primarily a place of rest, a place for the aged, or a convalescent or nursing home except as specifically provided under covered expenses for a Skilled Nursing Facility.

31. Treatment, care, services, supplies or procedures rendered or provided while a covered person is confined in a Hospital owned or operated by a state, province, or political subdivision, or owned or operated by the United States government or an agency of the United States government, provided however, that if charges are made by a Veterans Administration (V.A.) Hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service related disability, to the extent required by law, such charges will be considered Covered Medical Expenses had the V.A. not been involved.

32. Education, training or room and board while a person is confined in an institution which is primarily a school or other institution for training.

33. Charges for diabetes self-management training, education or medical nutrition therapy.

34. Charges incurred which are in excess of any specified limitation in, or which are specified as not payable in, any other provisions of this Section.

35. Services or supplies for which no charge is made or payment required.

36. Genetic testing unless the result of the test will directly impact the treatment being delivered to a patient who has a diagnosed medical condition.

37. Charges for surrogacy or surrogate fees, including but not limited to, charges in connection with the medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan, or a female Employee's or Dependent's carrying and delivering a child for someone else. Any child born of a covered person acting as a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse.

38. Charges incurred for any of the circumstances listed under the General Plan Exclusions in Section 15.

SECTION 8: PRESCRIPTION DRUG BENEFIT

8.01 Eligibility for Prescription Drug Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Prescription Drug Benefit. The benefit amounts are shown in the Schedule of Benefits. The Prescription Drug Benefit also applies to your Dependents and is subject to the Plan's coordination of benefits rules. Dependents that have primary coverage through another group plan should use those prescription drug benefits first, and this Plan will provide secondary coverage.

8.02 General Information

The Prescription Drug Benefit covers Prescription Drugs and is administered by a prescription benefit manager (PBM). Accordingly, the Prescription Drug Benefit is subject to the contractual agreements between the Fund and the PBM.

The Fund Office provides the PBM with eligibility data including primary and secondary coverage information. In most cases, the pharmacist has access to this information and will coordinate benefits at the point of purchase. If the coordination of benefits does not take place at the point of purchase, a claim will need to be submitted directly to the PBM.

8.03 The Retail Pharmacy Program

A. Using a Participating Pharmacy

The Retail Pharmacy Program offers benefits for short-term prescriptions (up to a 30-day supply). When you become eligible for benefits, you will receive the appropriate identification cards for use at any participating pharmacy.

To receive benefits, you must present your ID card and your prescription to the pharmacist. When you use a participating pharmacy, you pay only the applicable Co-Payment listed in the Schedule of Benefits.

You will receive the quantity prescribed by your Physician, up to the maximum described above, in the Schedule of Benefits and in accordance with clinical quantity limits based on usage considered reasonable, safe and effective. You do not need to submit any forms, receipts or claims. The pharmacist will submit the claim.

B. If You Do Not Use a Participating Pharmacy

You should be able to locate a participating pharmacy near your home and wherever you travel. If you choose to fill your prescription at a non-participating pharmacy or you fail to present your ID card to a participating pharmacy, the prescription will not be covered. If you must purchase medication from a non-participating pharmacy due to an Emergency or if you have lost or misplaced your ID card, you must pay the full price of the medication and then file a claim with the PBM for reimbursement. If the claim is covered, you will only be reimbursed the amount the Fund normally pays for that prescription minus any Deductible and/or Co-Payment.

8.04 The Mail Order Program

You may use the Mail Order Program to order up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. You are encouraged to use this service for maintenance medications which are medications you or your Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis. You and the Fund will both save money if you utilize the Mail Order Program for maintenance medications.

If your Physician prescribes a long-term medication that you need right away, ask the Physician to write two prescriptions — one prescription to be filled at a participating pharmacy pursuant to the Retail Pharmacy Program and one prescription for the remainder of the medication to be submitted to the Mail Order Program.

For more information on the Mail Order Program, please contact the Fund Office or PBM. You will be responsible for paying the Co-Payment listed in the Schedule of Benefits for each prescription ordered.

8.05 Covered Prescription Drugs

Unless otherwise excluded, both parts of the program cover prescriptions by a Physician for the following:

A. All federal legend drugs;

B. State restricted drugs;

C. Compound medications;

D. Federal legend oral contraceptives;

E. Insulin on prescription, including test strips, lancets and all diabetic supplies; and

F. Needles and syringes on prescriptions.

8.06 Drugs Not Covered

This Prescription Drug Benefit does not cover the following:

A. Over-the-counter prescription drugs and medicines or any other item which can be obtained without a Physician's prescription or any drug not legally dispensed by a registered pharmacist. This exclusion does not apply to non-prescription diabetic supplies.

B. Birth control medications unless prescribed by a Physician for therapeutic treatment of a Sickness.

C. Non-sedating antihistamines, including Allegra, Zyrtec and Clarinex;

D. Weight loss medications;

E. Drugs or hormones prescribed for the purpose of stimulating or enhancing growth;

F. Rogaine or similar drugs and preparations to promote hair growth;

G. Nutritional supplements, food supplements or substitutes, vitamins and minerals except prescribed prenatal vitamins;

H. Drugs or medicines which are not prescribed to treat a mental or physical condition for which the United States Food and Drug Administration (FDA) has approved usage of such product, or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage;

I. Any supply of a Prescription Drug that is in excess of the quantity limitations specified in the Plan or above the federal guidelines for such drug;

J. Any charges incurred which are in excess of any specified limitation in the Schedules of Benefits; and

K. Any of the circumstances listed under the General Plan Exclusions in Section 15.

8.07 Mandatory Generic Drug Program

If a brand name drug has a generic equivalent, the generic equivalent will be substituted for the name brand. If you or your Physician request a brand name drug instead of its generic equivalent, you will be responsible for 100% of the cost of the brand name drug.

If the PBM determines, in consultation with your Physician, that the brand name drug is Medically Necessary, the Plan will make an exception to its exclusion and you will only be responsible for the applicable brand name Co-Payment. Please contact the PBM for more information.

8.08 Other Pharmacy Programs

A. Specialty Drug Program

Specialty medications include high-cost biotech injectable, infusion, intravenous (IV) drugs and certain oral medications. Specialty drugs are often prescribed for diseases such as multiple sclerosis, rheumatoid arthritis, hepatitis C and asthma. Eligible individuals that are prescribed specialty drugs will automatically be enrolled in the Specialty Drug Program. Specialty drugs require prior authorization by the PBM in accordance with the Prior Authorization Program described below in Section 8.08(B).

The first specialty drug fill (up to a 30-day supply) should be filled at a participating retail pharmacy. After the first fill, all subsequent refills should be ordered through the PBM specialty pharmacy in 30-day quantities. Support services for you and your Dependents are available through the PBM as needed. The eligible individual will pay the applicable mail order Co-Payment for each 30-day supply. Orders for specialty drugs should be mailed or faxed to:

Sav-Rx Specialty Pharmacy
P.O. Box 8
Fremont, NE 68026
Fax: (402) 753-2890

B. Prior Authorization Program

The PBM's Prior Authorization Program is an extension of the Specialty Drug Program and targets medications that do not quite qualify as specialty medications but do benefit from additional clinical management.

Prior authorization is required for all injectable drugs, certain oral chemotherapy and hepatitis agents, certain topical testosterone preparations, specified controlled substances and certain antidepressants. Prior authorization may apply to additional drugs not enumerated above for both standard and/or urgent care requests. The prior authorization process shall be conducted in accordance with federal law.

Prior authorization may be requested by you or your Physician before the prescription is presented to the pharmacy. Otherwise, the prior authorization process begins when you present the prescription to the pharmacy. The PBM will contact your Physician to obtain the necessary documentation and will either approve or deny the request for prior authorization based on the clinical information received.

C. Therapeutic Interchange Program

The Therapeutic Interchange Program is a voluntary program that educates you about therapeutic alternatives in your treatment that may save you money. If your medication has a lower cost alternative, you may receive an educational letter from the PBM. You may show this letter to your Physician to discuss if the lower cost medication will work for you. To enroll in this program, please contact the PBM.

8.09 Smoking Cessation Benefit

The Plan will pay up to 90 days twice a year for Physician prescribed smoking cessation drugs (including over-the-counter drugs), provided you obtain a prescription from your Physician and purchase the product(s) at a participating pharmacy with your identification card. A prescription from your Physician is necessary even if the smoking cessation drug can be purchased over-the-counter.

8.10 Out-of-Pocket Maximum.

The maximum amount you pay for expenses under the Prescription Drug Benefit each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Plan pays 100% of all covered Prescription Drug Benefit expenses for the rest of the calendar year.

