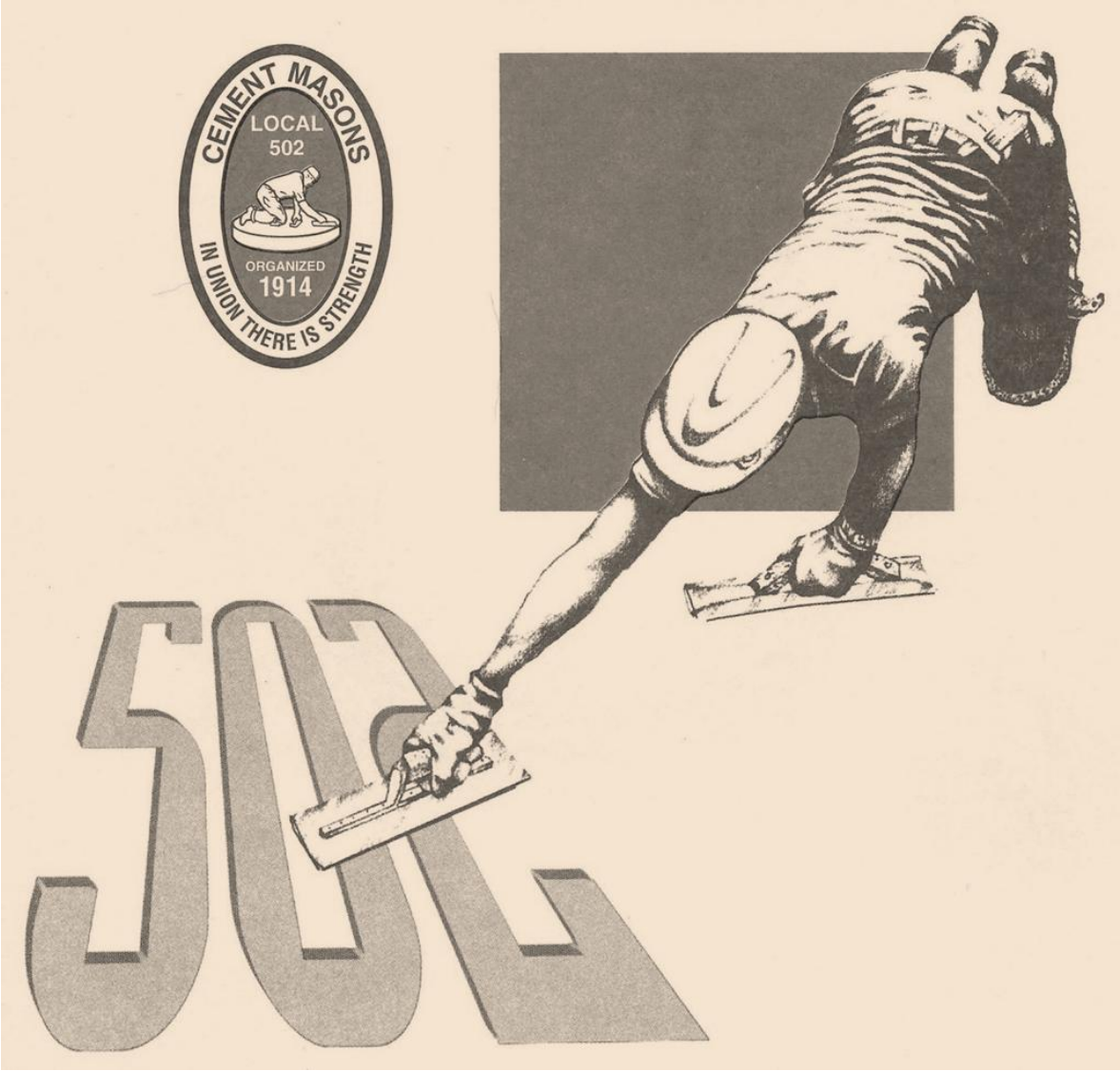
Cement Masons' and Plasterers Local No. 502 Welfare Fund



Summary Plan Description

October 1, 2014

USEFUL INFORMATION

FUND OFFICE; FUND ADMINISTRATIVE MANAGER

Mr. William Beeman
Fund Administrative Manager
Cement Masons' Local No. 502 Welfare Fund
739 South 25th Avenue
Bellwood, IL 60104-1995
Telephone: **708-544-9105 ext. 11**

ELIGIBILITY VERIFICATION

Call **708-544-9105 ext. 23, 15 or 19**

CLAIM INFORMATION

Call **708-544-9105 ext. 33, 34 or 35**

PPO NETWORK (BLUE CROSS BLUE SHIELD OF ILLINOIS)

Telephone: **800-810-2583**
Website: www.bcbsil.com

UTILIZATION REVIEW (MED-CARE MANAGEMENT)

Telephone: **800-367-1934**

PRESCRIPTION DRUG PROGRAMS (SAV-RX)

Member Services: **800-228-3108**
Website: www.savrx.com

DENTAL NETWORK (DENTAL NETWORKS OF AMERICA)

Member Services: **800-972-7565**
Website: www.dnoa.com

CEMENT MASONS' LOCAL NO. 502 WELFARE FUND BOARD OF TRUSTEES

Union Trustees	**Employer Trustees**
Patrick LaCassa	Donald Deetjen
Lawrence Picardi, Sr.	Gary Lundsberg
Sandra Hunt	Robert Krug
Antonio Acevedo	Mike Kolberg
Adam M. Higgins	Phil Diekemper
Jay La Sala	Michael Pirron

THE FOLLOWING DOCUMENTS ARE REQUIRED FOR NEW DEPENDENTS

For spouse:	Marriage certificate, birth certificate and Social Security card
For child:	Birth certificate, and Social Security card Prior divorce decree and custody order
Child 19 or older:	Must submit Special Enrollment form, birth certificate and Social Security card

LETTER TO NEW PARTICIPANTS

Notice About Your COBRA Rights - The following information is for newly eligible employees and their dependents. (It does not apply to non-bargaining unit participants whose coverage terminates due to lack of contributions.) It is intended to inform you, in a summary fashion, of your rights and obligations under the COBRA Coverage provisions of the law. More information about COBRA Coverage is on pages 17-20.

There may be other coverage options for you and your family. You may also buy coverage through the Health Insurance Marketplace created under the health care law. 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.

Qualifying Events and Maximum Coverage Periods - You (the employee) and your eligible dependents are entitled to elect COBRA Coverage and to make self-payments for the coverage for up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"): 1) a reduction in your hours; or 2) termination of your employment.

If you or an eligible dependent are disabled (as defined by the Social Security Administration for the purpose of Social Security disability payments) on the date of one of the qualifying events listed above, or if you or a dependent become so disabled within 60 days after an 18-month COBRA Coverage period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the date of that qualifying event. This 11-month extension rule does not apply to dependents during a 36-month maximum coverage period.

Your dependents (spouse or children) are entitled to elect COBRA Coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"): 1) a divorce or legal separation from your spouse; 2) a dependent no longer meets the Plan's definition of a dependent child; or 3) your death.

If your dependents are covered under an 18-month COBRA Coverage period and a second qualifying event (one of the events listed in the paragraph above) occurs, their COBRA Coverage maximum coverage period may be extended up to a maximum of 36 months minus the number of months of COBRA Coverage already received under the 18-month continuation. The maximum period of time that a dependent can have COBRA Coverage is 36 months, even if one or more new qualifying events occur to the person while he is covered under COBRA Coverage.

COBRA Coverage may not be elected by anyone who was not covered under the Plan on the day before the occurrence of a qualifying event except that, if a child is born to you, adopted by you, or placed for adoption with you after you become covered under an 18-month COBRA period, the child will have the same election rights as your other dependents who were covered on the day before the first qualifying event if a second qualifying event occurs.

Benefits Provided Under COBRA Coverage - COBRA Coverage is the same medical, dental/orthodontia and vision benefits that you and/or your dependents were eligible for on the day before the occurrence of the "qualifying event." Death and AD&D Benefits, Weekly Disability Benefits, and Family Supplement benefits are not provided under COBRA coverage.

Notification Responsibilities - You, your spouse, or child, as applicable, must provide written notification to the Fund Office if you get divorced or legally separated or if a child loses dependent

status. Notification must be provided within 60 days of the event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. If the Fund Office is not notified within 60 days, the dependent will lose the right to COBRA coverage. If your dependents are covered under an 18-month maximum COBRA period and then a second qualifying event occurs, it is the affected dependent's responsibility to notify the Fund Office within 60 days after the second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

In order to qualify for the 11-month disability extension, the Fund Office must be notified within 60 days of the disability determination by Social Security and before the end of the initial 18-month period. They must also be notified within 30 days of the date Social Security determines that you or the dependent are no longer disabled.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members.

Additional Rules Governing COBRA Coverage - Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. A person does not have to show that he is insurable to elect COBRA coverage. If coverage is going to terminate due to termination of your employment or a reduction in your hours and you don't elect COBRA coverage for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA coverage for up to 18 months for herself and any children within the time period that you could have elected COBRA coverage.

Electing COBRA Coverage - If you don't have sufficient employer contributions to continue coverage, or when the Fund Office is notified of any other qualifying event, you and/or your dependents will be sent an election notice that explains when coverage will terminate. It will also explain your right to elect COBRA coverage, the due dates, and the amount of the self-payments. An election form will be sent along with the election notice. Complete the election form and return to the Fund Office if you want to elect COBRA. A person has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. A COBRA election is considered to be made on the date of the postmark on the returned election form. If the election form is not returned within the allowable time period, you and/or your dependents will not be entitled to elect COBRA.

COBRA Coverage Self-Payment Rules - COBRA self-payments must be made monthly. The amount of the monthly COBRA self-payment is determined by the Trustees and is subject to change, but not usually more often than once a year. The amount due will be shown on the election notice. A person has 45 days after the date of the election to make the initial self-payment. Your first COBRA self-payment will be applied to your first month of COBRA coverage—not the month in which you make the payment.

Termination of COBRA Coverage - COBRA coverage for a covered person will end sooner than the end of the applicable maximum coverage period when the first of the following events occurs: 1) a correct and on-time payment is not made to the Fund; 2) the Fund no longer provides group health coverage to any employees; 3) if a person is receiving extended coverage for up to 29 months due to his or another family member's disability, Social Security determines that he or the family member is no longer disabled; 4) after electing COBRA coverage, the person becomes entitled to Medicare benefits; or 5) after electing COBRA coverage, the person becomes covered under another group health plan that does not have a preexisting condition exclusion.

Sincerely,
BOARD OF TRUSTEES

INTRODUCTION

To All Plan Participants:

The Trustees of your Welfare Fund are pleased to provide you with this new, updated Summary Plan Description booklet (SPD). It includes the changes that have been made in your Plan during the last several years.

This SPD provides information for active bargaining unit employees only (Class A). The SPD for retirees (Classes B & C) is provided as a separate Plan and Trust document

Be sure to read this booklet carefully (have your spouse read it, too) and keep it with your other important papers for future reference.

Sincerely,
Board of Trustees

ABOUT THIS BOOK

This booklet is only a summary.

This book is intended to give you an accurate summary of the benefits and provisions of your Plan. It is also the Plan Document for the Plan. The Trust Agreement, which you can read at the Fund Office, also contains provisions applicable to your Plan. Only the full Board of Trustees is authorized to interpret the Plan described in this book. Its interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious, as all Trustee decisions, including all determinations regarding benefit claims, require the exercise of Trustee discretion. No agent, representative, officer or other person from the union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about eligibility or claims, only the Fund Office is authorized to answer the questions for the Trustees. Matters that are not clear, or which need interpreting, will be referred to the Trustees.

PRONOUNS USED IN THIS BOOKLET

Wherever the term "you" or "your" is used, it means an eligible employee.

To avoid awkward wording, male personal pronouns are used in this book to refer to employees. Feminine pronouns are used when referring to spouses. Whenever a personal pronoun is used in the masculine gender, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine. Words in the singular form shall be deemed to include the plural form and vice versa.

Este libro es un resumen, en inglés, de sus derechos y beneficios bajo su Plan, Cement Masons' Local 502 Welfare Fund. Si Usted tiene dificultad comprendiendo cualquier parte de este libro, comuníquese a la Oficina del beneficios a 739 South 25th Avenue, Bellwood, IL 60104-1995. La oficina está abierta de lunes a viernes desde las 7:00 A.M. hasta las 3:30 P.M. También puede llamar a 708-544-9105 para asistencia.

TABLE OF CONTENTS

YOUR HOSPITAL AND DOCTOR PPO NETWORK

You and your family are encouraged to use providers (hospitals and doctors) that participate in the Plan's preferred provider organization (PPO).

