BRICKLAYERS AND MASONS' LOCAL UNION No. 5, OHIO

HEALTH & WELFARE FUND SUMMARY PLAN DESCRIPTION

UPDATED JANUARY 1, 2023

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INTRODUCTION

TO ALL FUND MEMBERS:

The Trustees of the Health & Welfare Fund are pleased to distribute this Summary Plan Description which updates and replaces prior Summaries, describes the essential features of your current Benefit Plan and includes the advisory information required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Benefit Plan is a health and welfare plan that provides certain supplemental death, accidental death and dismemberment, accident and sickness disability, hospital, surgical, medical and dental benefits. The Plan is self-administered by a Joint Board of Trustees. This updated document includes all amendments to the Benefit Plan since the last published update.

This Summary is a guide to the health protection and financial security provided to you and your dependents by the Benefit Plan. Necessarily, details and legal expressions in the formal Plan documents have been omitted. Although it is believed that there are no inconsistencies between this Summary and the formal Plan documents, the formal Plan documents will, of course, govern in case of any omission or inconsistency. We urge that you study and preserve this Summary as a ready reference and, as in the past, seek the timely advice and assistance of the Fund's Administration Office on any question or matter which concerns the Benefit Plan.

Sincerely,

THE BOARD OF TRUSTEES
Bricklayers and Masons'
Local Union No. 5, Ohio
Health & Welfare Fund

PLAN NAME
BRICKLAYERS AND MASONS'
LOCAL UNION No. 5, OHIO
HEALTH & WELFARE FUND

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INTERNAL REVENUE SERVICE IDENTIFICATION NUMBER OF FUND
34-0754400
Plan Number 501

FOREWORD

Explaining the Fund's Historical Background, Management and Administration

1. The Fund's Establishment, Regulation and Continuing Existence

The Health & Welfare Fund was established in March, 1953, in accordance with the Labor-Management Relations Act of 1947 (Taft-Hartley), as amended, and is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). The continuing existence of the Fund is dependent upon the provisions of the periodic employer-employee collective bargaining agreements made by and among the Bricklayers and Masons' Local Union No. 5, Ohio, the Mason Contractors', Terrazzo Contractors' and Marble Dealers Associations of Cleveland, Ohio, and unaffiliated employers who hire members of the Local Union in accordance with the general collective bargaining agreements. Members and beneficiaries may also receive, upon written request, a copy of the collective bargaining agreement and such agreement is available for examination by Members and beneficiaries at either the Office of the Local Union or the Fund's Administration Office.

All Employers, who are too numerous to mention in this Summary, are required to be registered with the Local Union. A complete list of employers and employee organizations that sponsor the Fund may be obtained by Members and beneficiaries by written request from either the Office of the Local Union or the Fund's Administration Office, and is available for examination by Members and beneficiaries at both offices. Also, Members and beneficiaries may receive, upon written request to the Fund's Administration Office, information whether a particular employer or employee organization is a sponsor of the Fund and, if a sponsor, its address.

The Fund is held, managed and administered in accordance with:

(a) The Trust Agreement, as amended from time to time; and

(b) The Benefit Plan, as amended from time to time, and the Rules and Regulations adopted by the Fund's Board of Trustees, as amended from time to time.

2. The Board of Trustees - Fund Administration

The Fund's Board of Trustees 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, the provisions of which previously have been published for the general information of the Employers and Local Union members.

The Fund's officers consist of a chairman and secretary of the Board of Trustees. Under the direction and general supervision of the Trustees, and with the advice of legal counsel, the day-to-day operations of the Administration Office are carried on by the Administration Office

Manager and staff. When necessary, the Trustees also seek actuarial advice on various features of the Benefit Plan.

3. Employer Contributions, Fund Financing and Investments

The Fund is financed at the per hour contribution rate fixed for annual periods by the collective bargaining agreement. Such contributions are required to be paid for all work performed for Employers by any International-Union journeyman, improver or apprentice employed within the geographical jurisdiction of the Local Union, which encompasses all of Cuyahoga, Medina and Lorain Counties, Ohio.

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 into the custodial bank account. Incidental to its trust duties for the Fund, the bank disburses monies from the Fund's General trust account for payment of benefit claims and operating expenses in accordance with direction by the Fund's Board of Trustees.

4. Increase, Modification or Termination of Benefits

The scope of the Fund's Benefit Plan is necessarily subject to the desires of the Local Union's membership and the amount of the Employer hourly contribution rate provided in future collective bargaining agreements. Therefore, since the Benefit Plan must be maintained on a financially sound basis, the increase, modification or termination of any benefit feature rests exclusively with the Fund's Board of Trustees as provided in the Fund's Trust Agreement.

5. Plan Year

The Plan Year for the Benefit Plan and Fiscal Year for the Fund are the same and begin on March 1 of each year and end on February 28 (29) of the following year. Each 12-month period commencing on March 1 constitutes an entire Plan Year and Fiscal Year for the purposes of accounting, as well as for reports required by the U.S. Department of Labor, the Internal Revenue Service or other regulatory agencies.

6. Determination from Internal Revenue Service

By original ruling letter dated August 3, 1954, the Internal Revenue Service determined that the Fund was exempt from Federal Income Tax under applicable provisions of the Internal Revenue Code.

7. Fiduciary Insurance - Fidelity Bonding

The Fund's Trustees and the Administration Office personnel are respectively and adequately covered by fiduciary insurance and a blanket fidelity bond.

8. Annual Audits - U.S. Department of Labor Reports

Each Fiscal Year the independent accounting firm makes a comprehensive audit of the Fund's operations and prepares certified financial statements. Such financial statements, or summaries thereof, are made available by the Trustees to the Local Union, the Employers, Fund members and other interested persons.

9. Reciprocity with other Health and Welfare Funds

Many reciprocal agreements have been made with health and welfare funds in other jurisdictions. If you have occasion to work outside the geographical jurisdiction of the Local Union, you should immediately contact the Administration Office to be advised on available reciprocal arrangements and what must be done to have health and welfare contributions deducted from your compensation transferred to the Administration Office as your "Home Fund." In no instance should you consider that reciprocity is "automatic." Normally you are required to make a request in writing with the "forwarding fund," and therefore you need the guidance of the Administration Office Manager.