SECTION 9: WELLNESS CENTERS

9.01 Eligibility for Wellness Centers

If you are eligible for Active Employee Benefits, you may access services provided by the Chicagoland Construction Trades Wellness Center Cooperative (Wellness Center Cooperative).

9.02 Medical Benefits under Wellness Centers

The Wellness Centers provide a full range of medical services at **no cost to you or your family**, including primary care services, annual wellness exams, motion health, urgent care, immunizations, wellness education, lab draws, physical therapy and vision care. The Wellness Centers also provide on-site access to select prescription drugs when prescribed by a Wellness Center provider.

The Wellness Centers are staffed by experienced physicians and medical assistants, and are open Monday through Friday and located at the following addresses:

UWC – Bellwood
2400 Madison Street
Suite 102A
Bellwood, IL 60104

UWC – Channahon
25407 S. Bell Road
Suite A
Channahon, IL 60410

UWC – Crestwood
4736 Cal Sag Road
Suite A
Crestwood, IL 60445

UWC – Crystal Lake
360 Station Drive
Suite 260A & 260B
Crystal Lake, IL 60014

UWC – Lemont
15900 W. 127th Street
Suite 221A
Lemont, IL 60439

UWC – Rosemont
6300 N. River Road
Suite 100A & 100B
Rosemont, IL 60018

UWC – Warrenville
28600 Bella Vista Parkway
Suite 2010A & 2010B
Warrenville, IL 60555

Please contact the Wellness Centers to schedule an appointment at (312) 421-1016 or visit https://unionwellnesscenters.com for more information.

9.03 Vision Benefits under Wellness Centers

The Wellness Centers also provide certain vision benefits through Union Eyes. The vision benefit through Union Eyes provides one comprehensive eye examination per calendar year and either one pair of glasses per calendar year or one year supply of contact lenses at no cost. Active Employees may also receive one pair of prescription or non-prescription safety glasses per calendar year at no cost.

SECTION 10: DENTAL BENEFIT

10.01 Eligibility for Dental Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Dental Benefit.

10.02 Payment of Dental Benefit

The Plan will pay benefits up to the Reasonable and Customary Charges pursuant to the Schedule of Benefits.

10.03 Dental PPO Network

The Fund contracts with a Dental PPO Network as an additional option with no change in benefits. If you use a provider in the Fund's contracted network, the charges may be lower and, as a result, both you and the Fund pay less.

10.04 Alternative Course of Dental Treatment

In determining the amount of benefits payable, the Fund Office may consider alternate courses of treatment appropriate to your condition and capable of accomplishing the desired results. The determination of such an alternative may be based on treatment that is:

A. Customarily used nationwide in the treatment of the condition; and

B. Recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice.

Once you know the exact amount of benefits payable for the treatment, you and your Dentist can discuss the dental treatment option that is appropriate for you. If an alternate course of treatment is suggested, and both you and your Dentist agree to proceed with the more expensive level of care, any charges in excess of the R&C Charge will not be considered covered dental expenses and you will be responsible for paying any excess costs.

10.05 Covered Dental Expenses

The following list provides examples of covered dental expenses, including services and supplies provided by a Dentist or provided under a Dentist's supervision:

A. Diagnostic and Preventative Services

1. Two routine oral examinations per calendar year.

2. Two routine prophylaxis treatments per calendar year.

3. Two fluoride treatments per calendar year for individuals up to age 16.

4. Space maintainers for individuals up to age 16. The Plan's allowance includes all adjustments within six months of installation.

5. The following x-rays:

    a. Bitewing x-rays are payable two films per calendar year.

    b. Full-mouth series or panorex x-rays are payable once every three calendar years.

    c. Extraoral x-rays payable two films per calendar year.

    d. Individual periapical or occlusal x-rays.

6. Emergency palliative treatment to temporarily relieve pain.

7. Bacteriologic cultures.

8. Biopsies.

B. Basic Services

1. Diagnostic casts once every two calendar years.

2. Amalgam restorations. Multiple restorations on one tooth surface will be treated as a single filling.

3. Pin retention limited to two pins per tooth. Pin retention is not covered in addition to cast restoration except under unusual circumstances and recommended by a Dentist.

4. Silicate or plastic restorations.

5. Composite restorations.

6. Stainless steel crowns.

7. Recementing of inlays, crowns and bridges.

8. Sedative fillings. A separate benefit is allowed only if no other service was performed during the same visit.

9. Palliative treatment. A separate benefit is allowed only if no other services other than x-rays were performed during the same visit.

10. Pulpotomies.

11. Root canal therapy.

12. Root scaling, once every two years.

13. Periodontal maintenance cleanings, two every two years.

14. Apicoectomies and retrograde fillings.

15. Hemisections.

16. Provisional splinting.

17. Repairs to full or partial dentures and bridges. Covered expenses are limited to work performed more than 12 months after the initial placement.

18. Relining of dentures. Covered expenses are limited to work performed more than 12 months after the initial placement.

19. Simple tooth extractions.

20. Root recoveries.

21. Alveoplasties.

22. General anesthesia when required for complex oral surgical procedures covered under the Plan.

C. Major Services

1. Gold inlays and onlays, provided the tooth cannot be restored with fillings. Covered expenses are limited to one every five calendar years.

2. Porcelain filings.

3. Crowns provided the tooth cannot be restored with fillings. Covered expenses are limited to one every five calendar years.

4. Gold posts and cores.

5. Frenectomy.

6. Occlusal adjustment, but only when performed in connection with periodontal surgery.

7. Full dentures. Covered expenses do not include charges for over-dentures or customized dentures.

8. Partial dentures. Covered expenses do not include charges for precision or semi-precision attachments.

9. Fixed bridges.

10. Treatment of temporomandibular joint (TMJ) dysfunction or syndrome.

11. Treatment of periodontal disease.

10.06 Orthodontia Care

If you or your eligible Dependent receives treatment from an orthodontist, the Fund pays the R&C Charges for the initial and subsequent installation of orthodontia appliances, including cephalometric x-rays, pursuant to the Schedule of Benefits.

10.07 Exclusions and Limitations

The following list provides examples of dental services and supplies that are not covered under the Plan.

1. Procedures that are not listed as a covered expense, or which are not necessary.
2. Dental services or supplies which are covered under the Medical Benefit.
3. Sealants.
4. Treatment by anyone other than a Dentist, except for cleaning and scaling of teeth performed by a licensed dental hygienist under the supervision and direction of a Dentist.
5. Services or supplies that are partially or wholly cosmetic in nature.
6. Crowns for teeth that are restorable by other means, or for the purpose of periodontal splitting.
7. Procedures related to the change of vertical dimension, change of occlusion, bite registration or bite analysis.
8. Replacement of bridges, partials, dentures, orthodontic appliances, inlays or crowns within five years of the date the prior prosthetic was placed, unless the replacement was made necessary by the extraction of functioning natural teeth or accidental bodily injury. Chewing injuries are not considered accidental bodily injuries.
9. Implants.
10. Replacement of lost or stolen appliances.
11. Precision or semi-precision attachments.
12. Denture duplication.
13. Charges for failure to keep a scheduled visit with the Dentist.
14. Services or supplies for which coverage is available under workers' compensation or employer's liability laws.
15. Services rendered by a Dentist beyond the scope of his license.
16. Charges incurred in excess of the maximum benefits stated in the Schedule of Benefits.
17. Any of the circumstances listed under the General Plan Exclusions in Section 15.

10.08 Incurred Dates

The Dental Benefit is payable only for covered dental expenses incurred while covered under the Plan. Charges are considered incurred as follows:

1. For dentures and partials – on the date the final impression is made.

2. For fixed bridges, crowns, inlays and onlays – on the date the teeth are prepared.

3. For root canal therapy – on the date the pulp chamber is opened.

4. For orthodontic treatment – the initial fee is considered incurred on the date the bands are placed or the appliance is inserted.

5. All other dental services – on the date the service is performed.

No benefits are payable for work incurred after your coverage under the Plan ends, or for work incurred while covered but completed more than 31 days after termination. Orthodontia benefits will be paid only until the end of the month in which your coverage under the Plan terminated.

SECTION 11: VISION BENEFIT

11.01 Eligibility for Vision Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Vision Benefit.

11.02 Covered Vision Expenses

The Vision Benefit covers expenses for exams, lenses or contacts and frames provided or ordered by an optometrist, ophthalmologist, or optician up to the maximums shown in the Schedule of Benefits.