YOU SAVE MONEY

PPO providers will provide medical services to you and your covered dependents at reduced rates. Because PPO providers discount their fees, the Fund is able to share its savings with you in the form of a higher reimbursement level for most covered services billed by PPO providers.

I.D. CARDS

You should already have received two medical I.D. cards. You should present one of your I.D. cards whenever you or a family member receives medical care (inpatient, outpatient or office). The I.D. card identifies you as a PPO participant so that the proper discounts can be applied to the bill. It also tells the providers how to submit their bills.

If you need additional I.D. cards, call the Fund Office.

HOW TO FIND PPO PROVIDERS

BCBS –IL

800-810-2583
www.bcbsil.com

Information about PPO hospitals and doctors is provided to participants as a separate document. If you need more current information, or need a list of PPO doctors near you, call the PPO's toll-free number on your medical I.D. card or visit their website.

UTILIZATION REVIEW

Med-Care Management

800-367-1934

You and your dependents can save money by using the Utilization Review program. This program is designed to make sure you and your dependents receive the most appropriate care in the most appropriate setting. It is also designed to cut down on waste and save you and the Fund money.

If you or a dependent are scheduled for a non-emergency inpatient hospitalization, call the Utilization Review company at the phone number shown on the inside front cover before your admission. In an emergency, make the call as soon as possible. Doctors or hospitals will usually make the call for you.

Having your proposed hospitalization reviewed is to your benefit, since it will help assure that you receive the maximum benefit payment possible under our health care benefit plan. By taking advantage of this service you can help keep your medical costs as low as possible.

CLAIM FILING AND CLAIM QUESTIONS

MEDICAL CLAIMS

Hospitals and doctors will usually file their claims for you based on the information on your medical I.D. card. You will receive an Explanation of Benefits (EOB) form explaining how your medical benefits were paid.

DENTAL, VISION, DISABILITY AND LIFE/AD&D CLAIMS

The Fund Office handles all non-medical claims. You should submit your claims, along with claim forms and correspondence, to the Fund Office at:

Cement Masons' Local No. 502 Welfare Fund
739 South 25th Avenue
Bellwood, IL 60104-1995

For vision claims, submit a detailed receipt.

FAMILY SUPPLEMENTAL BENEFIT CLAIMS

Send Supplemental claims, along with claim forms, to the Fund Office at:

Cement Masons' Local No. 502 Welfare Fund
739 South 25th Avenue
Bellwood, IL 60104-1995

Reimbursement checks will be made payable to you, and will be sent every six months in accordance with the following schedule:

You must submit your claim by:	**For payment in:**
June 30	August
December 31	February

See "How to File a Claim for Supplemental Benefits" on page 44 for more information.

PRESCRIPTION DRUG CLAIMS

There are no claims to file when you use a participating retail pharmacy or the participating mail-order pharmacy.

CLAIMS QUESTIONS AND ELIGIBILITY

Call the Fund Office for questions at **708-544-9105.**
Eligibility: Ext. 23,15 or 19
Claims: Ext. 35,34 or 33

CLAIM FILING TIME LIMIT

ALL claims must be filed within one year of the date the claim is incurred.

SCHEDULE OF BENEFITS

LIFE INSURANCE

Employees:

With 30 or more pension credits.....$50,000
With at least 20 but less than 30 pension credits.....$40,000
With less than 20 pension credits.....$30,000

Dependents:

Spouse.....$15,000
Child:
0 through 14 days.....$0
15 days through 6 months.....$250
6 months through age 26.....$5,000

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (ACTIVE EMPLOYEES ONLY)

Loss of life.....Principal sum
Loss of both hands, both feet, or the sight in both eye.....Principal sum
Loss of one hand or one foot, and the sight in one eye.....Principal sum
Loss of one hand, one foot or the sight in one eye.....1/2 Principal sum

The principal sum is equal to your life insurance amount.

WEEKLY DISABILITY BENEFIT (ACTIVE EMPLOYEES ONLY)

Weekly benefit amount.....$400

Maximum period payable per disability.....26 weeks

Day that disability benefits start:
Disabilities caused by accidental injury.....1st day
Disabilities caused by sickness.....8th day

WELLNESS BENEFITS

Physical exam benefit (for employees and spouses only)

Plan Payment percentage..... 100%

No deductible applies.

Well baby care (age 0 to 1 year old)

Plan Payment percentage..... 100%

No deductible applies.

ADDITIONAL ACCIDENT BENEFIT

Maximum amount payable per accident $300

COMPREHENSIVE MEDICAL BENEFIT

Calendar year deductible per person $175

Plan payment percentages:

PPO hospital charges (inpatient or outpatient) 90%

Non-PPO hospital charges incurred outside the PPO service area or for an emergency 80%

All other covered medical expenses.....80%

Out-of-pocket limit per person per calendar year (excluding deductible and prescription drug co-pays) $2,000

Non-covered charges DO NOT APPLY to your out-of-pocket limit. This includes charges in excess of R&C amounts.

Non PPO Surgical Centers are not covered.

PRESCRIPTION DRUG BENEFIT

Retail

Participant co-pays for up to a 30-day supply of a covered prescription drug purchased through a retail pharmacy:

Generic 10%

Formulary brands ..... .15%

Non-formulary brands..... 20%

Mail Order

Participant co-pays for up to a 90-day supply of a covered prescription drug purchased through the Plan's mail-order pharmacy:

Generic 10%

Formulary brands ..... .15%

Non-formulary brands..... 20%

FAMILY SUPPLEMENTAL BENEFIT

Maximum amount payable per calendar year per family.....$3,250

DENTAL BENEFIT

Calendar year deductible per person.....$50

Does not apply to preventive care.

Maximum payable per calendar year per person, excluding orthodontia.....$1,500

The maximum payable per calendar year does not apply to children under age 19.

Lifetime maximum payable per person for orthodontia.....$1,500

Plan payment percentages for covered dental expenses:

Preventive (no deductible)..... 70%

Restorative..... 70%

Orthodontia (no deductible)..... 50%

Orthodontia benefits are payable for dependent children only.

VISION BENEFIT

Maximum payable per person per calendar year.....$200

The maximum payable per calendar year does not apply to children under age 19.

ELIGIBILITY

The rules in this section apply to active bargaining unit employees. Eligibility for non-bargaining unit employees and their dependents is governed by the terms of their participation agreement.

WORK QUARTERS AND BENEFIT QUARTERS

A work quarter is a period of three (3) consecutive calendar months during which you meet the applicable eligibility requirements necessary to provide benefit coverage during the related (next) benefit quarter. A benefit quarter is a period of 3 consecutive calendar months during which you and your dependents are covered under the Plan because you have met the eligibility requirements during the related (prior) work quarter. A "lag month" separates each work quarter from its related benefit quarter.

Work Quarters *Work performed during . . .*	**Related (Next) Benefit Quarters** *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

INITIAL ELIGIBILITY

Employees

Returning Employees

You will become initially eligible on the first day of the benefit quarter following the work quarter in which at least 250 hours have been credited to you for work performed for a contributing employer.

New Employees

If you are new to this Fund, you must earn at least 200 credited hours in no more than two consecutive work quarters, or at least 250 credited hours in one work quarter. Your initial eligibility date will be the first day of the next benefit quarter.

Dependents

See page 50 for the Plan's definition of a dependent.

If you have dependents, their benefit coverage will start on the date that you become initially eligible. A person who later becomes your dependent while you are eligible will become eligible for benefits on the date that person meets the Plan's definition of a dependent.

BANKED HOURS

Your employer contribution hours in excess of 250 for a work quarter are credited to your hour bank. You can accumulate up to 1,200 hours in your hour bank at any one time.

CONTINUING ELIGIBILITY

After becoming initially eligible, you and your covered dependents will continue to be eligible in each successive benefit quarter as long as employer contributions are made on your behalf totaling at least 250 hours in the related work quarter.

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 banked hours and used to continue your eligibility.

REGULAR SELF-PAYMENTS

There are 2 types of self-payments: regular self-payments and COBRA self-payments. See pages 17-20 for more information about COBRA coverage

If you have some hours during a work quarter and/or have some hours in your hour bank, but the total is not enough to satisfy the 250-hour requirement, and if you were eligible during the prior benefit quarter, you can make a regular self-payment for the difference. The amount you will be required to pay will be the difference between 250 and your hours (contribution hours plus banked hours) times the current employer contribution rate.

You can make regular self-payments for up to a maximum of four (4) 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 4-quarter maximum period.

Additional Rules Governing Regular Self-Payments

The Fund Office will send a self-payment notice to your last known address advising you that a payment is due, the amount of the payment.

Payments are due before the fifth day of the benefit quarter. Your payment must be received by the Fund Office (not postmarked) on or before that date.

You must maintain continuous eligibility. If you fail to make a regular self-payment on time, you cannot make up the payment and your coverage will terminate. In such a case, you must once again satisfy the Plan's initial eligibility requirements before you will again be covered. You must also be available for work in order to make a regular self-payment.

Retain your check stubs. It is ultimately your responsibility to keep track of your credited hours and banked hours.

You cannot make a self-payment to gain initial eligibility.

A regular self-payment will provide all of the normal Plan benefits for you and your dependents for one benefit quarter.

While the Fund Office will attempt to notify you when a regular self-payment is due, it is your responsibility to make any required regular self-payments on time whether or not you receive a notice from the Fund Office.

If you exhaust your 4 quarters of regular self-payments, and are still not able to earn eligibility with worked hours, you will be able to make COBRA self-payments for an additional 18 months.

ELIGIBILITY DURING TOTAL DISABILITY

Short-Term Disabilities

If you become totally disabled while you are covered under the Plan, your eligibility for Plan coverage may be continued subject to the following rules:

1. A "qualifying" disability or sickness is one for which you are either receiving Weekly Disability Benefits from this Plan or for which you are drawing weekly workers' compensation benefits (even though you cannot get Weekly Disability Benefits for your occupational disability).

2. You will be credited with 20 hours for each full week of disability.

3. The maximum hours you can receive for any one period of disability is 520 hours (26 weeks times 20 hours per week) for a non-occupational disability, and 1,000 hours (52 weeks) if you are receiving workers' compensation.

Long-Term Disabilities

If your qualifying disability lasts longer than 26 weeks, and if you qualify for a disability pension from the Cement Masons' Local 502 Pension Plan, your Plan coverage may be continued until you reach normal retirement age (as defined by the Cement Masons' Local 502 Pension Plan). This disability extension does not apply to the Weekly Disability Benefit and will terminate earlier than your normal retirement age if you cease to be totally disabled.

ELIGIBILITY DURING MILITARY SERVICE

Be sure to call the Fund Office if you are called up to active military duty.

If you leave employment with a contributing employer to enter active duty in the uniformed services of the United States, 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 very similar to COBRA Coverage. This Plan will pay primary benefits before the military/government pays except for service-related disabilities.

This 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 last for more than four years (48 months), your banked hours 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 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.

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act (FMLA) requires certain employers (but not all—small employers are exempt) to grant unpaid leave of up to 12 weeks during a 12-month period. FMLA leave must be granted for specific reasons, such as the birth of a child or a serious family illness. Eligibility for this unpaid leave is determined by the employer, not by the Trustees of this Fund.

If you are granted a FMLA leave, your employer is required to maintain your coverage for the length of your leave (up to 12 weeks). Failure of your employer to submit contributions on a timely basis will result in loss of coverage under this Plan. See your employer if you think you may be entitled to a FMLA leave.

TERMINATION OF ELIGIBILITY

Termination of Employee Eligibility

You will cease to be eligible for benefits at midnight on the first to occur of the following dates unless you are entitled to elect COBRA coverage and an on-time COBRA self-payment is made:

1. The end of the last day of the benefit quarter corresponding to the last work quarter during which you had a total of 250 credited hours from some combination of employer contributions, banked hours and regular self-payments.

2. If you are eligible due to a disability extension, the date of your 65th birthday, or the date your total disability ends, whichever occurs first.

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

4. If you are eligible due to COBRA self-payments, on the earlier of: a) the last day of the month for which a correct and on-time self-payment has been made; b) the last day of the maximum coverage period to which you are entitled; or c) on the date any of the events stated in "Termination of COBRA Coverage" occurs (page 20).

