# BRICKLAYERS AND MASONS' LOCAL UNION NO. 5, OHIO HEALTH AND WELFARE FUND
## (MARCH 1, 2016 RESTATEMENT)

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# BRICKLAYERS AND MASONS' LOCAL UNION NO. 5, OHIO HEALTH AND WELFARE FUND (MARCH 1, 2016 RESTATEMENT)

Preamble

WHEREAS, the Bricklayers and Masons' Local Union No. 5, Ohio and the contributing Employers maintain the Bricklayers and Masons' Local Union No. 5, Ohio Health and Welfare Fund (the "Plan");

WHEREAS, the Board of Trustees for the Plan deems it desirable to restate the Plan;

NOW, THEREFORE, effective as of March 1, 2016, the Board of Trustees hereby adopts this document as a restatement of the Plan. The Plan provides certain supplemental death, accidental death and dismemberment, accident and sickness disability, hospital, surgical, medical and dental benefits and is intended to be an accident and health care plan under Section 105(e) of the Code and an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The terms and conditions of the Plan are as follows:

## ARTICLE I
## Definitions

The following terms are used in this Plan or in the Incorporated Documents. Any term not defined herein or in the Incorporated Documents shall have the definition given to it by usual practice in the industry. If a term is defined differently from the definition provided in the relevant Program, the definition provided in the Program shall govern.

### 1.1 Adverse Benefit Determination

Any adverse benefit determination as defined in Department of Labor Regulation § 2560.503-1, as well as any rescission of coverage, as described in Treasury Regulation § 54.9815-2712T(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

### 1.2 All Other Claims

Any claim for a benefit that is not a Pre-Service Health Claim, Post-Service Health Claim, Urgent Care Claim or Disability Claim, but that is otherwise a claim for a benefit under a Program.

### 1.3 Appeal or Internal Appeal

A review of an Adverse Benefit Determination under Section 7.3.

### 1.4 Beneficiary

The person or persons designated by a Participant to receive a death benefit under the terms of a Program.

### 1.5 Claimant

Any Participant or other individual claiming benefits under a Program.

### 1.6 Code

The Internal Revenue Code of 1986, as amended.

### 1.7 Concurrent Claim

Any claim for a benefit under a group health plan that involves an on-going course of treatment to be provided over a period of time or number of treatments.

### 1.8 Dependent

Any individual who qualifies as a dependent under the terms of a Program.

**1.9 Disability Claim**

Any claim for a benefit under a Program that provides a disability benefit.

**1.10 Eligible Member**

Any Fund Member, any Pensioned Member who is eligible for Medicare, and any shareholder and officer employee of Contractors that are Employers.

**1.11 Employer**

The Fund's Administration Office maintains a complete list of the employers and employee organization that sponsor the Fund and have employees covered by the Fund.

**1.12 ERISA**

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

**1.13 External Review**

A review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) under the external review provisions in the claims procedures of the Third Party Claims Administrator for the applicable Program pursuant to Section 7.2 or under Section 7.4, as may be applicable.

**1.14 Final External Review Decision**

A determination by an independent review organization at the conclusion of an External Review.

**1.15 Final Internal Adverse Benefit Determination**

An Adverse Benefit Determination from an appeal of a denied claim.

**1.16 Independent Review Organization**

An entity that conducts independent external reviews of Adverse Benefit Determinations.

**1.17 Insurer**

An insurance company that underwrites a benefit under a Program.

**1.18 Incorporated Documents**

Any insurance contracts, documents, summary plan descriptions, manuals, handbooks, health maintenance organization agreements, administrative documents or other written documents describing the benefits offered under a Program, as in effect from time to time, which are incorporated by reference under Article II.

**1.19 Local Union**

The Bricklayers and Masons' Local Union No. 5, Ohio.

**1.20 Participant**

Any individual who participates in a Program in accordance with the terms and conditions established for such Program, and who has not for any reason become ineligible to participate further in such Program. The participation requirements set forth for each Program must be met by an employee before becoming an Eligible Member with respect to such Program.