11.03 Exclusions and Limitations

Benefits shall not be paid by this Plan for any of the following services or supplies:

A. Vision expenses incurred while the individual was not eligible for benefits under this Section;

B. Vision treatment rendered by anyone other than a licensed optometrist, ophthalmologist or optician;

C. Services or supplies which are covered, in whole or in part, under any other benefit provided under this Plan;

D. Special procedures, such as orthoptics or visual training;

E. Medical or surgical treatment, or refractive surgical/laser procedures;

F. Sunglasses, plain or prescription;

G. Any amount of a charge that is in excess of a Reasonable and Customary Charge;

H. Charges incurred in excess of the maximum benefits stated in the Schedule of Benefits; or

I. Any charges which are excluded under the General Plan Exclusions listed in Section 15.

SECTION 12: WELLNESS BENEFITS

12.01 Wellness Benefits

The Plan offers two Wellness Benefits: (1) the Physical Exam Benefit; and (2) the Well Child Care Benefit.

12.02 Physical Exam Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Physical Exam Benefit. This benefit applies to you and your Dependent spouse. Dependent children are not eligible for the Physical Exam Benefit.

Under the Physical Exam Benefit, the Fund will pay 100% of the Reasonable and Customary Charges for routine physical examinations. The Physical Exam Benefit is not subject to the Deductible.

Covered expenses include the Reasonable and Customary Charges for a routine physical performed by a Physician, diagnostic tests and x-rays. The Physical Exam Benefit does not cover expenses related to a Sickness or Accident.

12.03 Well Child Care Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Well Child Care Benefit.

Under the Well Child Care Benefit, the Plan will pay 100% of the Reasonable and Customary Charges for routine well child care visits for Dependent children under six (6) years of age from PPO providers. The Well Child Care Benefit is not subject to the Deductible.

Covered expenses include the Reasonable and Customary Charges for routine examinations performed by a Physician, immunizations and diagnostic tests. Covered expenses do not include the Hospital charges for newborn nursery care, expenses related to a Sickness or Accident or services through Non-PPO providers.

SECTION 13: FAMILY SUPPLEMENTAL BENEFIT

13.01 Eligibility for Family Supplemental Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Family Supplemental Benefit.

13.02 Description of Family Supplemental Benefit

The Family Supplemental Benefit helps pay for healthcare expenses that are limited or not covered by the Plan. If you pay out-of-pocket for certain health care expenses for you or your covered Dependents, you can file a claim for reimbursement from the Fund up to the maximum shown in the Schedule of Benefits.

If you wish to submit an expense for reimbursement under the Family Supplemental Benefit, the following conditions must be met:

A. You or your covered Dependents must have incurred the expense while you were covered under the Plan; and

B. The expense must be for Medically Necessary services and/or supplies not payable under any other benefit of this Plan.

13.03 Covered Expenses under the Family Supplemental Benefit

Generally, covered expenses must be a "qualified medical expense" under Section 213(d) of the Internal Revenue Code. The following services and supplies are examples of expenses that may be eligible for reimbursement under the Family Supplemental Benefit. If you have questions about reimbursement of an expense, please contact the Fund Office.

A. Acupuncture.

B. Artificial limbs.

C. Braille books and magazines.

D. Car controls for the handicapped.

E. Duplicative prosthetic devices.

F. Guide dogs.

G. Injections.

H. Lasik and RK surgery.

I. Learning disability specialty school tuition.

J. Orthodontic care in excess of the maximum benefit under the Dental Benefit.

K. Orthopedic shoes.

L. Prescription Drug Co-Payments.

M. School physicals.

N. Special schools for the handicapped.

13.04 Exclusions under the Family Supplemental Benefit

No payment will be made payable under the Family Supplemental Benefit for the following services and supplies:

A. Expenses used to satisfy this Plan's medical or dental Deductibles.

B. Expenses applied to the out-of-pocket limit.

C. Non-PPO Outpatient Surgical Centers.

D. Dancing or swimming lessons.

E. Health club memberships.

F. Meals and lodging when away from home for medical treatment not received at a medical facility.

G. Nursing services for a healthy baby.

H. Expenses you deduct on your individual tax return.

I. Schools for problem children.

J. Group medical insurance premiums.

K. Trips or vacations taken for a non-medical reason (even if taken upon medical device).

L. Funeral expenses.

The above list provides examples of expenses that are not covered. Please contact the Fund Office for more information.

13.05 Payment of the Family Supplemental Benefit

In order to be reimbursed for a covered expense under the Family Supplemental Benefit, you must file a claim with Zenith American Solutions.

A. Prescription Drug Expenses

You may use your Family Supplemental Benefit Card to pay for prescription drug claims at participating pharmacies. If you have questions about your Family Supplemental Benefit Card, please contact Zenith at (800) 757-0071.

B. Other Covered Expenses

You may submit your other claims electronically through the Family Supplemental Benefits Card app (Zenith Flex) or at www.ZenithFlex.com. Paper claims may also be submitted to Zenith American Solutions at P.O. Box 91082, Seattle, WA 98111. Once submitted, you will generally be reimbursed within 2-3 weeks by check or direct deposit.

You must submit a claim for your Family Supplemental Benefit by January 31st following the calendar year in which the claim or expense was incurred. If you miss the January 31st deadline your claim may still be approved by the Trustees provided you show good cause and submit your claim prior to April 1st. Any claim submitted on or after April 1st will not be covered and your claim will be denied.

Expenses reimbursed through the Family Supplemental Benefit may not be claimed as a deduction on your federal income tax return.

13.06 No Vesting of Family Supplemental Benefit

The Family Supplemental Benefit is not a savings account from which you can withdraw at will. You and your Dependents are not vested in the Family Supplemental Benefit. Benefits payable under the Family Supplemental Benefit shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind, except as required under applicable law.

13.07 Your Right to Opt-Out

You may choose to permanently opt-out of your Family Supplemental Benefit and forfeit your right to reimbursement from the Family Supplemental Benefit at any time by notifying the Fund Office in writing. Any notice of opt-out received by the Fund Office is irrevocable.

SECTION 14: HEARING AID BENEFIT

14.01 Eligibility for Hearing Aid Benefit

If you are eligible for Active Employee Benefits, your coverage includes the Hearing Aid Benefit. The Hearing Aid Benefit applies to you and your Dependent spouse. Dependent children are not eligible for the Hearing Aid Benefit.

14.02 Hearing Aid Benefit

The Hearing Aid Benefit provides you and your eligible Dependent spouse with hearing aid devices, up to the maximums shown in the Schedule of Benefits. The Hearing Aid Benefit also includes hearing examinations, hearing screenings and hearing aid fitting fees.

14.03 Exclusions and Limitations

No payment will be made under the Hearing Aid Benefit for the following services and supplies:

A. Specialty hearing aids, such as cochlear implants or bone anchored hearing systems;

B. Charges incurred which are in excess of any maximum benefit or other limitation stated in the Schedules of Benefits; or

C. Any of the circumstances listed under the General Plan Exclusions in Section 15.

SECTION 15: GENERAL PLAN EXCLUSIONS

15.01 Exclusions from Coverage

The following non-exhaustive list of services and expenses are not covered under the Plan:

A. Care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan.

B. Charges incurred, or loss sustained, by a covered person for any specified type of care or treatment or loss during a stated period of time over which the person has already received Plan benefits totaling any applicable maximum benefit for that type of care and treatment or loss during that stated period of time as stated in the Schedule of Benefits.

C. Any charge or portion of a charge that exceeds the R&C Charges.

D. Charges incurred for, or loss sustained as a result of, an Accident, Sickness or disease which was sustained while the person was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

E. Charges incurred for, or loss sustained as a result of, an Accident, Sickness or disease for which benefits are or may be compensable in whole or in part under any workers' compensation or occupational disease law.

F. Charges incurred for, or loss sustained as a result of, treatment, care, services, supplies or procedures which are furnished, paid for or otherwise provided due to past or present service of any individual in the armed forces of a government or for services provided or made available by any military facilities.

G. Charges incurred for, or loss sustained as a result of, any Accident or Sickness caused by war or any act of war (whether war is declared or undeclared), any act of international armed conflict or any conflict involving armed forces of an international body, insurrection, riot or atomic explosion or other release of nuclear energy (except when being used for medical therapy). This exclusion does not apply to the Life Insurance Benefit.

H. Treatment provided outside the United States and Canada, unless the person is outside the United States and Canada due to a vacation, or the normal occupation of either the person or dependent, and the absence is for a period of less than 120 days.

I. Charges incurred for, or loss sustained as a result of, the completing of claim forms (or other forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

J. Charges that would not have been made if this Plan did not exist.

K. Charges incurred by a covered person which are specified as excluded.

L. Treatment, care, services, supplies or procedures rendered or provided while a covered person is confined to a Hospital owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.

M. Any expenses or charges for services or supplies not prescribed by a Physician or Dentist, unless such services or supplies are provided under the supervision of a Physician or Dentist or as specifically provided under the Plan.