5. The date the Trustees terminate this Plan.

Termination of Dependent Eligibility

A dependent will cease to be eligible for benefits at midnight on the first to occur of the following dates unless the dependent is entitled to elect COBRA

coverage and an on-time COBRA self-payment is made:

1. The date on which your eligibility for benefits terminates for reasons other than your death.

2. For a dependent spouse, on the date of your divorce from the spouse.

3. For a dependent child, the date the child fails to meet this Plan's definition of a dependent.

4. If COBRA self-payments are being made by or on behalf of the dependent, on the earlier of: a) the last day of the month for which a correct and on-time self-payment has been made; b) the last day of the maximum coverage period to which the dependent is entitled; or c) on the date any of the events stated in "Termination of COBRA Coverage" occurs (page 20).

5. The date the dependent enters the armed forces of any country on a full-time basis.

6. The date the Trustees terminate coverage for dependents under this Plan.

REINSTATEMENT OF ELIGIBILITY

Reinstatement After Termination of Eligibility

If you lose eligibility and do not make regular self-payments to continue your coverage, your eligibility will only be reinstated if you resatisfy the Plan's initial eligibility rule by having 250 hours in a work quarter.

Reinstatement After Military Service

After your release from active duty under circumstances entitling you to re-employment under federal law, your eligibility will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by federal law. More information about the re-employment rights of persons returning to work from the uniformed services of the United States is available from the Veterans' Employment and Training Administration of the United States Department of Labor. (Also refer to the section entitled "Eligibility During Military Service" on page 14 for more information about your rights when you are called up to active full-time duty.)

COBRA COVERAGE

Federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives you and your dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "continuation coverage" or "COBRA coverage."

QUALIFYING EVENTS/MAXIMUM COVERAGE PERIODS

18-Month Maximum Coverage Period

You and/or your dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 18 months after the date of occurrence of the following qualifying events:

1. A reduction in your hours.

2. Termination of your employment (other than for gross misconduct).

36-Month Maximum Coverage Period

Your dependents are entitled to elect COBRA coverage for up to 36 months when one of the qualifying events listed below occur:

1. Divorce from your spouse.

2. A child loses dependent status by failing to meet this Plan's definition of a dependent.

3. Your death.

29-Month Maximum Coverage Period

If you or a covered dependent is disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or a covered dependent becomes so disabled within 60 days after an 18-month COBRA coverage period starts, the maximum coverage period will be 29 months for the disabled person and all members of the disabled person's family who are covered by the same COBRA election. (The self-payment for the extra eleven (11) months of coverage may be increased.) You or the disabled dependent must notify the Fund Office within 60 days of such a determination by Social Security and before the end of the initial 18-month period and also within 30 days of the date Social Security determines that you or the dependent is no longer disabled.

Multiple Qualifying Events

If your dependents are covered under COBRA coverage under an 18-month maximum coverage period due to your termination of employment or reduction in hours and a second qualifying event (such as divorce or a child losing dependent status) occurs, your spouse or the child is entitled to elect COBRA coverage for up to a maximum of 36 months *minus* the number of months of COBRA coverage already received under the 18-month continuation. Only a person who was your dependent on the date of your termination of employment or reduction in hours is entitled to make an election for this extended period. Exception: If a child is born to you (employee), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as those of a person who was your dependent on the day before the first qualifying event. It is the affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

COBRA Coverage During Military Service

Refer to "Eligibility During Military Service" on page 14.

BENEFITS UNDER COBRA COVERAGE

A person electing COBRA coverage can make self-payments for the health care benefits for which he was eligible on the day before the qualifying event that would otherwise cause loss of coverage. COBRA coverage does not include Weekly Disability Benefits, life insurance or accidental death and dismemberment insurance, or the Family Supplemental Benefits.

NOTIFICATION RESPONSIBILITIES

- If you get divorced or if your child loses dependent status, you, your spouse or child must notify the Fund Office and request a COBRA election notice. The Fund Office must be notified within 60 days of the date of the qualifying event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. If written notification is not provided within these time limits, your spouse or child will not be entitled to COBRA coverage.

- For purposes of extending an 18-month maximum coverage period to 29 months, the Fund Office must be notified of the person's determination of eligibility for Social Security disability benefits within 60 days of the Social Security notice of such determination and before the end of the initial 18-month period. The Fund Office must also be notified within days of the date Social Security determines that the person is no longer disabled. If written notification is not provided within these time limits, you and your family members will not be entitled to COBRA coverage.

- It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make

sure that you are sent notification of your election rights as soon as possible, you or a dependent should also notify the Fund Office and request a COBRA election notice any time any type of qualifying event occurs.

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

COBRA ELECTION AND PAYMENT PROCESS

Election Notices and Forms

When the Fund Office is notified of a qualifying event, they will send you and/or your dependents an election notice that tells you about your right to elect COBRA coverage, the due dates, the amount of the self-payments, etc. An election form will be sent along with the election notice. This is the form you or a dependent fill in and send back to the Fund Office if you want to elect COBRA coverage.

Electing COBRA 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 coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents.

2. If you don't elect COBRA coverage for your dependents when they are entitled to COBRA coverage, your dependent spouse has the right to elect COBRA coverage for herself and any children within the time period during which you could have elected COBRA coverage for them.

3. A person electing COBRA coverage has 60 days after he is sent the election notice or 60 days after his coverage would terminate, whichever is later, to return the completed election form. An election of COBRA coverage is considered to be made on the date the election form is personally delivered or mailed (postmarked) to the Fund Office.

4. If the election form is not returned to the Fund Office within the allowable period, it will be considered that you and/or your dependents have waived your right to COBRA coverage.

5. You do not have to show that you or your dependents are insurable to be entitled to elect COBRA coverage.

6. A person who is already covered by another group health plan or Medicare may elect COBRA coverage. However, if a person becomes covered under another group health plan or Medicare after the date of the COBRA coverage election, his COBRA coverage will terminate (unless the person has a preexisting condition that would cause the other plan to limit or exclude benefits).

COBRA Coverage Self-Payment Rules

1. COBRA coverage self-payments must be made monthly. The amount of the monthly self-payment is determined by the Trustees based on federal regulations. The amount is subject to change.

2. A person electing COBRA coverage has 45 days after the date of election to make the initial payment. (However, if you wait 45 days to make the payment, one or more monthly payments may fall due within that period and must also be paid at that time.)

3. The due date for each following monthly payment is the first day of the month for which payment is made. A monthly payment is considered on time if it is received within 30 days of the due date.

4. If a self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. The person may not make up the payment or reinstate coverage by making future payments.

TERMINATION OF COBRA COVERAGE

COBRA coverage will normally terminate at the end of the applicable maximum coverage period to which the person was entitled. However, COBRA coverage will be terminated before the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct and on-time payment is not made to the Fund.

2. The Cement Masons' Local No. 502 Welfare Fund no longer provides group health coverage to any employees.

3. The person extended coverage for up to 29 months due to his or a family member's disability and Social Security has determined that the affected person is no longer disabled.

4. After electing COBRA coverage, the person becomes entitled to Medicare.

5. After electing COBRA coverage, the person becomes covered under another group health plan. Exception: This termination rule will not apply if the person has a preexisting medical condition that would cause benefits to be excluded or limited under the other plan.

LIFE INSURANCE

EMPLOYEE LIFE INSURANCE

If you die from any cause, a life insurance benefit in the amount shown on the Schedule of Benefits will be payable to your designated beneficiary.

Your Beneficiary

You must file a written designation of beneficiary with the Fund Office on a properly completed form. You may name a new beneficiary, without your prior beneficiary's consent, by filing a new form with the Fund Office. The change of beneficiary will be effective retroactively to the date you sign the form, whether or not you are living when the Fund Office receives it. The Plan is not responsible for any payments made before the change of beneficiary form is received. If you do not designate a beneficiary or if your beneficiary does not outlive you, your life insurance benefit will be paid to the living in the following order:

1. Your spouse
2. Your children, including legally adopted children
3. Your parents
4. Your brothers and sisters
5. The executor or administrator of your estate

See page 9 for life insurance amounts.

If two or more persons are entitled to your life insurance benefit, they will share equally.

Proof of Death

Life insurance benefits will only be paid following receipt of written proof of death acceptable to the Trustees.

Coverage During Total Disability

If you become totally disabled while eligible for life insurance benefits and before age 60, you will remain eligible for life insurance benefits during your period of disability. Proof of your disability must be submitted to the Fund Office within twelve months after the date your coverage ends (and after you have been disabled for at least nine months). You must submit proof of your continued disability periodically thereafter.

DEPENDENT LIFE INSURANCE

If your dependent dies from any cause, a life insurance benefit in the amount shown on the Schedule of Benefits will be payable directly to you. Life insurance benefits will only be paid following receipt of written proof of death acceptable to the Trustees.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Employees Only

Accidental death and dismemberment (AD&D) benefits are payable if you are an active employee, sustain one of the accidental losses shown on the Schedule of Benefits. The benefit amount depends on the type of loss. Benefits are only payable if the loss occurs within 180 days of an accidental injury that happened while you were covered under the Plan.

COVERED LOSSES

"Loss" with reference to hand or foot means complete severance through or above the wrist or ankle joint, and with reference to eye means the irrecoverable loss of the entire sight in the eye.

See page 9 for AD&D benefit amounts.

The amount payable for all losses resulting from any one accident cannot exceed the principal sum. If you suffer any combination of the losses on the Schedule of Benefits as the result of one accident, only one amount (the largest) is payable for all losses.

The amount paid for accidental death (loss of life) is in addition to your life insurance benefit. The payment will be made directly to you if you are living, otherwise it will be made to your life insurance beneficiary.

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for loss resulting from or caused directly or indirectly, wholly or partly, by any of the following:

1. Bodily or mental infirmity, or disease or illness of any kind.
2. Suicide or self-destruction, or any attempt thereat, while sane or insane.
3. Participation in an act which is in violation of a state or federal statute.
4. Declared or undeclared war.

WEEKLY DISABILITY BENEFIT

Employees Only

Weekly Disability Benefits are provided only for active eligible employees who are not maintaining eligibility through COBRA self-payments. Dependents are not eligible to receive Weekly Disability Benefits.

Weekly Disability Benefits are payable if you become totally disabled within 21 days after you last worked in covered employment, and if you are eligible for Plan benefits when the disability begins.

AMOUNT PAYABLE

The Plan pays $400 per week for up to 26 weeks per disability. Benefits start on the first day of a disability due to an accidental injury and on the 8th day of a disability caused by a sickness. A prorated benefit is payable for a partial week of disability.

DEFINITION OF TOTAL DISABILITY

The definition of total disability, as applied to this benefit, means a period of disability during which you are physically or mentally unable to engage in your occupation and during which you are not able to engage in performing any work or employment for compensation or profit. The disability must be due to a non-occupational accidental injury or sickness.

SUCCESSIVE PERIODS OF DISABILITY

Successive periods of disability resulting from or contributed to by the same or related causes will be considered one continuous period of disability unless the two periods are separated by two consecutive weeks of full-time work for a contributing employer. If the second period of disability is due to an accidental injury or sickness entirely unrelated to the cause of the first disability and begins after you have returned to full-time work for a contributing employer, then the second disability will begin a new period of disability if you are eligible for benefits on the day on which you return to work.

EXCLUSIONS AND LIMITATIONS

No Weekly Disability Benefits will be paid for any disability or period:

1. For which you are not under the direct care of a physician or any period or day for which a physician has not certified your total disability.

2. Related to an occupational injury or disease, or that is covered in whole or in part by any workers' compensation, employer liability law, occupational diseases law or any similar law.

3. After you become covered under another group health plan.

WELLNESS BENEFITS

PHYSICAL EXAM BENEFIT

Employees and Spouses Only

This benefit covers charges incurred for routine (preventive) physical examinations. No benefits will be payable under this benefit if you are sick or injured, or have symptoms of a sickness or injury. (However, the charges may be covered under the Comprehensive Medical Benefit.)

The Plan pays 100% of the covered expenses incurred during a calendar year. There is no deductible.

Covered expenses include the reasonable and customary charges for a routine physical performed by a physician, and diagnostic tests and x-rays ordered by the physician.

WELL BABY CARE

This benefit covers charges incurred for routine well baby care during the child's first year of life, other than the hospital's charges for newborn nursery care. If the child is sick or injured, or has symptoms of a sickness or injury, no benefits will be payable under this benefit. Charges for hospital nursery care and care of a sick or injured child may be covered under the Comprehensive Medical Benefit.

The Plan pays 100% of the covered expenses incurred during the first year of life. There is no deductible.

Covered expenses under this benefit are the reasonable and customary charges incurred for routine examinations by a physician, routine childhood immunizations and routine diagnostic tests.

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.

COMPREHENSIVE MEDICAL BENEFIT

This section explains the medical benefits provided by this Plan for participants under the Comprehensive Medical Benefit.