**1.21 Plan**

The Bricklayers and Masons' Local Union No. 5, Ohio Health and Welfare Fund, as set forth herein and as amended from time to time. Any references to the terms "Plan" or "plan" contained in the Programs will be for reference purposes only, and shall not be interpreted to mean an individual plan under the Code, ERISA or the Regulations issued thereunder.

**1.22 Plan Administrator**

The Board of Trustees designated in accordance with Article IV to carry out the day-to-day operations of the Plan.

**1.23 Plan Year**

The twelve-month period commencing March 1 and ending the following February 28 (or 29).

**1.24 Pre-Service Health Claim**

Any claim for benefit under a group health plan, other than an Urgent Care Claim, with respect to which the terms of the Program condition receipt of the benefit, in whole or in part, on the approval of the benefit in advance of obtaining medical care.

**1.25 Post-Service Health Claim**

Any claim for a benefit under a group health plan that is not a Pre-Service Health Claim or an Urgent Care Claim.

**1.26 Program**

Each Program providing benefits to Participants and their Spouses, Dependents and Beneficiaries under the Plan, as specified on Exhibit A hereto. All Programs offered hereunder shall collectively constitute one plan for purposes of the reporting and disclosure requirements of ERISA and the Code.

### 1.27 Regulations

The Federal Income Tax Regulations promulgated by the Secretary of the Treasury or the regulations under ERISA promulgated by the Secretary of Labor, as the context requires.

### 1.28 Spouse

The person to whom an Eligible Member is legally married.

### 1.29 Termination of Employment

The termination of an employee's employment with an Employer, as determined under the Employer's policies, as in effect from time to time.

### 1.30 Third Party Claims Administrator

With respect to any fully insured Program, the person or entity designated under the Program to process and/or review claims for benefits under the Program. With respect to any self-insured Program, the third party administrator, insurance company or other organization or individual to which the Plan Administrator has delegated the duty to process and/or review claims for benefits under a Program. If no separate Third Party Claims Administrator has been designated by the Plan Administrator with respect to a self-insured Program, the Plan Administrator will be the Third Party Claims Administrator for such Program. The Third Party Claims Administrator shall decide the Claimant's eligibility for all initial claims for benefits made under a Program.

### 1.31 Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, with deference given to the opinion of such physician.

## ARTICLE II
## Incorporation by Reference

### 2.1 Incorporated Documents

The Plan incorporates by reference the Incorporated Documents of the Programs listed on Exhibit A, which contain the substantive provisions governing benefits provided by the Plan. For certain benefits, the Incorporated Document for a Program is the Summary Plan Description for the Plan. As such Incorporated Documents are amended or superseded, the amended or successor documents will automatically become Incorporated Documents. In the event of any conflict between the provisions of the Plan and an Incorporated Document, the provisions of the Incorporated Document will prevail except with respect to Article VII. In the event there is no provision in an Incorporated Document corresponding to a provision of the Plan, to the extent applicable, the Plan provision will apply to the Incorporated Document.

### 2.2 Benefits Available

The benefits available under the Plan consist of the aggregate of the benefits available under each Program, including all limitations and exclusions with respect to such benefits. The benefits available under each Program are set forth in the Incorporated Documents for each Program listed on Exhibit A.

### 2.3 Termination of Rights to Benefits

Any termination or cessation of a Participant's coverage under a Program will be considered a termination or cessation of that same coverage under the Plan. The Plan provides no coverage other than that provided under each Program.

## ARTICLE III
## Participation

### 3.1 Participation

The requirements for participation in the Plan and the election procedures are specified in the Summary Plan Description for the Plan.

### 3.2 Coverage of Dependents

Subject to the eligibility and participation requirements of any Program, each Dependent will be eligible for coverage under the Plan with respect to the benefit provided under a Program on the date that the Employee becomes eligible or, if later, on the date he first becomes a Dependent.