10. The following Plan Description - Your Rights

The succeeding pages of this Summary itemize and describe the benefits available under the current Benefit Plan. Detailed information is also contained regarding Eligibility Rules, "Reserve Bank" Dollars, Elective Rights, Claims and Administrative Procedures which have been established in order to serve your interest and convenience.

We have included the following additional important information:

APPENDIX 1 - ERISA Rights Statement.
APPENDIX 2 - COBRA Important Notice.
APPENDIX 3 - Newborn's and Mother's Health Protection Act Notice.
APPENDIX 4 - Women's Health and Cancer Rights Act of 1998 Notice.
APPENDIX 5 - Notice Regarding Mental Health Parity and Addiction Equity Act.
APPENDIX 6 - Notice of Privacy Practices.
APPENDIX 7 - No Surprises Act.
APPENDIX 8 - Claims Procedure.

Undoubtedly, future changes in your Benefit Plan will occur. As such develop we will provide you with necessary information by way of an insert which can be placed in this Summary.

Finally, we again emphasize the importance of your careful reading of this Summary, and, on a continuing basis, request that you furnish the Administration Office with all information needed to insure that you obtain all the benefits to which you and your family are entitled.

GENERAL OUTLINE
OF THE FUND'S RULES, REGULATIONS AND PROCEDURES

The Member's Personal Responsibilities

(A) Maintenance of Personal Work Records

Contributions to the Local Union's fringe benefit funds are determined pursuant to the negotiated collective bargaining agreement. Most Employers fulfill their collective bargaining agreement obligations and timely report and remit monthly required contributions to the Administration Office. Unfortunately, however, some Employers are delinquent and others fail completely to report all contributions for work hours performed. Therefore, it is absolutely necessary that you maintain and preserve adequate and complete records of your work at the trade for each particular Employer. This includes pay envelopes, check stubs, your own personal daily work record book and any other data which would prove the hours you worked for an Employer at any particular time. The Fund's Administration Office and the Field Representatives of the Local Union will attempt to collect all contributions due the Funds from any delinquent Employer and, when necessary, will need the supporting personal data from you to establish the place, time and Employer for whom the claimed work hours were performed. For you to get your benefits, it is essential for each Employer for whom you work to pay in all amounts on your behalf in order to maintain your benefit eligibility.

(B) Administration Requirements

The continued efficiency of the Administration Office's functions, and the protection of your own personal interests, require that you have on file at the Administration Office a completed History and Beneficiary Designation Card, an Election as to Dependents' Coverage Card, and that you notify or contact the Administration Office whenever:

1. You change your home address or a dependent changes his or her home address;
2. You desire to change your beneficiary or your election as to coverage for Dependents' Benefits;
3. You marry, divorce or legally separate or a dependent child loses dependent status;
4. You are inducted into the Armed Forces, and subsequently are discharged;
5. You are uncertain as to whether your current Employer is making required monthly contributions on your behalf to the Administration Office;
6. You have occasion to work outside the geographical jurisdiction of the Local Union, and need information as to possible reciprocity arrangements with a Bricklayers' fund in the work area;
7. You transfer from the Local Union, or from active employment at the trade;

8. You require additional information on any aspect of the Fund's rules including self-pay contributions to maintain continuing eligibility under the Benefit Plan;

9. You desire to be furnished with Claim Forms for yourself, or a dependent member of your family;

10. You need an authoritative answer to any question concerning features of the Benefit Plan; and

11. You desire to appeal the denial of a self-insured benefit claim to the Board of Trustees, or question the allowance granted on a claim directly presented to Medical Mutual.

ELIGIBILITY REQUIREMENTS

All Fund Members who, are individually credited with sufficient "work credit" contribution dollars, as prescribed from time to time by the Board of Trustees, are eligible for applicable Members' and Dependents' benefits.

Eligible month-yearly periods are determined by applying cumulative monthly work credit dollars to benefit months as follows:

WORK MONTH	**BENEFIT MONTH**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

Monthly work credit dollars will always be applied to a benefit month regardless of whether you have other coverage. The "Normal Eligibility Requirements" established by the Trustees apply to the Members who actively work at the trade. An additional classification has been established for inactive pensioned Members who are eligible for Medicare and have accumulated "reserve bank" dollars. Otherwise, "reserve bank" dollars are applied until exhausted (see below).

Specifically, the Fund's current eligibility requirements are as follows:

NORMAL ELIGIBILITY REQUIREMENTS

On a periodic basis, the Fund's Trustees will determine the dollar charge amounts required for Member Only coverage and for Member and Dependent Coverage under the Health and Welfare Benefit Fund. These amounts will vary from time to time, based on changes in the

cost to the Fund of the insured and self-insured benefit program coverages and changes in administration costs and anticipated investment returns.

ELIGIBILITY REQUIREMENTS FOR PENSIONED MEMBERS WHO ARE ELIGIBLE FOR MEDICARE

Eligibility Requirements vary from year to year based on family status and costs. Information on the dollar requirements applicable to you is available from the Administration Office.

It is important that you and your dependents promptly enroll for Medicare coverage as soon as you become eligible for such coverage. Generally, you and your dependents will be eligible for Medicare at age 65, when totally disabled after collecting Social Security Benefits for two years, and when kidney dialysis is required. Even though you have coverage under the Fund, you must promptly enroll for Medicare to ensure adequate medical coverage.

ELIGIBILITY REQUIREMENTS FOR SHAREHOLDERS AND OFFICERS

The following rules pertain to the eligibility for coverage under the Health and Welfare Fund by officers and shareholders of Contractors that are Employers:

1. The Contractor is to elect in or out for all its shareholder and officer employees who are members of Bricklayers' & Allied Craftworkers Local Union No. 5 Ohio (the "Union").
2. If the Contractor elects in, it shall make a contribution for each shareholder and officer of 40 hours per week and 2080 hours per year.
3. Once a shareholder or officer is dropped by the Fund for any reason, including nonpayment, election out of coverage, dropping Union membership or otherwise, he or she will not be eligible to participate in the Health & Welfare Fund for a period of two years.
4. Excess contributions will be converted to a Supplemental Health Reimbursement Account for shareholders and officers in accordance with the normal rules applicable to Supplemental Health Reimbursement Accounts.