If you or any of your dependents have a non-occupational accidental injury or become sick, the Plan will provide benefits for the reasonable and customary amount of the expenses you incur for treatment of the injury or sickness. Payment will be made for the charges incurred for the treatment in accordance with the Comprehensive Medical Benefit payment provisions shown on the Schedule of Benefits.

CALENDAR YEAR DEDUCTIBLES

A $175-per-person deductible must be satisfied each year before the Plan will pay its share of the person's covered medical expenses.

You are responsible for paying the amount of the covered medical expenses used to satisfy deductibles for yourself and your dependents.

The deductibles must be met for each calendar year. However, if a person's individual deductible is entirely met by covered medical expenses incurred during October, November, or December of a calendar year, that person's individual deductible for the following year will waived.

Amounts you pay out-of-pocket to satisfy deductibles do not apply to your out-of-pocket limit.

PAYMENT PERCENTAGES

After your calendar year deductible has been satisfied, the Plan will pay 90% of your covered PPO hospital expenses (facility charges), and 80% of all other covered medical expenses. You are responsible for paying the remaining percentage of the covered expenses on behalf of yourself and your dependents.

Covered non-PPO hospital charges will be paid at the PPO payment percentage if the patient resides more than 50 miles from a PPO hospital, or if the treatment is due to emergency.

OUT-OF-POCKET LIMIT

The Plan keeps track of the amounts you have to pay out-of-pocket for your covered medical expenses during each calendar year. After your out-of-pocket co-payment shares for most covered medical expenses total the $2,000 out-of-pocket limit, and subject to the exceptions shown below, the Plan will pay 100% of the covered medical expenses you incur during the rest of that calendar year. The out-of-pocket limit applies to each covered person in your family separately.

Amounts that Do Not Apply to Out-of-Pocket Limits

Non-covered charges DO NOT APPLY to your out-of-pocket limit. This includes charges in excess of R&C amounts.

Your out-of-pocket payments for the following will not be applied to your out-of-pocket limit:

1. Deductibles.
2. Prescription drug co-pays.
3. Charges in excess of reasonable and customary amounts.
4. Charges not considered covered medical expenses.
5. Charges incurred in excess of any applicable maximum benefit.

MAXIMUM BENEFITS

Each person who is covered under this Plan may be entitled to benefits up to the maximum benefit amounts. These maximums are shown on the Schedule of Benefits.

The Schedule of Benefits starts on page 9.

There are separate maximum benefits for particular types of care or treatment. These are listed in the "Special Limitations" section on your Schedule of Benefits. Be sure to become familiar with your Schedule of Benefits so that you will know whether the Plan covers a particular type of care or treatment, what the amounts of the maximum benefits are, and whether they apply on a lifetime or calendar year basis.

Amounts applied to these special maximums also apply to your Comprehensive Medical Benefit lifetime maximum.

COVERED MEDICAL EXPENSES

The Plan only covers reasonable and customary charges for medically necessary services.

The following expenses are considered covered medical expenses under the Comprehensive Medical Benefit. Covered medical expenses are the actual reasonable and customary charges incurred by a covered person for the following medically necessary services and supplies that are required in connection with treatment of the covered person. If a charge is not a reasonable and customary charge, the Plan will recognize only the amount that is considered reasonable and customary.

Covered medical expenses include charges incurred for:

1. **Hospital** room and board and other necessary services and supplies provided by the hospital.
2. Services and supplies provided by a **skilled nursing facility,** an **ambulatory surgical center** or an **emergency treatment center** on an inpatient or on an outpatient basis, as the case may be. However, effective for charges incurred on and after November 1, 2014, non-PPO ambulatory surgical centers will not be covered.

3. **Physician's** professional services for medical and surgical services, including second surgical opinions.

4. **Chiropractic care** provided by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine, or a Registered Physical Therapist (under the direction of a physician) for treatment of the back, neck, spine and vertebra for conditions due to subluxation, strains, sprains, and nerve root problems.

5. **Nursing** services provided by a legally licensed registered nurse (R.N.) or licensed practical nurse (L.P.N).

6. **Physical therapy** provided by registered physical therapist under the direction of a physician.

7. **Occupational therapy** provided by a registered occupational therapist under the direction of a physician. Supplies are not covered.

8. **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 any injury or sickness. The treatment may be rendered in or out of a hospital and must be recommended by the attending physician.

9. **Pregnancy** and pregnancy-related conditions, including but not limited to in-hospital charges, physicians' delivery fees, prenatal laboratory and x-ray examinations, home birth delivery by an MD, sonograms and ultrasound testing, prenatal office visits, and anesthesia and its administration.

10. **Vasectomies and tubal ligations** for employees and spouses.

11. **Professional ambulance** transportation from the place where an injury occurs or an illness begins to the nearest hospital equipped to treatment for that condition.

12. **Drugs and medicines** properly identified and ordered in writing by a physician and dispensed by a licensed pharmacist or physician.

13. **Anesthesia** and its administration by a qualified physician.

14. Diagnostic **x-ray and laboratory examinations**, and other diagnostic imaging.

15. **Radiation therapy**.

16. **Chemotherapy** for malignancies.

17. **Oxygen** and its administration.

18. **Surgical dressings, casts, splints and braces,** including the first charge incurred for surgical supplies required to aid any impaired physical organ or part of an organ in its natural body function.

19. **Prosthetics such as artificial limbs and artificial eyes**. Only the initial charge for any such appliance shall be considered a covered medical expense.

20. **Blood and blood plasma** if not replaced.

21. **Rental of durable medical equipment** required for therapeutic use and prescribed by a physician, such as: respiratory devices, hospital beds, traction equipment, wheelchairs, walkers and crutches. Purchase of the equipment is covered in lieu of rental if the item cannot be rented or if the purchase price is less than the expected rental charges.

22. **Reconstructive surgery** for:

    a. Repair following surgery;

    b. For repair of a congenital defect of a newborn child; and

    c. On the nonaffected breast to achieve a symmetrical appearance.

23. 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 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.

24. Inpatient treatment at a hospital or an approved treatment facility for **substance abuse** and outpatient/office visits with a physician, licensed clinical psychologist or licensed social worker.

25. Inpatient treatment for **mental/nervous disorders treatment**, and outpatient treatment with a physician, or licensed clinical psychologist or licensed social worker when referred by a physician. Partial hospitalization and intensive outpatient treatment is paid the same as inpatient care.

26. **Infertility treatment** - Benefits are payable 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:

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 if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered.

27. **Organ transplants** - Benefits are payable for human organ transplant procedures. In order to be covered, the procedure must meet the coverage criteria established by Medicare (whether or not the person is covered by Medicare). Benefits are payable for both the recipient and the transplant donor.

    No benefits will be payable for any expenses that are payable by a governmental or charitable program or grant, or for the purchase of an organ or tissue that is sold, rather than donated, to the recipient.

28. **Home health care**, subject to the following provisions:

    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 care is for the same or related condition for which the patient was hospitalized and that proper treatment of the patient's condition would require hospital confinement in the absence of the services and supplies provided as part of the home plan of care.

    c. Covered expenses include the following services and supplies, provided such services and supplies are provided by or through an organization which meets this Plan's definition of a home health agency:

        - Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
        - Medical social services provided under the direction of a physician;
        - Part-time or intermittent home health aide services; and
        - Medical supplies (other than drugs and biologicals) and the use of medical appliances.

29. **Hospice care** by a covered hospice agency for persons with terminal medical conditions (life expectancy of 6 months or less). The Plan covers services and supplies provided by a hospice or provided through arrangements made by a hospice for care of a terminally ill person.

30. **Bariatric (obesity) surgery**, provided all of the following criteria are met:

    a. The person is 100 pounds over his medically desirable weight and has a Body Mass Index (BMI) of 45 or more;

    b. The obesity is a threat to the person's life due to the existence of complicating health factors, such as diabetes, heart trouble, hypertension, etc.;

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

    d. The surgery is performed at a PPO hospital.

    Bariatric surgery will only be covered for persons age 21 and older, and only one procedure will be covered during the patient's lifetime. The Plan will not cover post-surgical removal of excess skin following successful weight loss.

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

COMPREHENSIVE MEDICAL BENEFIT EXCLUSIONS

Refer to the general "Exclusions and Limitations" section starting on page 45.

PRESCRIPTION DRUG BENEFIT

The Plan has contracted with a prescription benefit manager so that you can purchase prescription drugs at discounted prices.

Sav-Rx
800-228-3108
www.savrx.com

You should already have received an information packet containing two prescription drug I.D. cards, a partial list of participating pharmacies, mail-order forms, formulary list, and additional information about the program. If you need additional prescription drug cards, call the Fund Office.

You cannot use this program for drugs that are not covered by the Plan.

RETAIL CARD PROGRAM

Each time you need a prescription filled, simply present your prescription drug I.D. card at a participating retail pharmacy. You will pay the following percentages of the discounted price directly to the pharmacy for up to a 30-day supply of the drug. The Plan pays the rest. There are no claims to file.

Generic 10%
Formulary brands 15%
Non-formulary brands 20%

MAIL-ORDER PROGRAM

The prescription benefit manger also provides a mail-order service for long-term or maintenance drugs, which are any drugs you take for 90 days or longer. Your cost will usually be lower through the mail-order program because of the volume discounts and the larger quantities supplied per fill. Since both you and the Fund save money when you order your long-term prescriptions by mail, you should use the mail-order pharmacy whenever possible.

What You Pay for Mail-Order Prescriptions

You will be able to order up to a maximum of a 90-day supply of a prescribed medication by paying the following co-pay amounts:

Generic 10%
Formulary brands 15%
Non-formulary brands 20%

The Fund pays 100% of the remaining cost.

"Formulary drugs" are brand name medications that have been evaluated by physicians and pharmacists and determined to be most effective for treatment of certain conditions for the most number of patients, and that are reasonably priced. The formulary is not a list of covered drugs. The fact that a drug appears on the list does not mean that it is covered by the Plan.

How to Use the Mail-Order Pharmacy

When your doctor gives you a new prescription, or changes the strength or dosage of a drug you are already taking, ask for one prescription for a 14-day supply that you can have filled right away at a local pharmacy and one for up to a 90-day supply that you can send to the mail-order pharmacy. If you are already taking a maintenance medication, you should ask your doctor for a new prescription.

The mail-order service is not for drugs taken on a short-term basis. You should continue to use your retail drug card for those drugs.

SAFETY AND COST CONTAINMENT PROGRAMS

Several programs apply to prescription drug benefits designed to promote patient safety and help you and your family save money. These programs are designed to control cost as well as to provide an incentive to purchase lower cost medications, saving you and the Fund money. Contact Sav-Rx with any questions about these programs.

Mandatory Generic Program

The Sav-Rx Mandatory Generic Program is designed to help decrease prescription drug costs for both you and the Fund. The substitution applies to generic medications that are rated as equivalent to the brand name by the U.S. Food and Drug Administration. Under this program, you are encouraged to use a generic drug substitute whenever it is available. If you or your physician requests a brand name drug instead of its generic equivalent, the brand name drug will not be covered.

There are some limited situations when the brand name medication is medically necessary. In these situations, an override may be available so you will only be responsible for the applicable brand name co-payment. You must submit to Sav-Rx a letter of medical necessity from the prescribing physician indicating a medical reason for which the brand name product is required. Sav-Rx can contact your physician to start this process. Please contact Sav-Rx at (800) 228-3108 with your physician's name and contact information, as well as the brand name drug that is requested.

Therapeutic Interchange Program

This 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 Sav-Rx. Please take this information to your physician to see if a lower cost medication will work for you.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS

You cannot use either the Retail Card or the Mail-Order Program for:

1. Any products or drugs which can be obtained without a doctor's written prescription, even though such drugs or medications are prescribed by a

doctor;

2. Experimental or investigative drugs or medications, or drugs not approved by the Federal Drug Administration for the condition being treated;

3. Drugs prescribed or used for cosmetic purposes;

4. Lifestyle drugs; or

5. Drugs or medications that are excluded from coverage under any provision or rule of the Plan, including but not limited to items listed in the "Exclusions and Limitations" section.

DENTAL BENEFIT

The Plan provides you and each of your eligible dependents up to $1,500 per calendar year in dental benefits. This calendar year maximum does not apply to children under age 19.

The Plan also provides orthodontia benefits for eligible children up to $1,500 per lifetime.

The Plan pays 70% of your covered charges (50% for orthodontia) after a $50 deductible per person per year. The deductible does not apply to covered preventive services or orthodontia benefits. Benefits will not be paid in excess of the $1,500 annual maximum or $1,500 lifetime orthodontia maximum.