N. Any expenses or charges for services or supplies:

1. Not provided in accord with generally accepted professional medical standards;

2. Not Medically Necessary; or

3. For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.

O. Treatment, care, services, supplies or procedures provided due to injuries sustained in the course of the commission of a felony for which the person is convicted, except for suicide or domestic violence.

P. Treatment, care, services, supplies or procedures which are Experimental or Investigative.

Q. Any expenses or charges for failure to keep scheduled visits, or for reports or medical requests not requested by the Plan.

R. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).

S. Charges incurred for any Hospital confinement or other medical care or service which a covered person would not be legally required to pay.

SECTION 16: COORDINATION OF BENEFITS

16.01 Benefits Are Coordinated

Under the Plan, your medical benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits are coordinated so that no more than 100% of your expenses are paid through the combined coverage of the plans.

16.02 Another Group Plan Defined

Another group plan or source refers to any plan providing benefits or services and includes:

A. Group blanket or franchise insurance coverage (such as coverage provided to college students);

B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;

C. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;

D. Any coverage under governmental programs;

E. Medical benefits coverage provided through automobile insurance (both no-fault and traditional fault policies), including but not limited to medical payment ("Med Pay") coverage and personal injury protection ("PIP") coverage;

F. Any coverage required or provided by statute; and

G. This Plan when you are covered as:

    1. An Employee and as a Dependent; or

    2. A Dependent child of more than one Employee.

16.03 How Benefits are Paid

Benefits coordination ensures that you receive maximum benefits and that benefits are not paid for more than 100% of the actual charges incurred.

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to its coordination of benefits rules. When this Plan is secondary, it will pay the difference between your Allowable Expenses under this Plan (as though there was no other coverage) and what your primary plan paid.

Whether or not you file a claim with another group plan, your Plan payments will be calculated as though you have received benefits to which you are entitled from the other sources, even if you have

not. This Plan coordinates benefits on the assumption that the other plans' rules were followed, that required providers were used and that the other plans' maximum benefits were paid.

This Plan defines Allowable Expenses as any necessary, reasonable and customary item of expense for medical care or treatment that is covered under at least one of the plans by which you are covered. If the Plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid as long as the service is covered under this Plan. Allowable Expenses do not include any portion of a charge that is not considered a Covered Medical Expense under this Plan.

If you or a Dependent is covered by another group plan or source in addition to this Plan, the order of benefit payment will be determined according to the Plan's coordination of benefits rules.

16.04 Order of Benefit Payment

For coordination with other plans the following rules apply:

A. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.

B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent.

C. For claims on behalf of Dependent children whose parents are not divorced or separated or for claims on behalf of Dependent children whose parents share custody, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.

D. For claims on behalf of Dependent children whose parents are divorced or separated, the following rules apply:

    1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility will be primary.

    2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary. The plan who covers the parent who had custody at the time the child reached age of majority will be primary.

    3. If there is no such court decree and the parent with custody has remarried, the order of benefit coordination will be as follows:

        a. The plan of the parent with custody is primary and pays benefits first;

        b. The plan of the step-parent with custody pays benefits second;

        c. The plan of the parent without custody pays benefits third; and

        d. The plan of the step-parent without custody, if any, pays benefits fourth.

E. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the spouse's plan will be primary and the parent's plan will be secondary.

F. A plan that covers you as an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

G. A plan that covers you as a current full-time employee or as a dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.

H. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, retiree or dependent, the COBRA Continuation Coverage is secondary.

I. A plan or policy of insurance that pays medical expenses for a specific risk, including, but not limited to, any automobile policy, motor vehicle policy, homeowner's policy or premises insurance policy is primary and pays benefits before this Plan.

J. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

16.05 Coordination of Benefits Implementation Rules

To implement the coordination of benefits rules, the Trustees, without consent of any person, will have the following rights to:

A. Release or obtain information considered necessary;

B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and

C. Recover payments in excess of the amount that should have been paid by this Plan.

16.06 Coordination of Benefits with Medicare

If you or your Dependent is eligible for Medicare and have not enrolled in Medicare Parts A and B, the Plan will assume that you have enrolled and will coordinate benefits under Medicare Parts A and B. This means that this Plan will only pay benefits equal to what it would have paid if you were enrolled in Medicare Parts A and B and you will be responsible for any difference.

A. When You are an Employee Age 65 and Over

If you are an Employee, this Plan will be primary and pay benefits first. If you are an Employee whose eligible Dependent is entitled to Medicare, the Plan will be primary to Medicare for that Dependent.

B. When You are an Employee Entitled to Medicare Due to Disability

If you are an Employee entitled to Medicare due to disability but are not yet entitled to Medicare due to age, this Plan will be primary and pay benefits first. If you are an Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

C. End Stage Renal Disease (ESRD)

There are special rules that apply to the first 30 months of ESRD (the initial 30-month period). If you are eligible for benefits under the Plan because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second. After the initial 30-month period, Medicare has primary responsibility, and this Plan will pay second.

SECTION 17: SUBROGATION AND REIMBURSEMENT

17.01 General Provisions

Generally, the Plan does not provide benefits to diagnose and treat illnesses or injuries for which a Third Party may be responsible or liable.

A. Conditional Benefit Payments

The Plan does not provide benefits to diagnose and treat illnesses or injuries for which a Third Party may be responsible or liable. However, if you incur an illness or injury for which a Third Party may be responsible or liable, the Fund may make one or more conditional benefit payments to or on behalf of you or your Dependent to cover claims arising from such illness or injury. Such payments are conditioned upon your compliance with this Section.

B. Work-Related Claims

The Plan does not provide benefits to diagnose and treat illnesses or injuries incurred through the course of employment. However, if you incur a work-related injury of illness for which a claim has been filed with a workers' compensation insurance carrier or with an appropriate state or federal court or agency, and that claim has been initially denied, then the Fund, upon request, may make one or more conditional benefit payments to or on behalf of you to cover claims arising from such illness or injury. Such payments are conditioned upon your compliance with this Section.

C. First-Party Claims

The Plan requires that you and/or your Dependent submit any available first-party claims before it will provide benefits to diagnose and treat an illness or injury for which a Third Party may be responsible or liable. First-party claims are claims made against your own insurance company such as medical payment (Med Pay) coverage and personal injury protection (PIP) coverage. You may be required to show proof that any first-party claims have been exhausted before the Plan will begin to pay benefits.

17.02 Reimbursement to the Plan

The Fund's right of subrogation and reimbursement arises when benefits are paid on behalf of you or your Dependent as a result of an Accident or Sickness for which another party may be responsible. By accepting benefits under the Plan, you agree to reimburse the Fund for all such expenses paid on your behalf or your Dependent's behalf related to the Accident or Sickness.

Under these circumstances, the Fund is entitled to full and total reimbursement (100%) of its past, present or future expenditures related to the Accident or Sickness from all Third Party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

17.03 Third Parties Defined

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

A. Any person or entity legally responsible for your injury;

B. Other benefit plans;

C. An insurance company, including but not limited to the party at fault's insurance;

D. Workers' compensation; or

E. Any other person or entity that is obligated to make payments which the Fund would otherwise be obligated to make.

17.04 Your Responsibilities

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

A. You and/or your Dependent must immediately notify the Fund Office whenever a claim against a Third Party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.

B. You and/or your Dependent must cooperate with the Fund by providing information requested by the Fund concerning subrogation or reimbursement. You must provide the Fund Office with the following:

   1. A signed Subrogation and Reimbursement Agreement;

   2. Information related to medical payment (Med Pay) coverage, personal injury protection (PIP) coverage or any other insurance policies;

   3. The names and addresses of all potential third parties and their insurer, adjusters and claim numbers;

   4. Any accident reports; and

   5. Any other information the Fund requests.

C. If you fail to meet your responsibilities, the Fund may withhold future benefit payments to you and your Dependents until you comply with these requirements.

D. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Fund the right to prosecute your claim and maintain an action against the Third Party on your behalf.

17.05 If You Are Reimbursed by a Third Party

The Fund is entitled to 100% reimbursement of all medical and disability claims paid on your behalf and/or your Dependent's behalf, related to the Accident or Sickness, from all Third Party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced of affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine of law. Therefore, if you and/or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you

must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

A. First, the Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the Accident or Sickness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA); and

B. Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above even if you and/or your Dependent are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all Third Parties.

You and your Dependents shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover the benefits paid. Such action includes, but is not limited to the following:

A. Initiating a claim to compel compliance with these terms or the terms of the Subrogation and Reimbursement Agreement;

B. Withholding benefits payable to you or your Dependents until you or your Dependent(s) comply; or

C. Initiating such other equitable or legal action it deems appropriate. The Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recovery payment.

Upon your full reimbursement to the Fund, future medical claims related to the Accident or Sickness not already paid by the Fund will be your and/or your Dependent's responsibility, unless and until you and/or your Dependents incur related expenses which exceed the proceeds from your and/or your Dependent's ultimate recovery.