### 3.3 Termination of Participation

An Eligible Member's participation under the Plan shall terminate upon the earliest of the following events:

(a) If the Eligible Member fails to satisfy the Eligibility Requirements established by the Board of Trustees; or

(b) If the Eligible Member is called into active service with the Armed Forces of the United States, his eligibility for benefits (except personal Loss of Life Benefits which are maintained at Fund expense) will cease, except to the extent provided by USERRA; or

(c) If the Eligible Member discontinues membership in the Local Union. Any excess balance in the Supplemental Health Reimbursement Account will be terminated and revert to the Fund; or

(d) If the Eligible Member works for an employer not signed to the Collective Bargaining Agreement and remains working in the bricklaying and masonry industry. Any excess balance in the Supplemental Health Reimbursement Account, will be terminated and revert to the Fund; or

(e) The Eligible Member's eligibility for Alternate Death Benefits shall cease whenever he discontinues membership in the Local Union.

## ARTICLE IV
## Plan Administration

### 4.1 Plan Administrator

The Plan is administered by the Plan Administrator. The Plan Administrator is the Board of Trustees, which consists of six members, three being appointed by the Director of the District Council, and three being appointed by the Mason Contractors' Association. The powers, rights and duties of the Trustees are specified in the Fund's Trust Agreement.

### 4.2 Powers of the Plan Administrator

Except as otherwise provided in the Incorporated Documents describing a Program, the Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan (including, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan), to determine the rights and status of Participants and other persons under the Plan, to decide disputes arising under the Plan, and to make factual determinations with respect to any matter for which it has administrative responsibility. Any determinations and findings with respect to the benefits payable hereunder and the persons entitled thereto, as may be required for purposes of the Plan, will be determined in accordance with the provisions of the Incorporated Documents for the applicable Program. In furtherance of, but without limiting the foregoing, the Plan Administrator shall have the following duties, responsibilities and authority with respect to the administration of the Plan and the Programs:

(a) To resolve all questions arising under the provisions of the Plan as to the entitlement of any individual to become a Participant;

(b) Except as otherwise provided in Section 4.3(b), to determine the amount of benefits, if any, payable to any person under the Plan;

(c) To keep records of all acts and determinations of the Plan Administrator and to keep all such records, books, accounts, data and other documents as may be necessary for the proper administration of the Plan;

(d) To make and publish such rules for the administration of the Plan that are not inconsistent with the terms thereof;

(e) To engage a Third Party Claims Administrator in connection with one or more self-insured Programs, with responsibility for the initial review, payment, and/or denial of claims for benefits for such Program;

(f) To employ counsel, accountants and other consultants to aid in exercising its powers and carrying out its duties hereunder; and

(g) To perform any other acts necessary and proper for the administration of the Plan.

### 4.3 Fiduciary Responsibilities

(a) Designation of Plan Administrator as Named Fiduciary. The Plan Administrator is hereby designated as a "named fiduciary" within the meaning of Section 402(a) of ERISA, with respect to the operation and administration of the Plan and is responsible, except to the extent provided by Subsections (b) and (c) of this Section, for administering the Plan in accordance with its terms.

(b) Designation of Third Party Claims Fiduciary for Fully-Insured Programs. The Insurer of all or any portion of any fully insured Program is hereby designated as the fiduciary responsible for claims administration and benefit determination under such Program or portion thereof.

(c) Procedures for Allocating or Delegating Fiduciary Responsibilities: The Plan Administrator may establish procedures for the designation of persons other than named fiduciaries to carry out fiduciary responsibilities under the Plan.

### 4.4 Expenses of the Plan Administrator

The expenses of administering the Plan, including, without limitation, the expenses of the Plan Administrator properly incurred in the performance of its duties under the Plan, will be paid by the Plan.

## ARTICLE V
## Funding

### 5.1 Funding of the Plan

(a) Employer Contributions.