VOLUNTARY DENTAL PPO NETWORK

To find a network dentist, contact DNoA:

866-522-6758
www.dnoa.com

You and your dependents can save money by using a network dentist. The Fund contracts with Dental Networks of America (DNoA) to provide a network of dentists. These network dentists have agreed to charge discounted rates. In addition, network dentists will not bill you for amounts in excess of their discounted fees. Network dentists will also submit claims for your care for you – you don't need to submit a claim form.

You don't need a referral to see a network dentist. You also don't need to use a network dentist to get benefits from the Fund. You can use any dentist you'd like. You can use a network dentist for some care, and a non-network dentist for other care.

COVERED DENTAL SERVICES

Preventive Services

The deductible does not apply to these preventive services.

The Plan pays 70% of the reasonable and customary charges for the following preventive care. No deductible applies.

1. Oral examinations, limited to two per calendar year.
2. Cleaning of teeth (prophylaxis), limited to two per calendar year.
3. Fluoride treatment for children under age 16, limited to two per calendar year.
4. X-rays as follows:
   a. Bitewing x-rays, limited to two films per calendar year.
   b. Full-mouth series or panorex, limited to one set every three calendar years.
   c. Extraoral x-rays, limited to two films per calendar year.
   d. Individual periapical or occlusal x-rays.

5. Space maintainers for children under age 16. The Plan's allowance includes all adjustments within six months of installation.

6. Bacteriologic cultures.

7. Biopsies.

Basic Services

After you satisfy your deductible, the Plan pays 70% of the reasonable and customary charges for the following basic restorative care.

1. Diagnostic casts, limited to one 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 documented by report.

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, limited to repairs or adjustments performed more than 12 months after the initial placement.

18. Relining of dentures, 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.

Major Services

After you satisfy your deductible, the Plan pays 70% of the reasonable and customary charges for the following major restorative care. The reasonable and customary allowance include 12 months of follow-up care.

1. Gold inlays and onlays, but only when the tooth cannot be restored by an amalgam filling, limited to one every five calendar years.

2. Porcelain filings.

3. Crowns, provided the tooth cannot be restored with fillings, and 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. No additional allowance will be made if the dentist also charges for over-dentures or customized dentures.

8. Partial dentures. No additional allowance will be made for precision or semi-precision attachments.

9. Fixed bridges.

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

11. Treatment of periodontal disease.

Orthodontia Services

The Plan pays 50% of the reasonable and customary charges for orthodontic care for dependent children. The lifetime maximum is $1,500 per child.

Covered services include orthodontic treatment, and cephalometric x-rays, which are limited to one every two calendar years.

ALTERNATE PROCEDURES

If alternate services can be used to treat a dental or orthodontic condition, covered dental expenses or covered orthodontia expenses will be limited to the reasonable and customary (R&C) charge for that service which is most commonly used nationwide in the treatment of that condition and which is recognized by the dental profession to be appropriate in accordance with the accepted nationwide standards of dental practice. In cases where you and/or your dentist choose a more expensive level of care, any charges in excess of the R&C level as determined by this provision will not be considered covered dental or orthodontia expenses.

TEMPORARY SERVICES AND SUPPLIES

Temporary services are considered an integral part of the final services rather than a separate service, and are therefore not eligible for benefits.

WHAT'S NOT COVERED

No Dental Benefits will be paid for:

1. Procedures that are not listed as covered services, or which are not necessary.
2. Sealants.
3. Crowns for teeth that are restorable by other means, or for the purpose of periodontal splinting.
4. Procedures related to the change of vertical dimension, change of occlusion, bite registration, or bite analysis.
5. Replacement of bridges, partials, dentures, orthodontic appliances, inlays or crowns within five years of the date the prior prosthetic was placed, unless the replacement is made necessary by:
   a. The extraction of functioning natural teeth; or
   b. Accidental bodily injury. Chewing injuries are not considered accidental bodily injuries.
6. Implants.
7. Replacement of lost or stolen appliances.
8. Precision or semi-precision attachments.
9. Denture duplication.
10. Procedures that are cosmetic in nature.
11. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a

dentist.

12. Any service, supply or expense listed as not covered in the "Exclusions and Limitations" section starting on page 45.

INCURRAL DATES

Dental Benefits are payable only for expenses incurred while covered. 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.

6. No benefits are payable for work incurred after coverage 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 coverage terminated.

VISION BENEFIT

PAYMENT OF BENEFITS

Under the Vision Benefit, each eligible person (employee or dependent) can receive up to $200 per calendar year toward the cost of eye examinations, frames and lenses. No deductible applies, and the Plan pays covered vision expenses at 100% until the $200 maximum is reached. This calendar year maximum does not apply to children under age 19.

You must use a licensed ophthalmologist, optometrist or optician in order to receive Vision Benefits.

WHAT'S COVERED

This benefit covers eye examinations, lenses and frames, or contact lenses.

WHAT'S NOT COVERED

Benefits are not payable for:

1. Orthoptic or visual training.
2. Medical or surgical treatment, or refractive surgical/laser procedures.
3. Sunglasses, plain or prescription.

FAMILY SUPPLEMENTAL BENEFIT

The Family Supplement Benefit amount is $3,250.

A Family Supplemental Benefit is available for you and your covered dependents. This benefit helps pay for healthcare expenses that are limited or not covered by the Plan.

The maximum per-family benefit is currently $3,250 each calendar year. The Plan pays 100% of these expenses and no deductible applies.

HOW THE FAMILY SUPPLEMENTAL BENEFIT WORKS

If you pay out-of-pocket for certain health care expenses for you or your dependents, you can file a claim for reimbursement from the Plan. The Plan will pay 100% of your cost for certain health care expenses, up to the maximum benefit per family each calendar year.

For example, suppose you incur $300 in covered vision care expenses in one calendar year. The Plan pays up to $200 under the Vision Care Benefit. You can file a claim under the Family Supplemental Benefit for the remaining $100 in benefits. The Plan will reimburse you for the full $100 as long as you have met the calendar year maximum benefit.

Contact the Fund Office with questions about what expenses are eligible for reimbursement, or for help filing a claim.

Vision Example

Set of glasses	$619
$200 vision benefit	-200
Remaining balance	**$419**

$419 claim submitted to the Family Supplement Benefit for reimbursement

Dental Example

Total dental charges	$2,500
Less Plan's share (Max)	1,500
Less deductible	50
Less member share (30%)	642
Remaining balance	**$308**

$308 claim submitted to the Family Supplement Benefit for reimbursement

The above examples assume that the submitted charges are covered under the Family Supplement Benefit, and that the member has not submitted any other claims during the year.

WHAT'S COVERED

To be covered under this program, expenses must be:

- Incurred while you are covered under the Plan,
- Incurred for you or one of your eligible dependents, and
- For medically necessary services and supplies not payable by the regular

benefit plan.

In general, covered supplemental expenses are healthcare expenses recognized by the Internal Revenue Service (IRS) as legitimate federal income tax deductions. (However, if an expense is reimbursed out of your Family Supplemental Benefit, you cannot deduct that expense on your individual tax return.)

The following expenses are examples of the types of services and supplies eligible for reimbursement under the Family Supplemental Benefit:

Examples of Covered Services

- acupuncture
- organ transplants treatment
- Braille books and magazines
- orthopedic shoes
- car controls for the handicapped
- oxygen
- prescription drug copays
- duplicate prosthetic devices
- school physicals
- artificial limbs
- orthodontic care in excess of the maximum benefit
- guide dogs
- special schools for the handicapped
- hearing aids and exams
- telephone for the deaf
- hearing treatment
- vision expenses such as orthoptics
- injections
- wheelchairs
- Lasik and RK surgery
- learning disability specialty school tuition

WHAT'S NOT COVERED

You cannot use your Supplemental Benefit for charges not listed in the "What's Covered" section above. Examples of non-covered expenses include:

Effective for charges incurred on and after November 1, 2014, non-PPO ambulatory surgical centers will not be reimbursable expenses.

- dancing/swimming lessons
- health club memberships
- expenses used to satisfy this Plan's medical or dental deductibles
- meals and lodging when away from home for medical treatment not received at a medical facility
- expenses applied to the out-of-pocket limit
- nursing services for a healthy baby
- expenses you deduct on your individual tax return
- schools for problem children
- group medical insurance premiums
- trips or vacations taken for a non-medical reason (even if on a doctor's advice)
- funeral expenses

The above list is just a sampling of items that are not covered under the Family Supplemental Benefit. Contact the Fund Office if you are not sure is an expense is covered.

HOW TO FILE A CLAIM FOR SUPPLEMENTAL BENEFITS

In order to be reimbursed for a covered supplemental expense, you must submit the following to the Fund Office:

a. A completed Family Supplemental Benefit claim form;

b. An itemized receipt showing payment;

c. A copy of the Explanation of Benefits denying payment or showing non-covered charges; and

d. For prescription drugs, a print-out from the pharmacy for each family member.

A claim for supplemental benefits must be submitted during either the year in which the claim was incurred, or the year in which the explanation of benefits is dated, whichever is later.

Reimbursement checks will be made payable to you, and will be sent every six months in accordance with the following schedule:

You must submit your claim by:	**For payment in:**
June 30	August
December 31	February

EXCLUSIONS AND LIMITATIONS

No payment will be made under this Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the following:

1. Services or supplies that are **not medically necessary.**

2. Any service or supply which is not rendered for the treatment or correction of, or is not in connection with, a **specific sickness, illness or accidental bodily injury** unless it is specifically stated as covered under this Plan.

3. Charges incurred by a person **who is not covered by the Plan**, including charges incurred before the person becomes covered under the Plan, or that are incurred after the person's coverage terminates.

4. Treatments, care, services or supplies which are **not recommended, ordered or approved by the attending doctor**.

5. **Custodial care**.

6. Physical, speech or other therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a **reasonable chance of improvement**.

7. Injuries, sicknesses or diseases sustained while working and that are covered by any **workers' compensation,** employer liability law, occupational diseases law or any similar law.

8. **Physical examinations** for employment, school, marriage or other reason that are not necessary for treatment of a sickness, except as specifically provided under the Wellness Benefits.

9. **Flu shots** and other inoculations and treatments to prevent the contraction of disease. This exclusion does not apply to immunizations during a child's first year of life which are payable under the Wellness Benefits.

10. **Travel** or ambulance **transportation** except in an emergency.

11. Effective for charges incurred on and after November 1, 2014, **non-PPO ambulatory surgical centers**.

12. **Over-the-counter drugs** and medicines, including nutritional supplements, food supplements, vitamins or any other items of a like nature which can be obtained without a doctor's prescription, or any other drugs or medicines not legally dispensed by a registered pharmacist according to the written prescription of a doctor. Exception: This exclusion does not apply to certain non-prescription diabetic supplies.

13. **Birth control** medications unless they are prescribed by a doctor **for**

therapeutic treatment of a specific sickness, or for contraceptive devices or any other method of contraception other than surgical sterilization procedures such as vasectomies and tubal ligations for employees and their spouses only.

14. **Rental or purchase** of any covered durable medical equipment or other equipment that is not used solely for therapeutic treatment of a single individual's injury or sickness.

15. **Any of the following items** or 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, communication devices, breast pumps or health club memberships.

16. Treatment for **substance abuse** in a facility that does not meet the Plan's definition of a covered facility.

17. The following **hospice** services:

    a. Services or supplies not provided as "core services" by the hospice providing the hospice care.

    b. Bereavement counseling after the patient's death.

    c. Administrative services; child care and/or housekeeping services; or transportation (except in emergency situations).

    d. Services or supplies that are rendered, provided or supplied by family members.

18. Expenses related to an overweight condition or condition of **obesity**, except as specifically stated as covered in the Covered Medical Expense section beginning on page 28. The Plan will not cover post-surgical removal of skin **following** successful weight loss.

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

20. **Eye refractions, eyeglasses, contact lenses** (except the first pair of contact lenses or eyeglasses required following cataract surgery), including any charges made for the fitting of any of these appliances, except as stated under the Vision Benefit, or when provided as a result of a non-occupational bodily injury to a physical organ and provided within 12 months of the date of the accident.

21. **Dental surgery, dental x-rays, dental treatment,** or any other care and treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, or for dental prosthetic appliances or the fitting of any of these appliances, except as stated under the Dental Benefit, or in No. 23 under "Covered Medical Expenses."

22. Plastic or **cosmetic surgery**, except for:

    a. Cosmetic surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident;

    b. The correction of congenital defects;

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

    d. Breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

23. **Reversal** of, or attempts to reverse, a previous elective sterilization.