17.06 Attorney Common Fund Doctrine Claims against the Fund

If you and/or your Dependent(s) retain your own attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain the Third-Party recovery. If the attorney(s) that you and/or your Dependent(s) retain in relation to an Accident or Sickness brings a separate claim or lawsuit against the Fund to recover his/her attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependent(s) are required to reimburse the Fund from the money you and/or your Dependent(s) recover from any Third Party for (i) any money judgment entered against the Fund in the lawsuit brought by the attorney and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your

Dependent(s) shall fully indemnify, hold harmless and defend the Fund and its Trustees, employees and agents from and against any such claims or lawsuits. The Fund shall have the right to appoint counsel.

To the extent the Fund is required to initiate a formal proceeding against you and/or your Dependent(s) to enforce its reimbursement rights, you and/or your Dependent(s) shall also be responsible for the Fund's attorney's fees and costs incurred. In addition, to the extent the expenses, including but not limited to attorney's fees and costs, incurred by the Fund exceed the amount you and/or your Dependent(s) recover from any Third Party or you and/or your Dependent(s) refuse or fail to reimburse the Fund from any Third Party recovery, the Fund shall have the right to withhold benefits payable to you and/or your Dependent(s) until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

17.07 Lien on Third Party Recoveries

You and/or your Dependent(s) grant the Fund a lien on the monies recovered from any Third Party in the amount of (i) all medical and disability claims paid on your and/or your Dependent's behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

SECTION 18: CLAIMS AND APPEALS

18.01 General Provisions

A. Exhaustion of Remedies

You must exhaust all of the claims and appeals procedures under the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action.

If you institute legal action after the denial of your internal appeal or after the denial of your external review, your lawsuit must be filed within 90 days of the date of such denial.

B. Discretionary Decision Making Authority of the Trustees

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan.

No determinations involved in or arising under the Trust Agreement or this Summary Plan Description/Plan Document will be subject to the grievance or arbitration procedure established in any Collective Bargaining Agreement between the Employers and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any Collective Bargaining Agreement.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

18.02 Filing Your Initial Claim for Benefits

A. What is a Claim?

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures.

If you make an inquiry about the Plan's provisions without a claim form, the Fund will not treat your inquiry as a claim for benefits. Additionally, if you request prior approval for a benefit that does not require prior approval by the Plan, that will not be treated as a claim for benefits. A claim may fall into one of the following categories:

1. Post-service claim – a claim for payment is requested for a treatment or supply that has already been received;

2. Disability claim – a claim for Weekly Disability Benefits;

3. Pre-service claim – a claim for pre-certification for a treatment or supply that requires approval in advance of obtaining care;

4. Urgent care claim – a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function, or that could subject the claimant to severe pain that cannot be adequately managed without the proposed treatment; or

5. Concurrent care claim – a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved. When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim

To file a claim for benefits offered under this Plan, you must submit a completed claim form within 365 days from the date the service for the charge is rendered.

You may obtain a claim form by calling the Fund Office. A claim may be filed by a participant, covered Dependent, an authorized representative or by a network provider. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. If a claim is filed by a provider, the provider will not automatically be considered a claimant's authorized representative.

1. Hospital, Physician and Medical Claims

The following information must be completed by you and the provider in order for your request for medical benefits to be a claim and for your claim to be decided:

a. Active Employee's name;

b. Patient's name;

c. Patient's date of birth;

d. Social security number of Active Employee;

e. Date of service;

f. CPT Plus 2022 Edition (the code for Physician services and other health care services found in the *Current Procedural Terminology* as maintained and distributed by the American Medical Association);

g. ICD-10 (the diagnosis code found in the *International Classification of Diseases, 10th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);

h. Billed charge;

i. Number of units (for anesthesia and certain other claims);

j. National Provider Identifier (NPI) of the provider; and

k. Billing name and address.

2. Prescription Drug Claims

You can avoid the need for filing direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the PBM Claims Department as identified on your identification card.

3. All Other Benefits

You should contact the Fund Office about how to file a claim for all other benefits provided under the Plan.

C. Where to File a Claim

1. Hospital, Physician and Medical Claims.

All Hospital, Physician and medical claims (both PPO and Non-PPO providers) should be filed electronically with Blue Cross Blue Shield. The Fund will consider your claim to have been filed as soon as it is received by the Fund Office. Both PPO and Non-PPO providers should complete the claim form for you and send it electronically to Blue Cross Blue Shield.

2. Prescription Drug Claims

For more information on where to file a Prescription Drug claim, please contact the PBM by using the number located on the back of your identification card.

3. All Other Benefits.

All other claims for benefits should be sent to the Fund Office at the following address:

Cement Masons' Institute Local 502 Welfare Fund
739 South 25th Avenue
Bellwood, Illinois 60104

18.03 Initial Claim Determination Timeframes

A. Claim Filing Deadline

You must file your claim for benefits as soon as possible following the date you incurred the charges. A claim is considered to have been filed on the day it is received by the correct claims office, even if it is incomplete.

If you fail to file your claim as soon as possible, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, you must submit your claim no later than 12 months from the date you incurred the charges unless you can show good cause for filing a claim beyond the 12-month deadline. The Board of Trustees will determine whether you have shown good cause. Under no circumstances may a claim be submitted later than 18 months from the date the charges were incurred.

B. Decision Timeframes

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Plan's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim.

The amount of time the Plan can take to process a claim depends on the type of claim.

1. Post-Service Claims

a. Ordinarily, the Fund will notify you of the decision on your claim within 30 days from the Fund's receipt of the claim.

b. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

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

2. Weekly Disability Benefit Claims

a. The Fund will make a decision on your Weekly Disability Benefit claim and notify you of the decision within 45 days.

b. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Fund will make its decision within 30 days of the time the Fund notifies you of the delay.

   The Fund may delay the period for making a decision for an additional 30 days, provided the Fund notifies you of the circumstances requiring the extension and the date as of which the Fund expects to render a decision, before the expiration of the first 30-day extension period.

c. If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and your claim may be denied.

   During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information or at the expiration of the 45 days, if you do not respond, the Fund will make its decision on the claim and notify you within 30 days.

3. Pre-Service Claims

a. Ordinarily, the Fund will notify you of the decision on your claim within 15 days from the Fund's receipt of the claim.

b. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

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

4. Urgent Care Claims

a. Ordinarily, the Fund will notify you of the decision on your claim within 72 hours from the Fund's receipt of the claim.

b. If an extension is needed because the Fund needs additional information from you to process your claim, the Fund will notify you of such extension within 24 hours. In that case you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or until you respond to the request (whichever is earlier). The Fund then has 48 hours to make a decision and notify you of the determination.

5. Concurrent Care Claims

a. If the concurrent care claim is urgent and made 24 hours prior to the end of the already authorized treatment, the Fund will notify you of its decision within 24 hours.

b. If the concurrent care claim is not an urgent claim, then the pre-service limits apply.

6. Life Insurance Benefit and AD&D Benefit Claims

a. Ordinarily, the Fund will notify you of the decision on your claim within 90 days from the Plan's receipt of the claim.

b. The Fund may extend this period one time for up to 90 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 90-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

18.04 Notice of Initial Decision.

You must be provided with a notice of the initial determination about your claim within certain timeframes after your claim is received. The notice must provide the following information:

A. The specific reason(s) for the denial of benefits or other adverse benefit determination;

B. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;

C. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

D. A copy of the internal and external review procedures and time periods to appeal your claim, and a statement of your right to bring a civil action under ERISA following an adverse benefit determination on review;

E. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to you at no cost upon request;

F. If your health or Weekly Disability Benefit claim was denied on the basis of medical necessity, Experimental or Investigative treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request; and

G. For Weekly Disability Benefit claims, the following additional information must be provided:

1. An explanation of the decision, including the basis for disagreeing with or not following:

   a. The views of the health care and vocational professionals who treated or evaluated you;

   b. The views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination; and

   c. A disability determination by the Social Security Administration.

2. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

18.05 Internal Appeal Procedures

A. Internal Appeal Filing Deadline

You have the right to a full and fair review if your claim for benefits is denied by the Fund. You must file your appeal in writing unless your appeal is an urgent care claim which may be submitted orally by telephone. You must make your request to the Fund Office within 180 days after receiving notice of denial, except with respect to Life Insurance and AD&D claims.

You must file a request for an appeal of the denial of a Life Insurance or AD&D claim within 60 days after receiving notice of the denial. Your appeal application must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any documents you feel are appropriate, as well as submitting your written statement.

B. Internal Appeal Process

The internal appeal process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

   a. It was relied upon by the Fund in making the decision;

b. It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

c. It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or

d. It constitutes a statement of Plan policy regarding the denied treatment or service.