The Fund is financed at the per hour contribution rate fixed for annual periods by the collective bargaining agreement. Each Employer is required to submit a monthly report to the Administration Office, with payment of the total monthly amount due on all contributions payable to the Fund. Total monthly receipts are deposited with FirstMerit Bank, N.A. (or its successor).

(b) Member Contributions. The Board of Trustees, in recognition of the seasonal and other unemployment factors which affect the construction industry, have granted "active" members of the Local Union the privilege to self-pay the dollars needed to maintain continuing eligibility for Fund benefit coverage. The current rules and procedures are set forth in the Summary Plan Description for the Plan.

## ARTICLE VI
## Benefit Elections

### 6.1 Election of Benefits

At the time of initial enrollment in any Program, an Eligible Member must make an election in a manner designated by the Plan Administrator indicating his choice of coverage under the Programs listed on Exhibit A, to be effective for the entire Plan Year or, if applicable, the remainder of the Plan Year in which he enrolls.

### 6.2 Changes to Benefit Elections

A Participant may change an election after the Plan Year to which such election relates has commenced and make new elections with respect to the remainder of such Plan Year in accordance with procedures and forms available from the Administration Office or the Third Party Administrator.

## ARTICLE VII
## Claims Procedure

### 7.1 Eligibility Determinations

All determinations as to the eligibility of an Eligible Member for coverage under a Program that are not accompanied by a claim for benefits under the Program will be made by the Plan Administrator, exercising the authority and discretion granted under Section 4.2. The decision of the Plan Administrator will be final and will not be subject to review. All determinations as to eligibility for coverage that are made in connection with a claim for benefits under a Program will be made in accordance with the claims procedures set forth in Sections 7.2, 7.3, and 7.4.

### 7.2 Initial Claims Processing

(a) A claim for benefits under a Program that is fully insured, and a request to review an Adverse Benefit Determination under such a Program, will be submitted to the Third Party Claims Administrator for the Program in accordance with the claims procedures established by such Program and set forth in the applicable Incorporated Documents. Notwithstanding the preceding sentence, any issue relating to the eligibility of an Employee or Dependent for coverage under a fully insured Program that is part of the claim for benefits will be determined by the Plan Administrator in a manner consistent with the claims procedure set forth in Sections 7.2(b) and 7.3.

(b) A claim for benefits under a Program that is self-insured, and a request to review an Adverse Benefit Determination under such a Program, will be submitted to the Third Party Claims Administrator for the Program in accordance with the claims procedures established by the Third Party Claims Administrator and set forth in the applicable Incorporated Documents. If a claims procedure for such Program has not been established by the Third Party Claims Administrator, or if no separate Third Party Claims Administrator has been designated by the Plan Administrator with respect to a self-insured Program and there is no other claims procedure established for the Program, the claims procedure described in Sections 7.2(b) and 7.3 will apply. Claims must be submitted in the manner approved by the Plan Administrator, which will be delivered to the Plan Administrator and accompanied by the substantiation (such as receipts, records of treatment, Participant certifications and other appropriate documents) that the Plan Administrator considers necessary and reasonable under the circumstances.

The initial review of claims for benefits shall be conducted on behalf of the Plan Administrator by one Employer Trustee and one Employee Trustee.

Initial claims will be processed within the following periods of time:

(1) **Health Claims:**

(i) **Urgent Care Claims:** 72 hours after receipt of the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure the Plan Administrator shall notify the Claimant no later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan will render a final decision within 48 hours after the earlier of the Plan's receipt of the information from the Claimant or the expiration of the 48 hours within which the Claimant was requested to provide the information.

(ii) **Pre-Service Claims:** 15 days after receipt of the claim. The period may be extended one time for up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant of the circumstances requiring the extension and the date by which a decision is expected to be rendered, prior to the extension of time of the initial 15-day period. If the extension is needed due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the specified information. The Plan has 15 days from the date it receives the requested information to render a final decision.