24. Treatment or consultations with a **marriage counselor, naprapath or naturopath**.

25. **Chelation therapy**, except when medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning.

26. **Sex transformations**.

27. **Penile implants**.

28. **Acupuncture** or accupressure.

29. **Smoking cessation** products or programs.

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

31. Any treatment, care, services, supplies, procedures or facilities that are **experimental or investigative**.

32. **Personal items**.

33. Services or supplies received from a provider that does not meet this **Plan's definition** of a covered provider, meaning those providers specifically stated as covered and defined by the Plan.

34. Care or treatment rendered to you or a dependent which is provided by a person who is a **relative** in any way to you or to the dependent receiving the care or who ordinarily lives in your home or in the home of the dependent receiving the care.

35. **Special education**, except when involving outpatient psychiatric treatment, or charges by a primarily educational or training institution.

36. Services or supplies furnished, paid for or otherwise provided due to past or present service of any person in the **armed forces** of a government; or any **military service-connected** injury or sickness.

37. Treatment of conditions or injuries incurred as a result of **war**, international armed conflict, insurrection, riot, or atomic explosion or other release of nuclear energy (except when being used for medical therapy).

38. Services provided by a **government hospital** where governmental coverage is primary.

39. Treatment provided **outside the United States and Canada**, unless:

    a. the person is outside the United States and Canada due to a vacation, or the normal occupation of either the person or a dependent; and

    b. the absence is for a period of less than 120 days.

40. 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). However, no benefits will be paid for such charges if the self-inflicted injury, suicide or suicide attempt was the result of the illegal use of drugs, whether or not the person has a medical (physical or mental health) condition.

41. Charges which would not have been made **if this Plan did not exist**.

42. Charges for **preparing medical reports**, bills or claim forms, or for mailing, photocopying, shipping or handling expenses.

43. Charges for **broken or missed appointments**, or telephone calls.

44. Any care or treatment of a person once the person has already received Plan benefits totaling the **maximum benefit** or limit for that type of care and treatment.

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

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

47. Charges for **surrogacy or surrogate fees**. This exclusion applies to, but is not limited to, charges in connection with:

a. The medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan; or

b. 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.

GENERAL PROVISIONS AND INFORMATION

DEFINITIONS

Ambulatory Surgical Center

A free-standing facility which is wholly owned and operated by a hospital on the same basis as the outpatient department of its main facility or a legally constituted institution which meets all of the following requirements:

1. It is established, equipped and operated primarily for the purpose of performing surgical procedures.

2. It operates under the supervision of one or more physicians as defined by the Plan.

3. It is equipped with at least two operating rooms, at least one post-anesthesia recovery room, and has the ability to perform diagnostic x-ray and laboratory procedures as required in conjunction with the surgery to be performed.

4. It continually provides nursing services by registered nurses for patient care in the operating rooms and the post-anesthesia recovery room(s).

5. It is licensed by the appropriate state agency and recognized by the local medical society.

Claims Administrator

The person or company retained by the Fund to administer the claim payment responsibility of the Plan.

Cosmetic Treatment or Surgery

Treatment or surgery to improve or preserve physical appearance.

Dentist

A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered, and who acts within the scope of his or her license.

Dependent

A dependent is:

1. The spouse of an eligible employee (from whom you are not divorced or legally separated);

Proper legal documentation of a child's status must be furnished to the Fund Office before the child will be considered a covered dependent.

2. A child of an eligible employee who has not reached his 26th birthday.

   The term "child" includes all of the following:

   a. Your natural child;

   b. Your legally adopted child or a child placed in your home for adoption;

   c. Your stepchild, meaning a natural child of your spouse or a child who is legally adopted by her; and

   d. A child for whom you are the legal guardian, provided the child lives with you in a normal parent-child relationship and does not provide more than 50% of his own support for the calendar year. Proper legal documentation of such a child's status must be furnished to the Fund Office before the child will be considered a covered dependent.

3. A child who is age 26 or older and who is permanently and totally disabled because of mental retardation, mental incapacity or physical disability as certified by a doctor. The child must have become disabled before becoming age 26; must remain disabled and be incapable of self-sustaining employment and be dependent upon you for the major portion of his financial support and maintenance, and specifically not provide more than 50% of his own support during any calendar year. The disability must be supported by a Social Security Disability award. Within 31 days after the child's 26th birthday, you must furnish, at your own expense, initial proof of the child's disability, including the Social Security Disability award, and that he became disabled before he became age 26. Subsequent proof of the child's continued disability may be required by the Trustees, but not more often than once a year. If the Trustees request proof of the child's disability in the future, you must furnish the proof or the child's coverage will terminate.

4. Any child of an eligible employee determined by the Trustees to be an "alternate recipient" under the terms of a Qualified Medical Child Support Order who lives in the custody of either you or his other parent, for whom you or the other parent, combined, pay more than 50% of the child's support for the calendar year, and who does not provide more than 50% of his own support for the calendar year.

   The Trustees, in consultation with the Fund Attorney, have adopted procedures for determining whether a particular court order qualifies as a QMCSO. If you would like a copy of the Plan's QMCSO procedures, please call or write the Fund Office. If you are a responsible party in a court action involving a child, you should request a copy of the Plan's procedures BEFORE the final order is entered.

Durable Medical Equipment

Equipment that: 1) can withstand repeated use; 2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and 3) is not disposable or non-durable.

Emergency

A medical condition in which: 1) the onset of symptoms are sudden, unexpected and acute; and 2) in the opinion of the attending physician, the symptoms present a potential hazard to the patient's life which requires immediate medical care.

Emergency Treatment Center

A freestanding facility, by whatever name called, which is engaged primarily in providing minor emergency and episodic medical care to its patients. A physician, an R.N. and a registered x-ray technician must be in attendance at all times that the center is open. The center's facilities must include x-ray and laboratory equipment and a life support system.

Experimental or Investigative

The use of any treatment, procedure, facility, equipment, drug, device or supply not yet generally recognized as accepted medical practice, including the use of any of such items requiring federal or other governmental agency approval for which such approval had not been granted at the time such service or supply was rendered or provided.

Home Health Agency

A public agency or private organization, or a subdivision of such agency or organization, which meets all of the following criteria: 1) it is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients; 2) it has established policies for 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 registered professional nurse; 4) it maintains clerical records of all patients; 5) it is licensed according to the applicable laws of the state in which it is located or provides services; and 6) it is eligible to participate under Medicare.

Hospice Agency

A public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization: must be eligible to participate in Medicare; must have an interdisciplinary group of personnel that includes the services of at least one doctor and one R.N.; must maintain clerical records on all patients; must meet the standards of the National Hospice Organization; and must provide, either directly or under other arrangement, the core services listed as covered hospice expenses on page 31.

Hospital

An institution which is engaged primarily in providing medical care and treatment to sick and injured individuals on an inpatient basis at the patient's expense and which fully meets every one of the requirements set forth below:

1. It is a hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH); or

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

3. It is an institution which fully meets all of the following tests:

    a. In return for payment from its patients, it provides on inpatient basis, 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 graduate nurses,

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

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

Infertility

The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy, as certified by a physician.

Injury

Bodily injury caused solely by an accident which results directly and independently of all other causes in a loss covered by the Plan.

Intensive Care Unit

An accommodation or part of a hospital, other than a postoperative recovery room, which, in addition to providing room and board: 1) is established by the hospital for a formal intensive care program; 2) is exclusively reserved for critically ill patients requiring constant audiovisual observation prescribed by a physician and performed by a physician or by a specially trained registered nurse; and 3) provides all necessary life-saving equipment, drugs and supplies in the immediate vicinity on a stand-by basis.

Medically Necessary

Only those services, treatments or supplies provided by a hospital, a physician, or other qualified provider of medical services and supplies, that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's injury or sickness. To be considered medically necessary, the service, treatment or supply:

1. Must be consistent with the symptoms or diagnosis and treatment of the eligible individual's condition, sickness, injury, disease, or ailment;

2. Must be appropriate according to standards of good medical practice;

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

4. Must be the most appropriate which can safely be provided to the eligible individual.

Mental or Nervous Disorder

A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Orthodontia; Orthodontic Treatment

The corrective movement of teeth through bone by means of an active appliance to correct a malocclusion (failure of the biting surfaces of the teeth to meet properly).

Physician; Doctor

A legally qualified physician or surgeon, provided the physician or the surgeon is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a dentist (as defined on page 50), a Doctor of Optometry (O.D.), (for covered vision expenses only), or a Doctor of Chiropractic Medicine (D.C.). Benefits for expenses incurred for treatment furnished by any such individual shall be payable only within the provisions and limitations of the Plan and only if the individual is licensed to practice medicine or surgery and/or is acting within the scope of his license at the time and place the services are performed.

Under no circumstances are social workers, marriage counselors, acupuncturists, naprapaths, or naturopaths included in the definition of physician.

Reasonable and Customary (R&C)

A charge is reasonable and customary if it does not exceed the amount normally charged by providers in a given area. The Claims Administrator will decide the factors needed to determine R&C charges.

Skilled Nursing Facility

A nursing facility, by whatever name called, which meets all of the following criteria: 1) it is an institution, or a distinct part of an institution, which has in effect a transfer agreement with one or more hospitals; 2) it is primarily engaged in providing inpatient skilled nursing care and related services for individuals who require medical or nursing care; and is not an institution which is primarily for the care and treatment of mental diseases or substance abuse; 3) it is duly licensed by the appropriate governmental authorities; 4) it has one or more physicians and one or more registered professional nurses responsible for the care of inpatients; and it requires that every patient must be under the supervision of a physician; 5) it maintains clinical records on all patients; 6) it provides 24-hour-a-day nursing services; 7) it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; 8) it has in effect a utilization review plan; and 9) it is eligible to participate under Medicare.

Substance Abuse

Alcoholism, alcohol abuse, drug addiction, drug abuse, or any other type of addiction to, abuse of, or dependency on any type of drug or chemical (excluding nicotine).

Temporomandibular Joint (TMJ) Dysfunction or Syndrome

TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching in and about the TMJ, limitation of the joint, clicking sounds during chewing, ringing, roaring or hissing in one or both ears, and/or hearing impairment.

Total Disability

For an employee, total disability means being prevented by accidental injury or disease from engaging in your regular job and doing no other work for pay or profit. For a dependent, total disability means being prevented by accidental injury or disease from engaging in substantially all the normal activities of a person of like age and sex in good health.

Treatment Facility for Substance Abuse

A rehabilitation facility for the treatment of persons suffering from alcoholism and/or drug abuse or drug addiction. To be considered an approved treatment facility for the purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or meet certain requirements specified by the Trustees.

Trust Fund; Fund

All cash and other property held by the Trustees of the Cement Masons' Local No. 502 Welfare Fund under the terms of the Trust Agreement.

CLAIM PROCEDURES

When used in the following explanation, the term "Fund Office" means the office or organization designated by the Trustees for handling claims.

When you file a claim, be sure to follow the proper claim filing procedures.

Claim Processing Time Limits

The amount of time the Fund Office an take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A disability claim is a claim for Weekly Disability Benefits.
- A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested.

If all information is provided to the Fund Office, your claim be processed as soon as possible. However, the processing time needed will not exceed the time frame allowed by law, which are as follows:

- For disability claims, within 45 days.
- For all other claims, within 30 days.

You may have an authorized representative (including a health care provider) act on your behalf, although the Trustees will verify that the person has been so authorized.

When Additional Information Is Needed - If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. If the request goes to your medical provider, you will receive a copy of the request. The request for additional information will be sent within the normal time limits shown above.

It is your responsibility to see that the missing information is provided to the Fund Office. The normal processing period will be extended by the time it takes you to provide the information, and the limit will begin once the Fund Office has received a response to its request. If you do not provide the missing information within 45 days, the Fund Office will make a decision on your claim without it, and your claim could be denied as a result.

If and when all necessary information has been received, approval or denial of a claim will usually be made within the following time periods:

- For disability claims, within 30 days.
- For all other claims, within 15 days.

Plan Extension - The time periods above may be extended if the Fund Office determines that an extension is necessary due to matters beyond the control of the Plan (but not including situations where it needs to request additional information

from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- For disability claims, 30 days. A second 30-day extension may be needed in special circumstances beyond the Plan's control.
- For all other claims, 15 days.

Claim Denials

If all or part of your claim is denied after the Fund Office has received a completed claim form and all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. The notification will state:

1. The specific reason for the determination with reference to the specific Plan provisions on which the determination is based.

2. A description of any additional material or information necessary for the claimant to perfect the claim, and the reason such information is necessary.

3. A description of the review procedures and the applicable time limits for following the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA.