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

3. Before the Fund can issue a final adverse benefit determination for a Weekly Disability Benefit claim, the Fund must provide to you, free of charge:

a. Any new or additional evidence considered, relied upon, or generated by the Fund in connection with the claim; and

b. Any new or additional rationale that is the basis for the adverse benefit determination.

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

5. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental or Investigational), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Internal Appeal

1. Urgent Care Claims.

If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

2. All Non-Urgent Pre-Service Care Claims.

If the appeal is for a non-urgent pre-service claim, you will be notified no later than 30 days after receipt of the request for appeal.

3. Weekly Disability Benefit Claims and Post-Service Care Claims.

Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. The Fund will advise you in writing in

advance if this extension will be necessary. For Weekly Disability Benefit claims, if additional information, required to be sent under Section 18.05(B)(3), is provided to you within 30 days of the next regularly scheduled meeting of the Board of Trustees, then the appeal determination will be postponed until the second regularly scheduled meeting following the date the additional information is provided. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) days after the decision has been reached.

4. Life Insurance Benefit and AD&D Benefit Claims.

The Fund will send you a notice of the Board of Trustees' decision on appeal within 60 days of the receipt of the appeal by the Fund Office.

18.06 Notice of Decision on Internal Appeal

The Fund will provide you with a written decision, in a culturally and linguistically appropriate manner, on any appeal of your claim. However, if your claim is an urgent care claim, you may be notified of the decision in writing, via fax or orally via telephone. The notice of a denial of a claim on appeal will state the following:

A. The specific reason(s) for the determination;

B. Reference to the specific Plan provision(s) on which the determination is based;

C. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

D. A statement of your external appeal rights (if applicable), an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an adverse benefit determination on internal appeal;

E. If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge;

F. If the determination was based on medical necessity or because the treatment was Experimental or Investigational or other similar exclusion, the Fund will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge; and

G. For Weekly Disability Benefit claims, the following additional information must be provided:

   1. An explanation of the decision, including the basis for disagreeing with or not following:

      a. The views of the health care and vocational professionals who treated or evaluated you;

      b. The views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination; and

      c. A disability determination by the Social Security Administration.

2. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.

3. A description of any contractual limitations period applying to your right to bring a civil action under ERISA following an adverse benefit determination on internal appeal, as well as the calendar date on which the Plan's 90 day limit for filing suit expires.

18.07 External Review Procedures

A. External Review Filing Deadline

If your health care claim involving compliance with cost-sharing and surprise billing protections was denied under the internal appeals procedures, resulting in an adverse benefit determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

However, you do not have a right to request external review if your health care claim did not involve compliance with cost-sharing and surprise billing protections.

B. External Review Process

The external review process works as follows:

1. Request for External Review

Within five days of the Plan's receipt of the request for external review, the Plan must determine whether:

a. You are or were covered under the Plan at the time of service or requested service;

b. The adverse benefit determination does not relate to your failure to meet the Plan's eligibility requirements;

c. You exhausted or are deemed to have exhausted the Plan's internal appeal process; and

d. You have provided all information and forms required to process an external review.

2. Determination of Eligibility for External Review

Within one business day after the completion of this review, the Fund must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Fund must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours

following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

3. Referral to an Independent Review Organization (IRO)

If your request is eligible for review, the Fund will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:

a. The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

b. The Fund must provide the claim file and any information considered in making the adverse benefit determination within five business days after the date of assignment to the IRO. Failure by the Fund to submit the information to the IRO may result in an immediate reversal of the adverse benefit determination. The IRO must send notice of such to you and the Fund within one business day.

c. The IRO must forward any additional information received from you to the Fund within one day of receipt and the Fund may reconsider and reverse its decision, terminating the external review. The Fund must provide notice within one business day of such a decision to you and the IRO.

d. The IRO will review all information received de novo and may not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

    i. The claimant's medical records;

    ii. The attending health care professional's recommendation;

    iii. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

    iv. The terms of the Plan;

    v. Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

4. Request for an Expedited External Review

You may make a request for an expedited external review if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. Content of Notice of Decision on External Review

The IRO will provide you and the Fund with a written decision. The notice of the decision will contain all of the following:

1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under Section 2793 of the Public Health Service Act.

18.08 Physical Examination

The Trustees have the right and opportunity, at the Fund's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while your claim for Plan benefits is pending.

18.09 Payment of Claims

The Fund will make payments due under the Plan immediately upon receipt by the Fund Office of proper written proof of loss.

The Plan may pay all or a portion of any benefits provided for health care services to the provider, unless you direct otherwise in writing at the time you file your claim. The Plan does not require that the services be rendered by a particular provider.

Upon your death, benefits accrued on your behalf will be paid at the Fund's option to the first surviving class of the following:

A. Your spouse;

B. Your Dependent children, including legally adopted children;

C. Your parents;

D. Your brothers and sisters; or

E. Any person the Trustees determine is entitled to payment.

The Fund will rely upon an affidavit to determine benefit payments, unless it receives written notice of valid claim before payment is made. The affidavit will release the Fund from further liability.

Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

18.10 Authorized Representatives

An authorized representative is the person who can act on the claimant's behalf to file a claim under the Plan. The Fund requires a written statement from the individual that he/she has designated the named individual(s) as the authorized representative along with the representative's name, address and phone number. Where the individual is unable to provide a written statement, the Fund requires written proof (*e.g.*, power of attorney for health care purposes, court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf. Please note

that an assignment of benefits does not satisfy this provision to designate a provider as an authorized representative.

Once the individual names an authorized representative, the Fund must route all future correspondence related to claims and appeals *to the authorized representative and not the individual*. However, the Fund will make every effort to copy the original claimant where possible. The Fund must honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization, unless the original claimant has limited the authorized representation to one claim or a series of claims related to the same Sickness or Accident. The individual may revoke a designated authorized representative by submitting a signed statement.

The Fund reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

18.11 Benefit Payment to an Incompetent Person

Benefit payments under the Fund may become payable to a person who is adjudicated incompetent or to a person who in the opinion of the Trustees is unable to administer such payments properly because of mental or physical disability. The Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose(s) for which paid if they are paid:

A. Directly to such person;

B. To the legally appointed guardian or conservator of such person;

C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or

D. By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Plan, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

18.12 Misrepresentation or Falsification by Participant

If you make an intentional misrepresentation or falsification of any information or a matter in connection with a claim for Plan benefits, the Trustees or their representative(s) may deny all or part of the benefits that might otherwise be due.

18.13 Workers' Compensation

The Plan does not cover any work-related injuries and does not affect any requirement for your coverage under any workers' compensation or occupational disease act or law.

18.14 Prohibition on Rescission

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage initiated by the Plan that has retroactive effect unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to a covered person before coverage may be rescinded.

18.15 Compliance Statement for Consolidated Appropriations Act of 2021

The Plan intends to operate in compliance with the Consolidated Appropriations Act of 2021 (CAA) and the regulations promulgated thereunder. As such time as further guidance is issued or revised, the new guidance shall be incorporated by reference herein to the extent necessary to comply with the CAA.

SECTION 19: DEFINITIONS

19.01 Definition of Plan Terms

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.

B. **Active Employee** means an Employee who is not retired.

C. **Ancillary Services** means emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided if there is no participating provider who can furnish such item or service at such facility.

D. **Board of Trustees and/or Trustees means** the Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the Trust Agreement for the Board of Trustees of the Cement Masons' Institute Local 502 Welfare Fund. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974 (ERISA).

E. **Chemical Dependency/Substance Abuse** means any abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol, or any other chemical (except nicotine).

F. **Collective Bargaining Agreement** is any applicable collective bargaining agreement now existing or executed in the future between the Union and an Employer which provides for Contributions to the Trust Fund, as well as any extensions, amendments, or renewals thereof.

G. **Contributions** are payments due from, or made by, an Employer to the Trust Fund on behalf of their Employees for work performed pursuant to the terms of the Collective Bargaining Agreement or pursuant to the terms of another written agreement between the Employer and the Board of Trustees.

H. **Co-Payment** means the fixed dollar amount you are required to pay for services at the time you receive services.

I. **Covered Employment** means work performed by an Employee for an Employer for which the Employer is required to make Contributions to the Fund on the Employee's behalf.

J. **Covered Medical Expenses** means the R&C Charges for expenses ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-occupational Accident or Sickness.

K. **Dentist** means a legally qualified Dentist practicing within the scope of his or her license or a legally qualified Physician authorized by his or her license to perform the particular dental service rendered.

L. **Dependent** means any one of the following:

1. An Active Employee's spouse from whom you are not divorced or legally separated (marriage license and birth certificate required).