ACCUMULATION OF WORK CREDIT "RESERVE BANK" DOLLARS FOR ELIGIBILITY PURPOSES

The Trustees have from time to time adopted equitable rules which allow cumulative credit of employer contribution dollars in excess of the charge amounts required for Member and/or Dependent Coverage. Such excess work credit dollars are commonly referred to as a Member's individual "dollar bank" and are available any time to satisfy monthly eligibility requirements. If not totally applied for this purpose, certain excess dollar amounts may be available for use under the Supplemental Health Reimbursement Plan Account, subject to that Account's applicable provisions. (See Supplemental Health Reimbursement Account in this Summary.)

ELIGIBLE "DEPENDENT" DEFINED

For all purposes of the Benefit Plan the term "Dependent" includes:

1. The spouse of the Member;
2. Children of the Member less than 26 years of age; and
3. Any child of the Member, without age limit if the child is incapable of self-support because of mental retardation or physical incapacity that commenced prior to the time the child reached 26 years of age.

Please note that coverage stops for a spouse and/or dependent at the end of the month of divorce or legal separation from the Member.

As requested by the Administration Office Manager, you must furnish satisfactory proof of an existing legal marriage or the dependency of a claimed dependent child.

The Benefit Plan recognizes Qualified Medical Child Support Orders ("QMCSOs") and provides benefits for eligible Dependents, as determined by the order. A QMCSO is a court order or administrative order, which has the force of law pursuant to the state's administrative procedure, relating to child support that provides for a child's coverage under the Plan. Contact the Administrative office for more information.

Special Enrollment Periods

If you initially failed to enroll a dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents on this Plan if your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Further, two additional circumstances allow for a special enrollment opportunity as follows: (1) the employee or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or (2) the employee or dependent becomes eligible for a subsidy under Medicaid or CHIP. In either of these circumstances, the employee or dependent must request enrollment within 60 days after the employee or dependent is terminated from, or determined to be eligible for, such assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you fail to timely enroll a new dependent or provide evidence of a dependent's eligibility, coverage will begin on the first of the month following the completion of enrollment and will not be retroactive to the date of the birth, marriage, adoption or placement for adoption.

The Plan will not be responsible for any bills or charges incurred prior to the first of the month following completion of enrollment.

ELECTIVE RIGHTS FOR DEPENDENTS' COVERAGE

The Trustees permit you to make periodic elections to have your work credit dollars applied for Dependents' coverage. This feature of the Plan is governed by the following basic rules:

1. All initial and subsequent elections as to Coverage or Noncoverage for Dependents' benefits must be recorded over your signature on cards furnished by the Administration Office upon request. Elections when made are effective as of the start of the next Benefit Month;
2. Such elections apply to both the self-insured and insured benefits provided for either "single" or "family" units;
3. Work credit dollars are first applied to cover eligibility requirements for your benefits. You are not permitted to exclude yourself and have your work credit dollars applied only for Dependents' coverage;
4. If your card on file at the Administration Office reflects the fact that you are unmarried, your work credit dollars will only be applied for Members' benefits. When you become married, you must notify the Administration Office of your change in status and execute a card noting your desire to be covered for Dependents' benefits; and
5. If your card on file at the Administration Office reflects that you are married, your work credit dollars will be applied for Dependents' coverage unless you duly execute a card noting your desire not to be covered for Dependents' benefits.

TERMINATION OF ELIGIBILITY FOR BENEFITS

General: A Member's eligibility for personal and applicable Dependent's benefits will cease under the following conditions:

1. If you fail to satisfy the Eligibility Requirements established by the Board of Trustees;
2. If you are called into active service with the Armed Forces of the United States, your eligibility for benefits (except personal Loss of Life Benefits which are maintained at Fund expense) will cease, except to the extent provided by USERRA (see Military Service below); or
3. If you discontinue your membership in the Local Union. Any excess balance in the Supplemental Health Reimbursement Account (as hereinafter described), will be terminated and revert to the Fund; or
4. If you work for an employer not signed to the Collective Bargaining Agreement and remain working in the bricklaying and masonry industry. Any excess balance in the Supplemental Health Reimbursement Account (as hereinafter described), will be terminated and revert to the Fund; or
5. Your eligibility for Alternate Death Benefits (as hereinafter described) shall cease whenever you discontinue your membership in the Local Union.

Military Service: A Member who is called into active service with the Armed Forces of the United States has significant rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), including the right to have continued coverage for Members and beneficiaries in certain cases. Please advise the Fund's Administration Office immediately upon entering into service with the Armed Forces so all your rights and benefits are protected as provided by law.

REINSTATEMENT TO ELIGIBILITY FOR BENEFITS

1. **General**: If your coverage for benefits is terminated, you will be reinstated to coverage when you satisfy the Eligibility Requirements then in effect.

2. **Following Discharge from the Armed Forces:** If you duly notify the Administration Office and commence work for a participating Employer following your discharge from the Armed Forces of the United States, you shall be given full credit for all unapplied work credit dollars reflected on your Administration Office record prior to your entry into the service. Such credit dollars, like "reserve bank" dollars, are available to satisfy eligibility requirements beginning as of the next Benefit Month.

PERMISSIVE SELF-PAY CONTRIBUTIONS TO MAINTAIN CONTINUING ELIGIBILITY FOR FUND BENEFITS

The 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 as follows:

1. The Administration Office Manager will reasonably and fairly determine whether you should be considered to be "active" and qualified for self-pay privileges;

2. In advance of each monthly benefit period the Administration Office Manager, following review of the Administration Office records, will mail you a notice, letter advising of the amount of employer contribution dollars credited to your account, and the date by which the dollar deficiency must be paid to continue benefit coverage, as elected;

3. All self-payments must be made by either check or money order. An appropriate receipt for any self-payment in whatever form will be issued by the Administration Office and duly recorded in its records; and

4. If you fail to exercise your self-pay privilege in accordance with a Notice letter, you can only reestablish eligibility for Fund benefits by accumulation of sufficient work credit dollars in a subsequent monthly period.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), provides that employees and their families who currently have group health coverage under a group health plan are to be given the opportunity to continue their group health cover age (called "Continuation Coverage") at group rates in certain instances where coverage under the group health plan would otherwise end (called "Qualifying Events"). See APPENDIX 2 for the current

Plan rules and procedures for COBRA. For Members, Continuation Coverage is an alternative to the Fund's current self-pay rules. For spouses and dependents, Continuation Coverage provides an opportunity to continue health coverage (when the Member does not elect Continuation Coverage for the spouse or dependent).