(iii) **Concurrent Care Claims:** 24 hours for Urgent Care Claims or within a reasonable period of time for all other claims. When notifying the Claimant of a reduction or termination of benefits for a previously approved and ongoing treatment plan, the Plan must provide the Claimant with enough advance notice to appeal the decision prior to the reduction or termination of benefits. If the Claimant requests an extension of the course of treatment that involves urgent care at least 24 hours before benefits would end, the Claimant's request for an extension must be decided upon as soon as possible, but no later than 24 hours after the request is received by the Plan.

(iv) **Post-Service Claims:** 30 days after receipt of the claim. This period may be extended one time up to 15 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If the extension is needed due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan has 30 days from the date it receives the requested information to render a final decision.

If the Plan Administrator determines that a claim is not properly filed and complete, the Plan Administrator will notify the Claimant of the failure and the proper procedures to be followed no later than 24 hours in the case of a failure to file a proper and complete claim involving urgent care and 5 days following the failure to file a proper and complete claim for all other health claims.

(2) **Disability Claims:** 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision still cannot be rendered, the period for making the determination may be extended for up to an additional 30 days. If such extensions are necessary, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(3) **All Other Claims:** 90 days after receipt of the claim. This period may be extended for up to 90 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. In no event shall such extension exceed a period of 90 days from the end of such initial period.

## 7.3 Claims Appeal Procedures

For self-insured benefits, an appeal from a claim denial shall be reviewed on behalf of the Plan Administrator by an Employer Trustee and an Employee Trustee who did not review the initial claim for benefits.

(a) **Health Claims:**

(1) **Urgent Care Claims:** Within 180 days after the receipt of a written notice that his claim was denied, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and additional documents relevant to his claim and may submit issues and comments in writing, or a request for an expedited appeal may be submitted orally or in writing. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan Administrator and the Claimant by telephone, facsimile, or other available similarly expeditious method. If the Claimant does not file such a request with the Plan Administrator within such 180-day period, the Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(2) **Pre-Service Claims:** Within 180 days after the receipt of a written notice that his claim was denied, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and additional documents relevant to his claim and may submit issues and comments in writing. If the Claimant does not file such a request with the Plan Administrator within such 180-day period, the Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(3) **Concurrent Claims:** Within 180 days after the receipt of a written notice that his claim was either denied or reduced, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and additional documents relevant to his claim and may submit issues and comments in writing. If the Claimant does not file such a request with the Plan Administrator within such 180-day period, the Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(4) **Post-Service Claims:** Within 180 days after the receipt of a written notice that his claim was denied, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and additional documents relevant to his claim and may submit issues and comments in writing. If the Claimant does not file such a request with the Plan Administrator within such 180-day period, the

Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(b) **Disability Claims:** Within 180 days after the receipt of a written notice that his claim was denied, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and additional documents relevant to his claim and may submit issues and comments in writing. If the Claimant does not file such a request with the Plan Administrator within such 180-day period, the Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(c) **All Other Claims:** Within 60 days after the receipt of written notice that his claim was denied, a Claimant may request in writing a review by the Plan Administrator. The Claimant or his representative may examine the Plan and any additional documents relevant to his claim and may submit issues and comments in writing. If the Claimant does not file such a request with the Plan Administrator within such 60-day period, the Claimant will be conclusively presumed to have accepted as final and binding the initial decision of the Plan Administrator on his claim.

(d) **Review Process:** If an appeal is filed within the requisite number of days as described above, the Plan Administrator will conduct a full and fair review of the claim, during which time the Claimant or his authorized representative will be given the opportunity to review the claim file and documents that are pertinent to the Claimant's claim and to submit issues and comments to the Plan Administrator in writing.

The Plan Administrator will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim. Such evidence shall be provided to the Claimant as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan Administrator issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale shall be provided to the Claimant as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

All claims and appeals shall be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

(e) **Timing of Notice of Decisions:** Once a decision is rendered, the Plan Administrator will mail or deliver to the Claimant a written decision on the matter

based on the facts and pertinent provisions of the Plan within the period described below:

(1) **Health Claims:**

(i) **Urgent Care Claims:** 72 hours after receipt of the Claimant's request for review.