4. The specific internal rule, guideline, protocol or similar criterion the administrator relied on to make the decision, if applicable.

5. If the decision was based on medical necessity or if treatment was deemed experimental, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Claim Appeal Procedure

If you want the Trustees to review your claim after a denial of benefits, write a letter to the Board of Trustees requesting a claim review. Attach any additional information that you think will help a favorable decision to be made on your claim. Submit your request for review within 180 days after the date the denial was mailed to you:

Board of Trustees
Cement Masons' Local No. 502 Welfare Fund
739 South 25th Avenue
Bellwood, Illinois 60104-1995

You can authorize someone else to file your request for review and other-wise act for you. You and/or your representative can review materials in the Fund's files that are related to your claim. You and/or your representative can submit written issues and comments to support your request for review. You and/or your

representative may also make a written request for a personal appearance before the Trustees. If a hearing is granted, your and/or your representative's appearance will be at your own expense.

Permission for you to utilize a representative does not provide the representative (particularly a health care provider) with an independent right to payment of benefits in the representative's name, to file or proceed with a review of a claim for benefits in the representative's name or to obtain any rights as a "participant" or "beneficiary" under the Plan. Any appeal can only be brought in the name of yourself or your dependent who are the only entities permitted to be a "participant" or "beneficiary" under this Plan.

Full and Fair Review - The Trustees will conduct a full and fair review of all the material submitted with your claim, the action taken by the Fund Office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will:

1. Be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, not the subordinate of such party.

2. Not afford deference to the initial adverse benefit determination.

3. Take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

You have the right, upon request and free of charge, to have copies of all documents, records and other information relevant to your claim for benefits.

With respect to a review of any determination based on a medical judgment, the Board of Trustees must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such health care provider must be "independent," which means the medical professional consulted must be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.

Notification Following Review - A review and determination of claims will be made no later than the date of the Trustees' meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a determination may be made by no later than the date of the second meeting.

If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Trustees. Before the start of the extension, you will be notified in writing of the extension, including a description of the special circumstances and the date as of which the determination will be made.

After a decision has been made, you will be informed in writing of the Trustees'

decision, normally within five calendar days of the review. When you receive the decision on your appeal, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; a statement of the claimant's right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights. However, you must exhaust the claim appeal procedures before going to court.

COORDINATION OF BENEFITS (C.O.B.)

Benefits are coordinated when both you and your spouse (and/or your children) are covered by this Plan as well as by one or more other group health plans. Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

- The C.O.B. provision applies only to other group plans, Medicare, HMOs and other prepayment, group practice and individual practice plans, medical benefits coverage provided through automobile insurance (both no-fault and traditional "fault" policies), and group indemnity benefits in excess of $100 per day. It doesn't apply to Medicaid or individual medical policies (other than automobile insurance). Also, C.O.B. applies only to health care benefits (medical, dental/orthodontia, vision). It doesn't apply to Death, Dismemberment or Weekly Disability Benefits.

- Benefits are paid under C.O.B. for "allowable expenses," which are expenses that are eligible to be considered for reimbursement.

- You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled from the other sources, even if you have not.

- When anyone in your family who is covered under another group health plan has a claim, be sure that claims are filed with all plans and that all required information about other coverage is provided on all forms.

  If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate 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.

Determination of Benefits

If you have a claim that is covered by two or more plans, one plan (the "primary" plan) pays its benefits first regardless of any other plans. The other plans ("secondary" plans), adjust their benefits so that the total benefits available to you are not greater than the allowable expenses.

A plan without a C.O.B. provision is always considered the primary plan.

If all plans have a C.O.B. provision, benefits are determined as follows:

1. The plan that covers the person (for whom the claim is filed) as an employee is primary over a plan that covers him other than as an employee.

2. If a person (for whom the claim is filed) is covered under a plan as an employee and is also covered under a plan as a laid-off or retired employee, the plan covering the person as an employee is primary. This rule applies in the same way to a dependent of a person who is covered under a plan as an employee and also under a plan as a laid-off or retired employee.

3. This Plan will pay secondary under these coordination of benefits rules when a person has COBRA under this Plan and, at the same time, coverage as an active employee or dependent of an active employee under another plan.

Determination of Benefits for Children

1. When both parents have health care coverage for their children, the primary plan is the plan of the parent whose birthday is earlier in the year (called the "birthday rule") if:

   a. The parents are married; or

   b. The parents are not separated (whether or not they ever have been married to each other); or

   c. A court decree awards joint custody without specifying that one party has the responsibility to provide health coverage.

   d. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

This Plan will not at any time coordinate benefits under a gender-based rule.

2. If parents are legally separated or divorced, whether or not they were ever married, their plans pay their children's health care expenses as follows:

   a. If a court has ordered one of the parents to provide health care coverage for a child, that parent's plan is primary on the child's claims.

   b. If there is no court order, the plans pay in the following order: first

the plan of the parent who has custody of the child; then, if the parent with custody has remarried, the plan of the stepparent; then the plan of the parent without custody.

3. 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 rule in No. 4 below applies.

4. If the rules stated above don't clearly show which plan pays primary, the plan that has covered the person for whom the claim is filed for the longest period of time will pay primary.

If a Husband and Wife Are Covered Under this Plan as Employees

Any claim for expenses incurred by either spouse shall first be paid as the claim of an employee and then coordinated as the claim of a dependent of the other spouse; and

Any claim for expenses incurred by a dependent child of such employees shall first be paid as the claim of the dependent of one of the parents and then coordinated as a claim of the other parent's dependent.

C.O.B. With Medicare (Active Employees and Their Dependents)

1. If you are an active employee age 65 or older and continue to work for an employer with 20 or more total employees, this Plan will pay primary benefits for you unless you choose Medicare as your only health care coverage. If your spouse is age 65 or older while you are still working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays. If she has her own plan, her plan will be primary, this Plan will be secondary, and Medicare will pay last. She can also choose Medicare as her only health care coverage instead of having coverage under this Plan or her own plan.

2. If you are an active employee age 65 or over and continue to work for a contributing employer who employs less than 20 total employees, this Plan will usually pay benefits for you and your spouse after Medicare pays its benefits unless this Plan is legally required to pay first.

3. If you or any of your dependents are eligible for Medicare for reasons other than being 65 or older, Medicare will usually pay primary benefits except under the following circumstances:

   - If a person is totally disabled and eligible for Medicare under the Medicare disability rules, this Plan will pay its normal benefits for that person before Medicare pays benefits unless the Plan is legally permitted to pay after Medicare.

   - If a person is an End Stage Renal Disease beneficiary under Medicare, for a period of up to 30 months this Plan will pay its normal benefits for

that person before Medicare pays benefits unless the Plan is legally permitted to pay after Medicare.

Enrollment in Medicare - Any person who is eligible to participate in Medicare is responsible for enrolling in Medicare Part A and Part B when eligible to do so. If a person is eligible to participate in Medicare, this Plan will pay benefits, including C.O.B. calculations, as if he is enrolled in both Part A and Part B of Medicare, even if he is not actually enrolled in both Parts. This means that this Plan will only pay benefits equal to the benefits it would have paid if the person were enrolled in both Parts. If a person is not enrolled, he will have to pay the amount normally paid by Medicare out of his own pocket.

At present there is no charge for Part A, which provides benefits for hospital and certain other expenses. Part B covers such items as doctors' services. The government makes a monthly charge for Part B. If you or a dependent want information about Medicare enrollment or benefits, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

SUBROGATION

If a participant or a dependent accepts benefits from the Fund, the participant or dependent is deemed to have accepted the Fund's subrogation rules.

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or his dependents for illness or injury to the participant or dependents and the participant or dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance cover-age, or any other first-party contract or claim, the Trustees of the Funds and the Fund shall be subrogated to all of the participant's or dependents' right of recovery against such person, corporation, insurance, carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim and shall have a right of reimbursement from the participant or dependent to the full extent of payments made by the Fund and for the cost of collection of these amounts, including attorney's fees. The full amount of benefits paid shall include any Preferred Provider Organization Charge or other payment to a medical discount provider paid with respect to the involved benefits which shall be considered part of the amount of benefits paid. The Trustees and the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph and this equitable lien by agreement shall be enforceable as part of an action to enforce plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the participant or dependents, as opposed to the general assets of the participant or dependents, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the participant or dependents. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the participant or dependents be "made-whole" or that the entire debt be paid to the participant or dependents prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred by the participant or dependents in recovering

the amounts or by any state law doctrine, such as the "common fund" doctrine, which would purport to impose such a reduction.

The participant or his or her dependents or the participant acting on behalf of a minor dependent shall execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The participant or dependents shall do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joinder of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the participant or dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund shall, if in the Fund's best interest and at the Trustees' sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the participant or dependents or paid on their behalf, together with the costs of collection, including attorney's fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by an uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery shall take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund's attorney's fees, shall be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the participant or dependents, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be distributed to the Fund. The remainder or balance of any recovery shall then be paid to the participant or dependents and their attorneys if applicable.

In the event of any failure or refusal by the participant or dependents to execute any document requested by the Trustees or the Fund or to take other action requested by the Trustees or the Fund to protect the interests of the Trustees or the Fund, the Trustees may withhold payment of benefits from the Fund or deduct the amount of any payments from amounts otherwise payable by the Fund for future claims of the participants or dependents. After making claim for benefits from the Fund, the participant or dependents shall take no action which might or could prejudice the rights of the Trustees or the Fund.

In the event the participant or dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim the Fund will request repayment of the amount of its equitable lien for the full amount of benefits paid by the Fund. If the participant and/or dependents

refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from participant and/or dependents by instituting legal action against the participant and/or dependents and/or by deducing such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The participant or dependents shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Trustees shall pay no legal costs or fees from the Fund without receiving a recovery and then only, in their sole discretion, within the terms of this provision. In the event that an attorney is hired by or on behalf of the participant or his dependents and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire such attorney. If the attorney representing the eligible individual nevertheless wishes to proceed, and creates a common fund from which the Trustees can recover pursuant to their equitable lien by agreement for subrogation and reimbursement, the Trustees, on behalf of the Fund, may agree to pay up to 10% of its recovery to include the attorney's legal fees. This 10% shall also include any prorated portion of the cost of recovery. If the attorney agrees to proceed, he will be considered to have waived the common fund doctrine.

These provisions shall apply to any case in which the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of this provision, and any subrogation and reimbursement claim or lien presented by the Fund or Trustees, where the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of these provisions, shall be construed to involve an equitable lien by agreement under these provisions.

(If you want more information about Subrogation, contact the Fund Office.)

TRUSTEE INTERPRETATION, AUTHORITY AND RIGHT

The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. All decisions of the Trustees, including those regarding claims for benefits, are subject to and require the use of Trustee discretion. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase,

decrease or eliminate benefits. However, no amendment may be adopted which alters the basic principles of the Trust Agreement founding the Fund, is in conflict with collective bargaining agreement provisions applicable to contributions to the Fund, is contrary to laws governing multi-employer ERISA trust funds, or is contrary to agreements entered by the Trustees. In addition, and as more fully explained in the "Plan Discontinuation or Termination" section, the Trustees or, the Union and Employer Association by a written agreement, may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

PLAN DISCONTINUATION OR TERMINATION

The Plan of Benefits and the Trust Agreement under which the Plan was founded may be terminated under certain conditions: if there is no longer a collective bargaining agreement or participation agreement requiring contributions to the Fund; or, if it is determined that the Fund is inadequate to carry out the purposes for which the Fund founded. The Plan may be terminated at any time by a vote of the Trustees, if the action is taken in conformity with applicable law. In such a case, benefits for covered expenses incurred before the termination date will be paid on behalf of covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets; and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

ADDITIONAL PROVISIONS

Overpayments; Duty of Cooperation

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Plan has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Plan, at its option, may require immediate repayment in full, set off the overpayment from current and future benefit payments, or institute legal action to collect the overpayment.

You and your covered dependents must provide the Plan with any information the Plan deems necessary to determine eligibility, process claims or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred and other damages related to that over-payment.

A claim for benefits will be rejected and the Plan will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Plan may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

Circumstances Which May Result in Claim Denials or Loss of Benefits

The Trustees or their representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

1. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

2. The claim wasn't filed within the Plan time limits.

3. The expenses that were denied are not covered under the Plan or were not actually incurred.

4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.

5. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a deductible or co-payment.

6. Another party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expenses and you or your dependent did not comply with the rules governing subrogation; or another plan was primarily responsible for paying benefits for the expenses.

7. The Trustees amended the Plan eligibility rules or decreased Plan benefits.

8. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf.