1. **Availability:** Continuation Coverage is available to "qualified beneficiaries" who have a Qualifying Event. A "qualified beneficiary" is a Member, a Member's spouse or a Member's child who, on the day before the Qualifying Event, has group health coverage under the Fund. A "Qualifying Event" occurs (i) when a Member completes a work crediting month with insufficient dollars credited to his account to continue his single or family coverage (whichever applies) for another month; (ii) when a Member or former Member dies and a loss of coverage results for his spouse and/or dependents; (iii) when a former Member becomes entitled to Medicare and a loss of coverage results for his spouse and/or dependents; (iv) when a Member or former Member divorces or obtains a legal separation and a loss of coverage results for his spouse and/or dependents and (v) when a dependent child of a Member or former Member ceases to qualify as a dependent under the Fund's rules and a loss of coverage results for the dependent;

2. **Notice:** A spouse or dependent who loses group health coverage as a result of a Member's or former Member's divorce or legal separation or a dependent child ceasing to qualify as a dependent [Events (iv) and (v)] has an obligation to notify the Fund of the loss of coverage within sixty days of the date coverage is lost. If notice is not timely given, the Fund has no obligation to permit the spouse or dependent to elect Continuation Coverage. Once the Fund determines that a Qualifying Event has occurred or in the case of divorce or a dependent ceasing to qualify as a dependent, the Fund receives timely notice from the spouse or dependent, each qualified beneficiary who loses coverage on account of the Qualifying Event will be sent a notice letter and form for electing Continuation Coverage The notice letter and form to a Member will also discuss and provide for a Member's election to self-pay. A separate mailing will be made to each residence at which an adult qualified beneficiary resides;

3. **Election:** A qualified beneficiary has sixty days from the later of the date of the notice letter or the date he or she loses coverage to elect Continuation Coverage. The letter and election form will state the date that the form must be completed and returned to the Fund in order to elect Continuation Coverage. If returned by mail, the election form must be postmarked before the sixty-day period ends. A qualified beneficiary's right to elect Continuation Coverage will expire if the qualified beneficiary fails to elect Continuation Coverage by completing and returning the election form by the date stated therein. The notice letter and form will also state the date the form must be completed and returned to the Fund in order to self-pay;

4. **Cost:** The notice letter and election form will state the cost of the Continuation Coverage, which is 102% of the Plan's cost for such coverage. If a qualified beneficiary elects Continuation Coverage, the first premium is due by the first day of the month next following the election. However, make-up premiums for any pre-election period of Continuation Coverage are due within 45 days of the election date. Thereafter, premiums for any month are due on or before the first day of the month. You will not be billed for Continuation Coverage; it is your obligation to pay the applicable premium on time. The necessary payments must be made either by check or money order (payable to Bricklayers' No. 5 Funds) and must be mailed or delivered

to the Administration Office. Employer contribution dollars credited to a Member's account will not be used to pay Continuation Coverage premiums; and

5. **Length of Coverage:** If a qualified beneficiary elects Continuation Coverage, the Continuation Coverage period terminates either 18 months after a loss of coverage resulting from insufficient dollars or 36 months for all other Qualifying Events after the event that caused loss of coverage. Continuation Coverage, however, will terminate sooner if the applicable premium is not paid on a timely basis (a "Grace Period" of no more than 30 days will apply to late payment of the monthly premiums), if the qualified beneficiary becomes entitled to Medicare, or if the qualified beneficiary becomes covered under a single-employer or multi-employer group health plan (as an employee or otherwise). Approximately 30 days before the Continuation Coverage ends, a short notice will be sent to each qualified beneficiary informing him when the Continuation Coverage ends and of any conversion privilege available from the Fund's group health insurer.

THE PROCESSING AND PAYMENT OF CLAIMS

1. The Claims Procedure is set forth in Appendix 8.

2. **Medical Mutual Claims:** Medical Mutual payments are made directly to your hospital for all services to which you are entitled under the Fund's Plan provided that you receive services in a contracting hospital. Medical Mutual claim procedures require that your doctor complete a form describing his professional services.

2. **General Claims which are Self-Insured by the Fund:** Claim forms may be obtained from the Administration Office by either telephone or letter request and will be mailed to your home with a letter of instructions.

   Your claim will be paid by the Administration Office, the check being made to the Member, or Provider, dependent on the claimant. In all instances, you will receive an explanatory letter detailing the nature and extent of the benefits being allowed or denied.

3. **Self-Insured Death Claims:** In case of your death, your surviving spouse or next of kin should notify the Administration Office and forward a copy of the Death Certificate. The Administration Office will advise as to any further details, and payment of the applicable death benefits will be made to your designated beneficiary.

No action at law or equity based on an adverse determination under the Plan shall be brought after the expiration of three (3) years from the date of the final appeal denial. You may only bring an action in connection with the Plan in the United States District Court for the Northern District of Ohio.

Subrogation, Reimbursement, and Assignment

Subrogation and reimbursement allow the Plan to recoup the value of any benefits (medical, disability, Rx, etc.) paid on behalf of a participant covered by this Plan who is injured, suffers an illness or condition to which the claims relate through the actions or omissions of a

person or entity accountable for the injury or illness or condition to which the claims relate (hereinafter called an "Accountable Person"). The subrogation and reimbursement process helps the overall financial stability of the Plan by ensuring the Plan is not the only entity paying for illness and injuries caused by an Accountable Person.

a. Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the Claimant may have against any Accountable Person, whether by suit, settlement, or otherwise, who may be liable for a Claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the Claimant's behalf, regardless of whether liability is admitted or contested.