(ii) **Pre-Service Claims:** 30 days after receipt of the Claimant's request for review.

(iii) **Concurrent Claims:** After a request for review or appeal is received, the Plan must make a decision within:

- 72 hours for Urgent Care Claims;
- 30 days for Pre-Service Claims; and
- 60 days for Post-Service Claims.

(iv) **Post-Service Claims**: 60 days after receipt of the Claimant's request for review.

(2) **Disability Claims:** 45 days after receiving the request for review or appeal. The Plan may extend the review period an additional 45 days if necessary. If this is the case, the Plan must notify the Claimant within the initial 45-day period of the extension and provide the Claimant with the reason for the extension and the date a decision can be expected. If the extension is due to the Claimant's failure to submit necessary information, the time frame for the Plan making a decision is put on hold until the Claimant responds to the request.

(3) **All Other Claims:** 60 days after receipt of the Claimant's request for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which a determination is expected to be rendered.

(f) **Deemed Denial:** If the Plan Administrator fails to notify the Claimant of its decision with respect to the request for review within the time specified by this Subsection, the claim will be deemed to have been denied on review. In such a case with respect to a claim under a Program that is a group health plan, the Claimant shall be deemed to have exhausted the internal claims and appeals process, except in the case of de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the violation was for

good cause or due to matters beyond the control of the Plan Administrator and the violation occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator and the Claimant. In the event of a deemed denial with respect to a claim under a Program that is a group health plan, the Claimant may initiate an external review pursuant to Section 7.4. The Claimant may request a written explanation of the violation, which shall be provided within 10 days and include a specific description of the bases, if any, for asserting the violation should not cause the internal claims to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under Section 7.4, the Claimant has the right to resubmit and pursue the Internal Appeal of the claim. Within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan Administrator shall provide the Claimant with notice of the opportunity to resubmit and pursue the Internal Appeal of the claim.

(g) **Notice of Adverse Benefit Determination:** The decision of the Plan Administrator pursuant to this Section will:

(1) Be written in a manner calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner;

(2) State the specific reason(s) for the adverse decision;

(3) With respect to a claim under a Program that is a group health plan,(i) include information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request (which request shall not be considered a request for an Internal Appeal an External Appeal), of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning); (ii) include a description of the Internal Appeal and External Appeal procedures; and (iii) disclose the availability of, and contact information for, any applicable office health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes;

(4) Make specific reference(s) to pertinent provisions of the Plan on which the decision is based;

(5) Notify the Claimant that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

(6) Provide the Claimant a description of any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information

about such procedures, and a statement of the Claimant's right to bring an action under ERISA Section 502;

(7) In the case of a group health plan or disability plan, notify the Claimant if any internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, and (i) either provide a copy of the internal rule, guideline, protocol, or other similar criterion or (ii) specify that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;

(8) In the case of a group health plan or disability plan, provide the Claimant with the following statement: "You and your plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.";

(9) In the case of an Adverse Benefit Determination under a group health plan or disability plan that is based on a medical necessity or experimental treatment or similar exclusion or limit, provide the Claimant with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

(10) To the extent permitted by applicable law, be final and binding on all interested persons, except as may be provided in Section 7.4.

**7.4 External Review**

(a) **Applicability:** This Section applies solely to requests for External Review under a Program that is a group health plan. Any such request for External Review will be submitted to the Third Party Claims Administrator for the Program in accordance with the claims procedures established by the Third Party Claims Administrator and set forth in the applicable Incorporated Documents. If a claims procedure for such Program has not been established by the Third Party Claims Administrator, or if no separate Third Party Claims Administrator has been designated by the Plan Administrator with respect to such Program and there is no other External Review established for the Program, the provisions of Section 7.4(b) shall apply to the request for External Review.