2. Each child of an Active Employee from the date he or she first becomes a child of the Active Employee to the end of the calendar month in which such child attains age 26 (birth certificate required).

3. A child of an Active Employee who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

    a. Such incapacity began before the end of the month such child attains age 26;

    b. Such child is primarily dependent upon the Active Employee for financial support and maintenance;

    c. Proof of such incapacity, which must include proof of a Social Security Disability award, is submitted at no expense to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate; and

    d. Proof of the child's continued disability is submitted to the Trustees annually by the Active Employee.

4. An Active Employee's children include natural and legally adopted children, children placed in the Active Employee's home for adoption, and step children. A Dependent child will also include a child of an Active Employee who has been appointed legal guardian by a court of competent jurisdiction, provided such child is dependent upon the Active Employee for more than one-half of his or her financial support and lives with the Active Employee in a parent-child relationship. Proof of such guardianship may be required.

    In the case of a divorce, the Active Employee may provide a certified copy of the divorce decree that indicates the spouse is solely or jointly responsible for health insurance. If a Dependent spouse is a widow or widower, the spouse must provide a certified copy of the death certificate of the former spouse.

M. **Emergency** means the sudden and unexpected onset of a medical condition which poses a significant jeopardy to the person's health and for which immediate medical attention and relief are necessary. To qualify as an Emergency, the condition must meet all of the following requirements:

1. Severe symptoms must be present and must be so severe that immediate medical relief is required, regardless of the time;

2. The symptoms must occur suddenly and unexpectedly (a chronic condition which has existed for any period of time does not qualify unless the symptoms suddenly become so severe that immediate medical attention is required);

3. Immediate medical attention must be secured in person; and

4. The medical condition, as evidenced by the symptoms, must be one for which immediate medical care is normally required. If the final diagnosis or the degree of severity of the symptoms is not of such a nature that immediate medical care would normally be required, the condition will not qualify as an Emergency.

N. **Emergency Medical Condition** means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

O. **Emergency Services** with respect to an Emergency Medical Condition means:

1. A medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department, as applicable, to Stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

3. Unless consent to Non-PPO services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a Non-PPO provider or Non-PPO emergency facility after the covered individual is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

P. **Employee** means a person who is working for an Employer who is required under a Collective Bargaining Agreement or other agreement to make Contributions to the Fund on his behalf. Also included as Employees are employees of the following organizations: The Welfare Fund, the Cement Masons' 502 and Plasterers Area 5 Annuity Fund, the Pension Fund, the Cement Masons' Local No. 502 Apprentice Education and Training Fund and the Union.

Q. **Employer** means any person, firm, association, partnership or corporation which enters into a Collective Bargaining Agreement with the Union which requires Contributions to this Fund or who enters into a participation agreement accepting the Trust Agreement. Employer also means the Union (with respect to its Employees which are covered under a participation agreement between the Union and the Trustees), the Welfare Fund, the Cement Masons' 502

and Plasterers Area 5 Annuity Fund, the Pension Fund, and the Cement Masons' Local No. 502 Apprentice Education and Training Fund and the Union.

R. **Employer Hourly Contribution Rate** means the hourly rate of Contribution for an hour worked by an Employee under the Collective Bargaining Agreement.

S. **Experimental or Investigative Procedure or Treatment** means the use of any treatment, procedure, facility, equipment, drug, device, or supply which the use of is not yet generally recognized as accepted medical practice, or the use of any such item which requires federal or other governmental agency approval, and the approval has not been granted at the time such service or supply was rendered or provided.

The Trustees have the authority to determine whether a treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, procedure, facility, equipment, drug, device or supply does not, in itself, make it eligible for payment.

T. **Fund and/or Trust Fund** means the Cement Masons' Institute Local 502 Welfare Trust Fund.

U. **Home Health Agency** is a public agency or private organization (or a subdivision of such agency or organization) which meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients;

2. It has established policies governing the services which it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;

3. It provides for the supervision of its services by a Physician or a registered professional nurse;

4. It maintains clerical records on all of its patients;

5. It is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services; and

6. It is eligible to participate in Medicare.

V. **Hospice Organization** means a public or private agency or organization primarily engaged in providing a coordinated set of services at home or in an outpatient or institutional setting to persons suffering from a terminal or medical condition. The agency or organization must:

1. Be eligible to participate in Medicare;

2. Have an interdisciplinary group of personnel that includes the services of at least one Physician and one registered nurse (R.N.);

3. Maintain clerical records on all of its patients;

4. Meet the standard of the National Hospice Organization; and

5. Provide either directly or indirectly or by another arrangement, the "core services" listed as Covered Medical Expenses.

W. **Hospital** is an institution which, in return for payment from its patients, is engaged primarily in providing medical care and treatment on an inpatient basis to sick and injured individuals and which fully meets the following requirements:

1. It is a hospital, a tuberculosis hospital or a psychiatric hospital, as those terms are defined in Medicare, which is qualified to participate in Medicare, and to receive payments under and in accordance with the provisions of Medicare;

2. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. It is an institution which fully meets each of the following requirements:

a. It provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;

b. It provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s);

c. It is operated continuously with organized facilities for operative surgery on the premises; and

d. It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics or a nursing or convalescent home.

X. **Medically Necessary** means a service or supply that:

1. Is consistent with the symptoms of diagnosis and treatment of the person's injury or sickness;

2. Is appropriate with regard to standards of good medical practices and recognized by an established medical society in the United States;

3. Must not be solely for the convenience of the eligible individual, a physician or a hospital; and

4. Could not have been omitted without adversely affecting the person's condition or quality of medical care.

Y. **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.

Z. **Mental or Nervous Disorder** means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.

AA. **Outpatient Surgical Center** means a facility which meets all of the following criteria:

1. It is a health care institution or facility, either freestanding or as part of a Hospital, which is equipped and operated with permanent facilities for the primary purpose of performing surgical procedures on patients on an outpatient basis and which a patient is admitted to and discharged from within a 24-hour period;

2. It must be regularly licensed as an outpatient surgical facility (by whatever name called) by the governmental or other agency which has the responsibility for such licensing;

3. It must maintain medical records on all of its patients;

4. It must employ a licensed anesthesiologist and a registered nurse;

5. It must be under the full-time supervision of a Physician who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.);

6. It must have at least two operating rooms and a recovery room;

7. Any Physician performing surgery on the premises must also be allowed to perform surgery in a local Hospital;

8. It must be equipped to handle medical emergencies; and

9. It must have an agreement with a local Hospital to treat patients who develop problems.

An office maintained by a Physician for the practice of medicine or dentistry, or a facility primarily engaged in the termination of a pregnancy, will not be considered an approved Outpatient Surgical Center under this Plan.

BB. **Pension Plan** means the Cement Masons' Union Local 502 Pension Fund.

CC. **Physician** means a legally qualified physician, doctor or surgeon who is licensed to practice medicine or surgery within a particular state and who is acting within the scope of his or her license at the time and place services are performed.

DD. **Plan** means this document as adopted by the Trustees and as amended by the Trustees.

EE. **Prescription Drugs** mean legal drugs and medicine approved by the United States Food and Drug Administration (FDA) and dispensed by a pharmacist pursuant to the written prescription of a Physician.

FF. **Qualifying Payment Amount (QPA)** means the median contracted rate on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation.

GG. **Reasonable and Customary Charge** means the following:

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as a payment in full under its contract with a Plan PPO or similar organization.

2. For service or supply where the fee is not determined under (1) above, the fee shall be based on 120% of the amount that would be allowed by Medicare.

   The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under the subsections listed above.

HH. **Self-Payments** are any payments made by Active Employees or Dependents for the purpose of maintaining eligibility under the Plan.

II. **Sickness** includes pregnancy, childbirth, abortion and related medical conditions among other illnesses.

JJ. **Skilled Nursing Facility** means a facility, an institution, or a distinct part of an institution, by whatever name called, which meets all of the following criteria:

1. It is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist them in reaching a degree of body functioning to permit self-care in essential daily living activities;

2. It complies with all licensing and other legal requirements;

3. It provides 24-hour-a-day supervision by one of more Physicians or one or more registered nurses responsible for the care of its inpatients;

4. It provides 24-hour-a-day nursing services by licensed nurses under the supervision of a registered nurse, and it has an R.N. on duty at least eight hours a day;

5. Every patient is under the supervision of a Physician;

6. It has available at all times the services of a Physician who is a staff member of a general Hospital;

7. It maintains daily medical records on all patients;

8. It provides appropriate methods and procedures for the dispensing and administering of drugs and biological;

9. It has a utilization review plan;

10. It has a transfer agreement with one or more Hospitals;

11. It is eligible to participate under Medicare; and

12. It is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or similar institution.

KK. **Stabilize(d)** means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

LL. **Total Disability or Totally Disabled**

1. If you are an Active Employee, it means you are completely unable to perform each and every duty pertaining to your occupation or employment, and you are doing no other work for pay or profit.