Payment of benefits is conditional upon the Claimant's written agreement to fully cooperate and reimburse the Plan for any benefits paid should the Claimant recover monies or damages, or be compensated for the illness or injury from the Accountable Person or any other source.

b. Subrogation and Reimbursement Forms

The Claimant must sign forms assigning subrogation and reimbursement rights to the Plan. The Plan administrator may withhold payment of any benefits due under the Plan if the forms are not executed by the Claimant or if the forms are modified in any way by the Claimant without the consent of the Plan. If the Claimant is a minor or is incompetent to execute the forms, the Claimant's parent, spouse or legal representative must execute the forms upon the request of the Plan administrator.

Payment of Plan benefits before the signed forms are received does not modify or invalidate the Plan's subrogation and reimbursement rights. By accepting benefits from the Plan, every Claimant shall be deemed to have conclusively agreed to cooperate with the Plan to enforce its subrogation and reimbursement rights, and to hold any recovery in trust for benefit of the Plan. The Plan's subrogation and reimbursement rights shall apply regardless of whether the Claimant executes the forms.

c. Rights to Reimbursement with Source of Funds Specifically Identified

In situations where an Accountable Person is liable, the Claimant must reimburse the Plan the full value of the claims paid in connection with the illness or injury, but only to the extent he or she recovers settlement, judgment or insurance proceeds (from any source) connected with the illness or injury. A source includes, but is not limited to, an Accountable Person and/or an Accountable Person's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by the Claimant, and organization, corporation, or government agency.

The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise even though the Claimant may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a

Claimant to be "made whole" before the Plan is entitled to assert its subrogation rights. Even though the subrogation rights of the Plan are specifically unequivocally due from the first dollar received by the Claimant or beneficiary, the Plan reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the Plan has the right to recover from the first dollar received, the Trustees may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the Claimant, in the sole discretion of the Trustees.

The Plan's rights also apply to any recovery made by a Claimant regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

d. Equitable Lien by Agreement

Once the Plan makes or is obligated to make payments on behalf of a Claimant, the Plan is granted, and the Claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the Claimant or beneficiary from any source to the extent of payments made or to be made by the Plan on the Claimant's behalf.

e. Claimant Must Set Aside Funds

The Claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Claimant shall reimburse the Plan immediately upon recovery.

f. Claimant's Duty to Reimburse

The Claimant shall immediately notify the Plan if he or she is involved in or suffers an illness or injury for which an Accountable Person may be liable. The Claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an illness or injury for which the Plan may make payments on the Claimant's behalf. The Claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement.

g. Reduction of Future Benefits

The Claimant has the responsibility to seek damages for future accident-related benefit expenses. The Plan has the discretion to take into consideration future accident-related medical expenses in negotiating a settlement. The Plan may settle all accident-related claims (past, present and future) in full (meaning that upon settlement, the Plan shall not be responsible for any further accident-related benefit expenses). The Plan reserves the right to deny future accident-related care with the understanding that the Claimant shall be responsible for any future accident-related claims, as those benefits should be paid directly from the Claimant's settlement proceeds.

h. Disavowal of Common Law Defenses

The Plan specifically disavows any claims that a Claimant may make under any federal or state common law defense, including, but not limited to, the common fund doctrine, the double-recovery rule, the make-whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. The Plan further asserts that the "Common Fund" doctrine does not apply to any proceeds recovered by an attorney the Claimant or the Claimant's dependents may hire regardless of whether proceeds recovered are used to repay the benefits paid by the Plan.

The Claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, illness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

i. Enforcement of Rights

The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests through any appropriate legal or equitable remedy. These remedies include, but are not limited to, the initiation of a cause of action under ERISA section 502(a)(3), the initiation of an injunctive action to ensure the claim payment amounts that the Plan has advanced are preserved and not disbursed, or any other actions under applicable federal or state law and the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any source, whether through settlement, judgment or otherwise. Enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after the Claimant receives them. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

j. Cooperation

The Claimant and his or her legal representatives must do whatever is necessary to enable the Plan administrator to exercise the Plan's rights and must do nothing to prejudice the Plan's rights. The Plan administrator may require the Claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a reimbursement agreement.

The Claimant shall assist and cooperate with representatives the Plan designates. The Claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement rights. The Claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

In the event a Claimant fails to reimburse the Plan the full value of its subrogated interest or otherwise fails to cooperate, the Plan shall be entitled to recover the Claimant's debt to the Plan in accordance with Plan rules for recovery and overpayments. This means that the Plan may, among other things, suspend all benefit payments due to a Claimant and deduct the amount

of the subrogated interest from future benefit payments or to apply employer contributions made to the Claimant's behalf against the amount owed to the Plan.

k. Anti-Assignment

You cannot assign your right to receive payment for benefits under the Plan to anyone else, including your health care provider. The Plan will not honor an assignment of your claim to anyone. When this occurs, you must pay the provider and the Plan is not obligated to pay additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone to receive your payment for you, including your provider. We will not honor an assignment of your claim to anyone. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to initiate a court proceeding. Nothing contained in the written description of the Plan's medical coverage shall be construed to make the Plan liable to any third-party to whom a participant may be liable for medical care, treatment, or services.

For example: After receiving treatment from an out-of-network physician, the out-of-network physician asks Joe to sign a form assigning his right to reimbursement for the claim under the Plan to the physician. This assignment has no effect due to the Plan's anti-assignment provision. The Plan will not honor the assignment of Joe's claim to the physician. If Joe receives reimbursement directly from the Plan for services rendered by the physician, Joe is responsible for paying the physician directly.

COVID-19 Emergency Extension of Certain Deadlines

This Subsection addresses the following deadlines:

- Deadlines to elect COBRA coverage, make COBRA premium payments, and notify the Plan of a qualifying event or determination of a disability;
- Deadline for Special Enrollment; and
- Deadline for Claims and Appeals.

Effective March 1, 2020, when determining the deadlines listed in the preceding paragraph, the Plan will disregard the period beginning March 1, 2020 and ending on the earlier of:

- One year from the date the deadline would have been under normal, non-emergency COBRA procedures; and
- The date that is 60 days after the announced end of the "National Emergency" or such other date announced by the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service, and Department of the Treasury.