(b) **External Review Process:** External Reviews shall be made in accordance with Department of Labor Regulation § 2590.715-2719(c) and such other applicable guidance issued by the Department of Labor or the Department of Treasury.

## ARTICLE VIII
## Amendments

### 8.1 Right to Amend

The Board of Trustees reserves the right to amend the Plan, in whole or in part, including, without limitation, the right to amend any of the Programs. All amendments to the Plan shall be made in writing and executed by an Employer Trustee and an Employee Trustee.

### 8.2 Nonvested Benefits

The right to amend or terminate the Plan and any Program includes the right to change, limit, curtail or eliminate any or all coverages and/or benefits for any treatment, procedure or service (including with respect to Participants who are receiving benefits or Participants who are former Fund Members, if any), regardless of whether the coverage or benefits relate to an injury, defect, illness or disease that was contracted or that occurred before the effective date of amendment or termination. Nothing in the Plan, any Program or Incorporated Document may be construed to provide vested, non-terminable or non-changeable benefits or rights thereto.

## ARTICLE IX
## Miscellaneous

### 9.1 No Contract of Employment

Nothing contained in the Plan shall be construed as a contract of employment between any Employer and any employee, or as a right of any employee to continue in the employment of any Employer.

### 9.2 Nontransferability of Interests

Except as may otherwise be provided by law or in the Incorporated Documents, a Participant's rights, interests or benefits under the Plan or the Programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntarily or involuntarily, prior to being received by the persons entitled thereto under the terms of the Programs, and any such attempt shall be void. Neither an Employer nor the Plan will in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

### 9.3 Facility of Payment

The Plan Administrator may pay the amount otherwise payable to a Claimant to another person or institution that it reasonably determines to be entitled to such payment if the Claimant:

(a) Dies before all Plan benefits have been paid;

(b) Is a minor with no legal guardian;

(c) Is incompetent or incapable of executing a valid receipt and without an appointed legal guardian or representative; or

(d) Fails to give the Plan a forwarding address.

After making such payment to another person or institution, the Plan will have no further liability for the benefit payment.

### 9.4 Right to Receive Necessary Information

Any Participant claiming benefits under the Plan must furnish to the Plan Administrator such information as the Plan Administrator reasonably requests to implement the Plan or any relevant Program.

### 9.5 Mistake of Fact

Any misstatement or any other mistake of fact in any enrollment procedure, beneficiary designation, certificate, notice, or other document filed with an Employer or the Plan

Administrator shall be corrected when it becomes known, and proper adjustment made. Neither the Plan Administrator nor any Employer shall be liable in any manner for any determination of fact made in good faith on the basis of such misstatement.

### 9.6 Misrepresentation or Fraud

A Participant who receives a Plan benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts to the Plan or any relevant Program and will be liable for all collection costs including attorneys' fees and court costs. In addition, to the extent determined by the Plan Administrator in its sole discretion, such Participant's coverage under the Plan will be terminated as specified in Section 3.4(g).

### 9.7 Right to Offset Future Payments

In the event of an erroneous payment or payment amount, the Plan may reduce future benefits payable to or on behalf of such Participant by the amount of the error. This right of offset does not limit the Plan's right to recover an erroneous payment in any other manner.

### 9.8 Right to Recovery

If the Plan pays an expense in a total amount exceeding the amount necessary to satisfy the Plan's obligation, the Plan has the right to recover the excess directly from the person to or for whom the payment was made. This right of recovery does not limit the Plan's right to recover an erroneous payment in any other manner.

### 9.9 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust all claim, review, and appeal procedures provided by the Plan (and/or any insurance contract applicable to a fully insured Program). No person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

### 9.10 Reliance

The Plan Administrator may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. Subject to the claims and appeals provisions of Sections 7.2 and 7.3, a good faith action or omission based on this reliance will be binding on all parties.