2. If you are a Dependent, it means you are completely unable to perform all the normal activities of a person of like age and sex as a result of a non-occupational accidental bodily injury.

MM. **Trust or Trust Agreement** means the Agreement and Declaration of Trust, including all amendments and/or modifications, establishing the Cement Masons' Institute Local 502 Welfare Trust Fund.

NN. **Union** means the Cement Masons' Union Local No. 502 and the Plasterers' Area 5 of the Operative Plasterers' and Cement Masons' International Association of the United States and Canada.

OO. **Other Terms**

Additional terms are defined in other Sections of this Plan as follows:

	Terms	**Section**
1.	Allowable Expenses	16.03
2.	COBRA Continuation Coverage	2.03
3.	Deductible	7.02
4.	Durable Medical Equipment	7.07
5.	Family and Medical Leave Act (FMLA)	2.01
6.	Qualified Medical Child Support Order	2.02
7.	Qualifying Event	2.03

SECTION 20: ADDITIONAL PLAN INFORMATION

20.01 Plan Name

Cement Masons' Institute Local 502 Welfare Trust Fund.

20.02 Board of Trustees

A Board of Trustees is responsible for the operation of this Fund. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union which have entered into Collective Bargaining Agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the address below:

Board of Trustees of the Cement Masons' Institute Local 502 Welfare Trust Fund
739 South 25th Avenue
Bellwood, Illinois 60104

As of the date of this Restatement, the Trustees are as follows:

Union Trustees	Employer Trustees
Mr. Kevin J. Farley Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. Steve Baumgartner Baumgartner Const Inc. 30W751 North Aurora Road Naperville, Illinois 60563
Mr. Lawrence J. Picardi, Sr. Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. Mike Dynowsk Elliot Construction Corporation 21W171 Hill Avenue Glen Ellyn, Illinois 60137
Mr. Antonio Acevedo Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. John Hallberg R. Olson Concrete Contractors 170 North Garden Avenue Roselle, Illinois 60172
Ms. Sandra Hunt Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. Lance Hornaday W.E. O'Neil Construction Co. 1245 West Washington Boulevard Chicago, Illinois 60607
Mr. Guadalupe Rodriguez Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. Michael Kolberg Ed Fogarty Concrete Construction 25239 Parkside Drive Plainfield, Illinois 60544
Mr. Jay La Sala Cement Masons' Local No. 502 739 South 25th Avenue Bellwood, Illinois 60104	Mr. Robert Kutrovatz Martam Construction, Inc. 1200 Gasket Drive Elgin, Illinois 60120

20.03 Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor and Plan Administrator.

20.04 Plan Numbers

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 36-2196729.

20.05 Agent for Service of Legal Process

Mr. Dennis R. Johnson
Johnson & Krol, LLC
311 South Wacker Drive, Suite 1050
Chicago, IL 60606
(312) 372-8587

Service of legal process may also be made on the Board of Trustees or any individual Trustee at the address listed above.

20.06 Source of Contributions

The benefits described in this Welfare Fund booklet are provided through Employer Contributions and Self-Payments. The amount of Employer Contributions and the Employees on whose behalf Contributions are made are determined by the provisions of the Collective Bargaining Agreements. The amount of Self-Payments is determined by the Trustees.

20.07 Collective Bargaining Agreement

The Fund is maintained in accordance with Collective Bargaining Agreements between the Union and the following contractor associations: Chicago Associated General Contractors f/k/a Builders Association of Chicago; Concrete Contractors Association of Greater Chicago; Illinois Road and Transportation Builders Association f/k/a Illinois Road Builders Association; Mid-America Regional Bargaining Associations; and Midwest Wall and Ceiling Contractors NFP. Other agreements may be in effect from time to time. The agreements specify the Contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of participants working under a Collective Bargaining Agreement or a list of participating Employers.

20.08 Trust Fund

All assets are held in Trust for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis, except for the Life Insurance Benefit and AD&D Benefit, which are insured.

The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

20.09 Discretionary Authority of Plan Administrator

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

20.10 Plan Year

The records of the Plan are kept separately for each plan year. The plan year is the calendar year that begins on January 1 and ends on December 31.

20.11 Type of Plan

This Plan is maintained for the purpose of providing life, accidental death and dismemberment, disability, medical, dental, vision, hearing aid and prescription drug benefits. The Plan benefits are shown in the applicable Schedule of Benefits.

20.12 Gender

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

20.13 Assignment

No participant, Dependent or beneficiary entitled to any benefits under this Plan shall have the right to assign, alienate or impair in any manner his legal or beneficial interest, or any interest in assets of the Fund, or benefits of this Plan. Neither the Fund nor any of the assets thereof, shall be liable for the debts of any participant, Dependent or beneficiary entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceedings.

Notwithstanding the above, the Fund shall pay benefits to the service provider on behalf of a participant and/or a Dependent upon authorization of such payment by the execution of a claim form assignment statement and if the Physician or supplier agrees to accept the Reasonable and Customary (R&C) Charge as the full charge for the items or services provided (except Co-Payments and Deductibles).

The Fund does not guarantee the legal validity or effect of such assignment nor does it guarantee that it will choose to honor all or any such authorizations.

20.14 Amendment and Termination

You do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

20.15 Severability Clause

If a provision of the Trust Agreement or the Plan or any amendment made to the Trust Agreement or to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or the Plan.

20.16 Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable workers' compensation laws or occupation disease laws of any state.

20.17 Recovery of Benefits Paid in Error

If for any reason, any benefit paid to a covered person under this Plan is determined to have been in error, or wholly or partially in excess of the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide, including, but not limited to, withholding benefits payable to you and/or your Dependent(s) until such time that the Fund is reimbursed in full for such erroneous benefit payment.

20.18 HIPAA Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice is available from the Fund Office.

This Plan and the Plan Sponsor will not use or further disclose information ("protected health information") that is protected by HIPAA, except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan. The Fund also hires professionals and other companies to assist it in providing health care benefits. The Fund will require all of its business associates to also observe HIPAA's privacy rules.

You will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Fund or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Fund maintains a privacy notice, that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office if:

1. You need a copy of the privacy notice;

2. You have questions about the privacy of your health information; or

3. You wish to file a complaint under HIPAA.

20.19 HIPAA Security Procedures

The Fund will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The Board of Trustees shall, in accordance with the Security Regulations:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information (PHI) that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate Separation" means the Board of Trustees will use PHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee or fiduciary of the Fund who uses or discloses PHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's sanction policy.

3. Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Take appropriate action related to any Security Incident of which it becomes aware.

The above HIPAA Security Procedures do not apply to PHI (1) that the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.504(f)(1)(ii) or (iii)) or (2) that qualifies as Summary Health Information and that the Fund receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). Unless defined otherwise in this booklet, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

20.20 The Fund's Use and Disclosure of Your Protected Health Information

A. How the Fund Uses and Discloses Your Protected Health Information

The Fund will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Fund will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

The Fund will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Fund will disclose PHI to the Pension Plan of the Cement Masons' Local Union No. 502, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment

Payment includes activities undertaken by the Fund to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, Plan maximums and Co-Payments as determined for an individual's claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Subrogation of health benefit claims;

5. Establishing Employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives) inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth,

Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Fund.

C. Definition of Health Care Operations

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

7. Business management and general administrative activities of the entity, including, but not limited to:

    a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

    b. Customer service, including the provision of data analyses for policyholders, Plan Sponsors, or other customers;

    c. Resolution of internal grievances; and

    d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

D. The Fund's Disclosure of Protected Health Information to the Board of Trustees

For purposes of this Section, the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document, or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Fund, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. Report to the Fund any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make the information available that is required to provide an accounting of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of HHS for the purposes of determining compliance by the Fund with HIPAA;

10. If feasible, return or destroy all PHI received from the Fund that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Fund and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI.

1. The Plan Administrator; and

2. Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Fund. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

20.21 Statement of ERISA Rights

As a participant of the Cement Masons' Local No. 502 Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

A. Receive Information About Your Plan and Benefits

You have the right to:

1. Examine, without charge, at the Plan Administrator's office, all documents governing the Plan. These include insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may assess a reasonable charge for the copies.

3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

You also have the right to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

C. 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 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.

D. 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 from the Fund and do not receive them within

30 days, you may file a lawsuit 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 which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all of the Plan's claims and appeals procedures before filing a lawsuit. If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a lawsuit. 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.

E. Receive Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

1. By calling (866) 444-3272;

2. Sending electronic inquires to www.askebsa.dol.gov; or

3. Visiting the website of the EBSA at www.dol.gov/ebsa.