"National Emergency" refers to the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and the determination, under

the Robert T. Stafford Disaster Relief and Emergency Assistance Act, that a national emergency exists beginning March 1, 2020, which the President issued on March 13, 2020.

SUMMARY OF FUND BENEFITS

I. Benefits Available to both Members and Dependents:

II. Benefit Available to Former Benevolent Association Members:

III. Members' Benefits Exclusively For:

(A) Eligible Members:

$75.00 per week for 13 weeks Page 26

(B) Alternate Members:

Death Benefit (Self-Insured)
$2,500.00 maximum Page 26

Medicare Supplement Benefit for Social Security Disability (Self-Insured)
$400.00 maximum Page 26

DESCRIPTION OF FUND BENEFITS

Benefits Available to Members and Dependents

Effective January 1, 2023

Option 1 – Buy-Up Plan.

Deductible: **$250**/single, **$500**/family (Network)
$500/single, **$1,000**/family (Non-Network)

Out-of-pocket limit: **$2,500**/single, **$5,000**/family (Network)
Unlimited/single, **Unlimited**/family (Non-Network)

To be eligible, a Member must have the required hours. For 2023, the hours needed to elect this plan will be **ninety-five (95)** for single coverage and **one hundred forty-six (146)** for family coverage. For those Members who wish to remain in the Buy-Up Plan (and have the required hour bank), they will be asked to elect/enroll during the "election period" (by or before October 15). The Trustees reserve the right to change the hour requirements.

Option 2 – Core Plan.

Deductible: **$750**/single, **$1,500**/family (Network)
$1,500/single, **$3,000**/family (Non-Network)

Out-of-pocket limit: **$3,000**/single, **$6,000**/family (Network)
Unlimited/single, **Unlimited**/family (Non-Network)

To be eligible, a Member must have the required hours. For 2023, the hours needed to elect this plan will be **eighty-four** (**84)** for single coverage and **one hundred thirty (130)** for family coverage. For those Members who wish to remain in this plan (and have the required hour bank), they will automatically be enrolled in the Core Plan. A member will not need to complete an enrollment form. The Trustees reserve the right to change the hour requirements. The Urgent Care co-pay will be $55 and the prescription drug plan for the Core Plan will include a 3rd tier copay for Brand, Non-Formulary Drugs, as shown below.

	Buy-Up Plan	**Core Plan**
Generic Copay	$10 Retail / $20 Mail Order	$10 Retail / $20 Mail Order
Brand (Formulary)	$40 Retail / $80 Mail Order	$40 Retail / $80 Mail Order
Brand (Non-Formulary)	$40 Retail /$80 Mail Order	$60 Retail / $120 Mail Order

Note: Mail Order is a 90-day supply.

Important additional information about the benefits:

- The In-Network Calendar Year Annual Deductible includes only charges applied to the coinsurance amount payable by the member.
- The Out-of-Network Calendar Year Annual Deductible includes only charges applied to the coinsurance amount payable by the member.
- Neither pharmacy copayments nor coinsurance payments for Out-of-Network providers apply to the In-Network Calendar Year Annual Out-of-Pocket Limit.
- In-Network covered services are subject to a 20% coinsurance, except as follows:
    - Covered preventive benefits and organ transplant services are covered at 100%; and
    - The following services, when rendered by an In-Network Provider, require a copayment for each visit or confinement, as specified:
        - Emergency Room services for an Emergency Medical Condition - $250 copayment;
        - Office visit - $35 copayment;
        - Outpatient Specialist visit - $55 copayment; and
        - Urgent Care visit - $35 copayment.
- A Retail Prescription Drug copayment for a Brand Name Drug with a Generic equivalent is the stated copay plus the difference in cost between the Brand Name and Generic.
- A Mail Order Prescription Drug copayment for a Brand Name Drug with a Generic equivalent is the stated copay plus the difference in cost between the Brand Name and Generic.
- Effective December 26, 2020 through the end of the Public Health Emergency, the Plan will waive cost-sharing for any FDA-authorized or FDA-approved COVID-19 vaccine, including the administration of any such vaccine by a Network or Non-Network Provider. The Plan will pay Non-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.
- Effective after the Public Health Emergency ends, the Plan will cover any FDA-authorized or FDA-approved COVID-19 vaccination as a Preventive Service.
- Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the Plan will waive cost sharing for the following services:

- Diagnostic tests to detect the virus that causes COVID-19 that are approved or authorized by the FDA, including the administration of such tests; and
- Items and services furnished to individuals during provider office visits (whether in person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

- Effective June 1, 2020, the Plan will waive cost sharing for **Express Care Online**; the Plan will not cover any telemedicine except for services provided through **Express Care Online**.

Medical Mutual Hospital and Medical Services

The comprehensive in-patient, out-patient and emergency service Hospital Care Benefits provided at Fund expense for eligible Members and their dependents are encompassed by an administrative services Contract with Medical Mutual.

Similarly, the Medical Mutual medical, surgical, obstetrical, and diagnostic services rendered by physicians to eligible Members and their dependents, as well as other related benefits, are provided under the Contract with Medical Mutual.

The Plan self-insures these benefits. Medical Mutual processes and pays the claims consistent with the terms of the Plan and the certificate of coverage issued by Medical Mutual.

The scope and extent of benefits available to eligible Members of the Fund (and eligible members of their families) are explained in detail in the Medical Mutual certificate of coverage (and updates) distributed from time to time to all Fund Members.

Specific benefit coverage and exclusions are set forth in the certificate which Medical Mutual will provide you. The certificate describes limits on benefits, coverage of preventive services, medical tests, devices, and procedures, and when preauthorization or utilization review are required. The certificate is incorporated into this Summary Plan Description by reference. If you need another copy, contact the Fund or Medical Mutual. Advance notification is required for all elective in-patient hospital admissions, and notification is required within one business day for all emergency admissions.

Any questions you may have relating to your Medical Mutual coverage which is not answered by reference to the Medical Mutual certificate should be directed to Medical Mutual customer service.