### 9.11 Qualified Military Service

Notwithstanding any other provision of the Plan to the contrary, any Participant covered under the Uniform Services Employment and Reemployment Rights Act of 1994

("USERRA") may continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA and regulations issued thereunder.

**9.12 Family and Medical Leave Act Coverage**

Notwithstanding any other provision of the Plan to the contrary, any Participant who is on an authorized leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") may continue to participate and be eligible to receive benefits under the Plan in accordance with FMLA and regulations issued thereunder.

**9.13 Health Insurance Portability and Accountability Act of 1996**

**General:** Notwithstanding any other provision of the Plan to the contrary, the Plan will comply with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in the Summary Plan Description

**9.14 Continuation Coverage**

Notwithstanding any other provision of the Plan to the contrary, the Plan will comply with all applicable requirements of the continuation coverage provisions of Section 4980B(f) of the Code and Sections 601 through 609 of ERISA, as set forth in the Summary Plan Description.

**9.15 Qualified Medical Child Support Orders**

Notwithstanding any other provisions of the Plan to the contrary, the Plan will comply with all applicable requirements as defined in ERISA Section 609(a)(2) to determine whether medical child support orders are qualified medical support orders and to administer the provision of benefits under such qualified orders.

**9.16 Newborns' and Mothers' Health Protection Act of 1996**

Notwithstanding the provisions of the Plan to the contrary, the Plan will comply with all applicable requirements of the Newborns' and Mothers' Health Protection Act of 1996.

**9.17 Women's Health and Cancer Rights Act of 1998**

Notwithstanding the provisions of the Plan to the contrary, the Plan will comply with all applicable requirements of the Women's Health and Cancer Rights Act of 1998.

**9.18 Mental Health Parity and Addiction Equity Act of 2008**

Notwithstanding the provisions of the Plan to the contrary, the Plan will comply with all applicable requirements of the Mental Health Parity and Addiction Equity Act of 2008.

**9.19 Construction**

(a) **Governing Law:** The Plan's provisions and all Plan matters, including actions of the parties involved, will be construed and enforced according to applicable Ohio

law (other than its choice of law provisions) unless they are preempted by Federal law.

(b) **Headings:** The headings of Articles, Sections and Subsections are for convenience of reference only and are not to be regarded as part of the Plan nor utilized in interpreting the Plan.

(c) **Gender and Number:** Except when otherwise indicated by the context, any masculine terminology used herein also includes the feminine and the use of the singular also includes the plural, unless the context clearly indicates to the contrary.

**9.20 Severability**

If any provision of the Plan or the application thereof to any circumstance(s) or person(s) is invalid, the remainder of the Plan and the application of such provision to other circumstances or persons will not be affected thereby.

**BRICKLAYERS AND MASONS'**
**LOCAL UNION NO. 5, OHIO**
**HEALTH AND WELFARE FUND**

## Exhibit A
## Plan Programs and Incorporated Documents

| Program | Funding | Benefit |
|---|---|---|
| Anthem Blue Cross and Blue Shield | Self-Insured | Health |
| Anthem Blue Cross and Blue Shield | Self-Insured | Dental |
| Sav-rx Prescription Services | Self-Insured | Prescription |
| Supplemental Health Reimbursement Plan | Self-Insured | Health |
| Loss of Life Benefit for Certain Former Benevolent Association Members | Self-Insured | Death Benefit |
| Ordinary Loss of Life Benefit | Self-Insured | Death Benefit |
| Non-occupational Accidental Death or Dismemberment Benefit | Self-Insured | AD&D |
| Non-occupational Accident and Sickness Weekly Disability Benefits | Self-Insured | Temporary Disability |
| Occupational Weekly Disability Benefits | Self-Insured | Temporary Disability |
| Alternate Death Benefit | Self-Insured | Death Benefit |
| Medicare Supplement Benefit for Social Security Disability | Self-Insured | Health |
| Medicare Supplement Benefit for Social Security Age 65and Over | Insured | Health |