9. The Plan of Benefits was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Office.

Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death and to examine any and all hospital or medical records relating to a claim.

Payment of Benefits

Health care benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits stated on the Schedule of Benefits according to the following provisions:

1. Blue Cross Blue Shield of Illinois (BCBS-IL) PPO providers and out-of-network hospitals should send their bills directly to BCBS-IL (the address is on your BCBS-IL I.D. card). The Plan's share of the expenses will be paid directly to the PPO provider or to the out-of-network hospital. The BCBS-IL PPO provider or the out-of-network hospital will bill you for your share of the expenses, which you must pay directly to the provider. (If an out-of-network hospital requires payment from you, see No. 2 below for how benefits are paid.)

2. Out-of-network doctors and other non-doctor and non-hospital service providers may send bills directly to the Fund Office if you "assign" benefits. The Fund Office will pay the Plan's share of the expenses directly to the provider. If an out-of-network doctor (or hospital) or other non-doctor or non-hospital provider requires payment, you must pay the bill and file a claim with the Fund Office for reimbursement. The Plan will reimburse you the Plan's share of the expenses.

3. In most other cases, benefit payments on claims for yourself and for your dependents will be made to you (the employee) unless you assign benefits. Death and AD&D benefits will be paid to your beneficiary. Benefits are payable only when the required forms and information have been received by the Fund Office.

4. The Trustees may, from time to time, enter into negotiated fee arrangements with health care providers under the terms of which the Fund will receive discounts on fees charged for such services. In such cases, any amount in excess of the negotiated (discounted) fee will not be considered a covered expense.

5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his business affairs, the Plan may pay benefits to his guardian or, if there is no guardian, to the individual who has assumed his care and principal support. If the person dies before all due amounts have been paid, the Trustees may make payment to the executor or administrator of his estate, to his surviving spouse, parent, child or children, or to any individual the Trustees believe is entitled to the benefits.

6. In determining the satisfaction of any deductible amounts and the amount of

benefit payments, a charge for any service, treatment, or supply will be considered incurred on the date the service or treatment was rendered or on the date the supply was provided.

Any payments made by the Plan in accordance with these rules will fully discharge the Plan's liability to the extent of its payments.

Non-Assignability of Fund Assets

No covered person who is entitled to any benefit under this Plan shall have the right to assign, alienate, transfer, encumber, pledge, mortgage, hypothecate, anticipate or impair in any manner his or her legal or beneficial interest in any assets of the Fund or benefits to this Fund. Neither the Fund nor any of the assets thereof shall be liable for the debts of any covered person entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceeding.

No assignment of any present or future right, interest, or benefit under this Plan shall bind the Trustees without their written consent thereto. The Trustees may, at their option, accept validly executed assignments of benefits made by an eligible employee or the spouse of the employee when such assignments are executed in favor of a provider of covered medical services or supplies. However, no assignment of benefits can assign more than the assignor's right to payment of benefits and will not be deemed to assign any other right or interest that the assignor has under the Plan, including, but not limited to, the right to seek review of a benefit denial.

Work-Related Injuries

This Plan is not in place of and does not affect any requirement for coverage under any workers' compensation law, occupational diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

If the Fund denies an eligible individual's claim for the reason that it is work-related, and the worker's compensation carrier also denies his claim, the Fund may agree to provide benefits under certain conditions. These conditions include the Trustees' determination, in their sole discretion, that a meritorious appeal of the worker's compensation claim exists, that a timely appeal of the worker's compensation claim exists, and that the eligible individual and the worker's compensation carrier are responsible for reimbursing the Fund out of any recovery obtained for the full amount of benefits that the Fund had provided in connection with a work-related claim.

Release of Information

You must provide the Fund Office with any required authorization for release of necessary information relating to any claim you have filed.

Length of Maternity Hospitalizations

A federal law requires that a covered person and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a caesarean section. Further, a Plan cannot require the provider (hospital or doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section.) The Plan will provide benefits for the covered expenses incurred by an eligible female employee or dependent spouse during the prescribed time periods, subject to all Plan conditions, limitations and exclusions.

Breast Cancer Rights

The Plan provides benefits for post-mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

HIPAA PRIVACY RIGHTS

The Plan has responsibilities under the Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: 1) identifies you or may reasonably be used to identify you; 2) is created or received by a health care provider, health plan, employer or health care clearinghouse; and 3) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact:

Administrative Manager
Cement Masons' Local 502 Welfare Fund
739 South 25th Avenue
Bellwood, Illinois 60104-1995
(708) 544-9105

Breach Notification Rules under HITECH

Covered entities and BAs must only provide the required notification if a Breach involves unsecured PHI. Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in guidance issued under the Health Information Technology for Economic and Clinical Health Act ("HITECH").

1. Definition of Breach

A Breach is the acquisition, access, use, or disclosure of protected health information in a manner not permitted under HIPAA that compromises the privacy or security of the PHI. In the event that any of these events occur, a Breach is presumed unless the Fund or BA, as applicable, demonstrates there is a low probability that the security or privacy of the PHI was compromised based on a risk assessment that considers, at a minimum:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person to whom the PHI was disclosed or who used the PHI;
- Whether or not the PHI was actually acquired or viewed;
- The extent to which the risk to the PHI was mitigated; and
- Any other relevant factors due to the specific facts and circumstances at issue.

The term Breach does not include:

- Unintentional acquisition, access, or use of PHI by a workforce member acting under the authority of a covered entity or BA, if such acquisition, access or use was made in good faith, within the scope of authority, and does not result in the further unauthorized use or disclosure in a manner not permitted under HIPAA.
- Inadvertent disclosure of PHI from a person authorized to access PHI at a covered entity or BA to another person authorized to access PHI at the covered entity or BA. In both cases, the information cannot be further used or disclosed in a manner not permitted by the Privacy Rule.
- Disclosure of PHI where the Fund or Business Associate has a good faith belief that the unauthorized individual, to whom the impermissible disclosure was made, would not have reasonably been able to retain the information.

2. Detecting, Reporting and Investigating Potential Breach

In the event that any Trustee, employee, representative or agent knows or suspects that a potential Breach has occurred, a written report must be immediately submitted to the Privacy Official.

Once a report is made, the Privacy Official shall immediately undertake a risk assessment internally or refer the matter to Fund Counsel to determine whether there is a low probability that the PHI has been compromised or there is more than a low probability that the PHI constitutes a Breach under HIPAA. The risk assessment will be documented and presented to the Trustees regardless of the finding. If the Privacy Official determines that a Breach occurred, the Fund will follow the notification procedures discussed below.

3. Notification to Individuals in the Event of a Breach

In the event of a finding of a Breach by the Privacy Official, the Fund (or its BA, if applicable) will notify the individual whose PHI is the subject of the Breach without unreasonable delay and in no case later than 60 calendar days after the Breach Discovery Date. The Breach Discovery Date is the first day the Breach is known or would have been known to the Fund upon exercising reasonable diligence. The Fund is deemed to have knowledge of a Breach if such Breach is known or would have been know upon exercising reasonable diligence by any person employed by the Fund, its agent or BA other than the person committing the Breach.

The notification to individuals shall be sent first class mail in one or more mailings as information becomes available. The notification will include the following information, if known, written in plain language:

- A brief description of what happened, including the date of incident and the Breach Discovery Date.
- A description of the types of PHI involved in the breach, but not the actual PHI.
- Any steps individuals should take to protect themselves from potential harm resulting from the Breach.
- A brief description of the Fund or BA actions to investigate, mitigate and protect against future Breaches.
- The contact information for individuals to ask questions or learn additional information, which shall include a toll-free number, website, email address or postal address.

In the event the Fund has insufficient or out-of-date information for individuals affected by the Breach, the Fund will provide substitute notice as permitted under HITECH.

4. Notification to the Media and HHS

If the Breach involves more than 500 residents of a single state or jurisdiction, the Fund or BA will notify prominent media outlets in addition to providing the individual notice as required under HIPAA.

Additionally, if the Breach involves more than 500 residents, (regardless of where they live) the Fund will notify HHS contemporaneously to the notice to individuals. When a Breach involves less than 500 individuals, the Fund

shall document the Breach and notify HHS not later than 60 days after the end of the calendar year in which the Breach occurs in the manner specified by HHS.

5. Mitigation Policy

The Fund will mitigate, to the extent possible, any harmful effect that is known of a use or disclosure of PHI in violation of this Policy or applicable law.

Rescissions of Coverage

The Trustees may rescind coverage, effective on the date they determine to be appropriate, subject to any limitations on that right that may apply under applicable law. The Trustees do have the right to rescind coverage in the event of an act or practice that constitutes fraud or that constitutes an intentional misrepresentation of material fact. In cases of fraud or intentional misrepresentation of material fact, they may pursue all available legal and equitable means to recover benefits erroneously paid for coverage improperly provided for any participant or beneficiary.

YOUR RIGHTS UNDER ERISA

As a participant in 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 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

In certain cases you can 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 Coverage rights.

You will be provided a certificate of creditable coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA Coverage, when your COBRA Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants, covered dependents 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 health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

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

Administrative Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material

You can read the material listed in the previous section by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than the Fund Office. The Fund Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material. Before requesting material, call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Fund Office address and phone number are shown on the inside front cover.

ADMINISTRATIVE INFORMATION

Name of Plan/Fund

The name of the Trust Fund through which your Plan is provided is the Cement Masons Institute Local 502 Welfare Trust Fund, which is commonly referred to as the Cement Masons' Local No. 502 Welfare Fund.

Your Plan is the program of health and welfare benefits established by the Trustees pursuant to the Trust Fund.

Plan Sponsorship and Administration

Your Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees is the Plan Administrator. The Board is divided equally between Trustees selected by the Union and by Trustees appointed by contributing employers. The names and addresses of the individual Trustees are shown on page 78.

The Union that appoints the Union members of the Board of Trustees is the Cement Masons' Union Local No. 502 or the Operative Plasterers' and Cement Masons' International Association of the United States and Canada. A complete list of employers and the employee organizations sponsoring the Fund may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and 2520.104b-30. This right includes a "superseded" collective bargaining agreement if such agreement

controls any duties, rights or benefits under the Plan.

The Trustees are assisted in the administration of the Fund by a salaried Administrative Manager, who is an employee of the Fund. The name and address of the Fund Administrative Manager, which is also the address of the Fund Office, is shown on the inside front cover of this book and on page 77.

Service of Legal Process

Service of legal process may be made on the Board of Trustees or on any individual Trustee. Service may also be made on the Fund's Administrative Manager.

Source of Financing/Plan Participation

The Fund receives contributions from employers under the terms of collective bargaining agreements and participation agreements and from the Union, the Fund itself and the Cement Masons' Local No. 502 Pension Fund. The Fund also receives self-payments from employees for the purpose of continuing coverage under the Plan. It may also receive fees from its prescription benefit manager.

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements or participation agreements, meet the eligibility requirements set forth in this Plan, and if the required contributions are made to the Fund on their behalf. Administrative employees of the Union, the Fund, and the Pension Fund are also entitled to participate in the Plan if they meet the eligibility requirements set forth in this Plan..

Type of Plan/Accumulation of Assets/Payment of Benefits

The Cement Masons' Local No. 502 Welfare Fund is classified as a health and welfare benefit plan, providing benefits of the type described in the following paragraph. Employer contributions and self- payments are received and held in trust by the Trustees pending the payment of benefits and administrative expenses. U.S. Bank is the custodian of assets for the Fund.

The Fund provides medical, surgical, hospital, disability, dental/orthodontia, and vision on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes. The Fund provides life insurance and accidental death and dismemberment insurance benefits through policies procured by the Trustees from Metropolitan Life Insurance Company, 177 South Commons Drive, Aurora, IL 60504.

Although, Blue Cross Blue Shield of Illinois reprices PPO claims involving medical, surgical and hospital benefits, and a contracted administrator, Group Administrators, Inc., provides claim processing services, the services of these companies are in the nature of claim processing and/or limited to the amount the Fund must pay providers, and all benefits paid remain self-insured.

This Plan is not an insurance policy and no benefits are provided by or through an insurance company.

Plan/Fund Year

The Fund's financial records are maintained on a 12-month fiscal year basis, beginning January 1 of each year and ending December 31 of the same year.

Plan/Fund Identification Numbers

The Employer Identification Number (EIN) assigned to this Fund by the I.R.S. is 36-2196729. The Plan Number (PN) assigned to the Plan of Benefits is 501.

PLAN PROFESSIONALS

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To write to the Board of Trustees, mail your letter to:

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739 South 25th Avenue
Bellwood, Illinois 60104-1995