Gene Therapy

The Health and Welfare Plan will not cover gene therapy or any drugs, procedures, or health care services related to it that introduce, or is related to the introduction of, genetic material into a person intended to replace or correct faulty or missing genetic material.

Charges Incurred by Surrogate Mother

Charges incurred by a covered person acting as a surrogate mother are not covered under the Plan. This includes but is not limited to any and all charges incurred by the surrogate mother

for prenatal care and delivery of the child and any charges incurred by the child born to the surrogate mother unless and until the Plan is otherwise required to provide coverage for the child because the child is a Dependent as defined by the Plan. For the purpose of this Plan, a "surrogate mother" is defined as a person who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party. All expenses paid by the Plan in such cases may be recovered from the Participant, the Participant's spouse, and/or the third party or any related parties. Care, services, or treatments required as a result of complications from a surrogate pregnancy by the Participant or Participant's spouse will not be covered under the Plan.

Medical Mutual Annual Dental Care Benefits

The dental care coverage will be granted on a calendar year basis for any covered dental services rendered to you or your dependents up to a maximum of $800.00 per year for each covered person.

The Medical Mutual Dental certificate of coverage more fully explains your dental coverage and is incorporated into this Summary Plan Description by reference. Any questions you may have relating to your Medical Mutual coverage which is not answered by reference to the Medical Mutual Dental certificate should be directed to Medical Mutual customer service.

Sav-Rx Prescription Services Benefits

Benefits are provided for medically necessary prescription drugs that are prescribed by a physician. Long-term maintenance prescriptions must be filled through the Sav-rx mail order service. The benefits are explained in detail in the Sav-rx Prescription Drug pamphlet available through the Fund Administration Office. This pamphlet more fully describes your prescription services benefits and is incorporated into this Summary Plan Description by reference. Any questions you may have relating to your prescription coverage should be directed to Sav-rx customer service.

Paladina (now Everside) Health Primary Care

Members and their dependents have the voluntary option to select Paladina (now Everside) Health as their Primary Care Provider. Everside Health operates a Direct Primary Care service to members who enroll to receive healthcare services at the private medical clinics established in the local community. Services provided include acute healthcare, preventive health care, health education, health counselling, and telemedicine.

Generally, services received at Everside are at no cost to the member and are paid for by the Fund directly.

In order to receive care from Everside, Members and Dependents must opt-in to the program. You may enroll by contacting the Fund Administration office, or Everside.

You will be disenrolled in the program if, over a nine-month period, you do not receive any care from Everside. If you are disenrolled, you will need to reenroll in order to participate in this program and receive care through Everside.

Benefit Available to Former Benevolent Association Members

The principal sum of $400.00 is payable in the event of your death from any cause or at any time or place providing you were a member of the Cleveland Bricklayers Benevolent Association on September 30, 2010 and listed on the October 1, 2010 Appendix on file in the Administration Office file.

Benefits Available to Eligible Members Only

Supplemental Health Reimbursement Account (SHRA)

Participants will be able to use their excess employer contribution dollars as a Supplemental Health Reimbursement Account (SHRA). The SHRA may be used for many out-of-pocket health care expenses that are not covered by the Fund's regular health insurance. Participants must have a minimum of six months of coverage banked before they are eligible to use their SHRA. The dollar amount in excess of this six-month minimum level will be available to them for their SHRA. Detailed claim filing instructions and forms are available through the Fund Administration office.

Active participants will receive annual statements of their dollar bank that will show monthly contributions, monthly deductions for Health and Welfare Benefit Plan coverage, and any monthly deductions made from their SHRA. These annual statements will be mailed by May 15th each year. Participants are encouraged to review these statements for accuracy and to monitor their employers' reporting. Additionally, current activity statements of the dollar bank and SHRA will be available during the year upon request of the participant. The participant should contact the Administration Fund Office to obtain a current activity statement.

Option to Terminate Coverage When Covered by Medicare (SHRA)

A retired member who is covered by Medicare has the option to terminate your coverage under the Health and Welfare Plan's group insurance and purchase a Medicare supplemental policy through an insurance company of your choice. An election form to terminate your coverage must be completed and filed with the Fund Administration Office. Furthermore, the retired member may submit the premiums paid for their Medicare supplemental policy to the Health & Welfare Fund for reimbursement from the member's SHRA. The necessary election form and reimbursement claim forms are available through the Fund Administration Office.

Electing to terminate your group insurance will also terminate the coverage of your dependents. However, your dependents may be eligible for continuation of their group health insurance through COBRA.

Loss of Life Benefits (SHRA)

In the event of your death from any cause or at any time or place, the dollar amount balance in your SHRA may only be used to continue the group health benefit coverage of your dependents that were covered by the Health and Welfare Plan at the time of your death.

Loss of Life Benefits

Life Insurance

A Death Benefit provided through life insurance in the principal sum of $20,000.00 is payable in the event of your death from any cause of death for:

1. Active Eligible Members, and
2. Retirees who were Active Eligible Members when they retired and who remain Members in good standing with the Union and die on or before the fourth anniversary on which the Member's retirement benefit commenced.

Only the Non-Occupational Accidental Death and Dismemberment Benefit is payable in addition to this Death Benefit provided through life insurance.

Payment will be made in a lump sum to your designated beneficiary. In any case where it is impossible for the Administration Office to make payment of Death Benefits to a beneficiary designated by you, payment will be made to the administrator or executor of your estate.

Eligible Member's Loss of Life Benefit

A Death Benefit in the principal sum of $4,000.00 is payable in the event of your death from any cause or at any time or place while you are an Eligible Member. This Death Benefit is not payable if you are eligible for the $20,000.00 Life Insurance Benefit. Payment of the Death Benefit will be made in a lump sum to your beneficiary.

In any case where it is impossible for the Administration Office to make payment of the Death Benefit to a beneficiary designated by you, payment will be made to the administrator or executor of your estate.

Non-Occupational Accidental Death and Dismemberment Benefits

These Benefits are payable to you for injuries or death resulting from accidents occurring while off-the-job. Injuries, fatal or otherwise, which are compensable under any Workmen's Compensation Act are not covered.

The full principal sum ($4,000.00) to which you are entitled will be paid for the accidental loss of:

Life
Both hands
Both feet
Sight of both eyes
One hand and sight of one eye
One foot and sight of one eye
One hand and one foot

One-half of the principal sum ($2,000.00) will be paid for the accidental loss of one hand, one foot or the sight of one eye.

The Accidental Death Benefit is payable in addition to Eligible Loss of Life Death Benefit.

Non-Occupational Accident and Sickness Disability Benefits

The Benefit Plan provides a $125.00 weekly benefit if you become totally disabled and are unable to work as the result of a non-occupational accident or sickness. This benefit is payable as of the first day of disability and will be continued for the maximum period of 13 weeks for any one period of disability.

Your inability to work must be supported by the written statement of your attending physician. The Trustees reserve the right to request additional information or documentation regarding the accident or sickness before approving the disability benefit.

If you suffer successive periods of disability, they will be considered separate periods with respect to the maximum 13 weeks' allowance:

1. If the disability periods are unrelated and separated by any period of active work; and
2. If the disability periods are related and separated by at least two weeks of active work. Active work is 8 hours per day and 40 hours per week for a total of 80 hours of work.

Occupational Weekly Disability Benefits

The Benefit Plan supplements Workers' Compensation benefits by allowance of $75.00 per week disability benefits for a maximum of 13 weeks.

Benefits Available to Alternate Members

1. **Definition:** To qualify as an "Alternate Member" of the Fund, a bricklayer or mason must satisfy the following prerequisites at the time his claim accrues:
   (a) Current Membership in the Local Union;
   (b) Inability to satisfy the general Eligibility Requirements then in effect; and
   (c) Sufficient past years' Membership in the Local Union, as an employee, to be eligible for the Alternate Benefits provided.

   2. **Alternate Death Benefit:** This benefit is paid in a lump sum to the designated beneficiary of an eligible Alternate Member on a graduated basis depending upon the decedent's number of years' Membership in the Local Union. The amount varies from $125.00 for one year's membership to $2,500.00 for 25 or more years Membership. This Death Benefit is not payable if you are eligible for the $20,000.00 Life Insurance Benefit.

3. **Medicare Benefit for Social Security Disability:** A benefit is available to members under age 65 who are receiving a Social Security Disability and covered by Medicare. A reimbursement for the premiums actually paid by the member for

a Medicare Supplemental insurance policy up to $400.00 per month provided the following criteria is met:

(a) You received Health and Welfare contributions for at least 60 months immediately prior to your disabling event;
(b) You are paying for a Medicare Supplemental insurance policy; and
(c) You are under age 65. (At age 65 this benefit is no longer available)

LOSS OF BENEFITS

There are several ways that you may lose or become ineligible for part or all of benefits anticipated under the Plan.

1. You fail to file a Claim Form;
2. You fail to show proof of illness, injury or disability;
3. You fail to notify the Administration Office when you work outside its jurisdiction;
4. You fail to preserve adequate and complete records of your work at the trade;
5. You fail to notify the Administration Office that your current employer may not be making required contributions on your behalf to the Administration Office;
6. You fail to make timely self-pay contributions;
7. You fail to appeal timely a denied benefit claim;
8. You fail to notify the Administration Office of a change in marital status or number of your dependents;
9. You transfer from the Local Union or from active employment at the trade;
10. You failed to be an active member in good standing with the Local Union; and
11. Concerning the primary care benefits provided by Paladina (Everside) Health, you fail to enroll in the program; additionally, you will be disenrolled in the program if you do not receive care from Paladina (Everside) Health over a nine-month period.

DISCRETIONARY AUTHORITY

The Board of Trustees shall have all such powers as may be necessary to discharge its duties relative to the administration of the Fund, including, by way of illustration and not limitation, discretionary authority to interpret and construe the terms and conditions of the Fund, to determine and decide all questions of fact and all disputes arising under the Fund including, but not limited to, the eligibility of any Member to participate hereunder and the right of any Member or beneficiary to receive benefits hereunder.

FINAL COMMENT

This Summary describes and explains the basic and essential features of the Fund's current Benefit Plan. However, it should not be regarded as a complete restatement of all the

Fund's Rules and Regulations. Consequently, you should not hesitate to contact the Administration Office regarding any aspect of the Benefit Plan or the Fund's administrative practices. It is the earnest desire of the Trustees and the Administration Office to serve your interests and your cooperation is deeply appreciated.

We again urge that you do not hesitate to contact the Administration Office for additional information and guidance, and also appreciate the following basic concepts:

1. The Fund does not confer on a Member employee the right to continue in the employ of any employer or affect his Local Union membership rights and responsibilities; and
2. No employee participating in the Fund has a right to receive any part of the employer contributions to the Fund except in the form of Fund benefits or to receive cash payments instead of required employer contributions to the Fund.

Appendix 1

ERISA RIGHTS STATEMENT

As a participant in Bricklayers and Masons' Local Union No. 5, Ohio Health & Welfare Fund (the "Fund") you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Fund participants shall be entitled to:

Examine, without charge, at the Fund Administration Office, or other specified location in Bricklayers Hall, 9525 Sweet Valley Drive, Valley View, Ohio 44125, all Fund documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Fund with the U.S. Department of Labor, such as the detailed annual reports and summary plan description.

Obtain certain copies of all Fund documents and other benefit plan information upon written request to the Administration Office. The Administration Office may make a reasonable charge for the copies.

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

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund and its employee benefit plan. The people who operate your Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Fund participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund 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 Trustees 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 Trustees. 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. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file 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, for example, if it finds your claim is frivolous. If you have any questions about your Fund, you should contact the Administration Office Manager or a member of the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of labor
200 Constitution Avenue, NW
Washington, DC 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.

Appendix 2

VERY IMPORTANT COBRA NOTICE REGARDING CONTINUATION OF GROUP HEALTH INSURANCE

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Fund. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Fund and under federal law, you should review the remainder of the Fund's Summary Plan Description or contact the Fund Office.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Fund coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Fund because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

The child stops being eligible for coverage under the Fund as a "dependent child.

"**When is COBRA continuation coverage available?**
The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. The employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to: Plan Administrator.

How is COBRA continuation coverage provided?
Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may

elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Fund is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Fund as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my Fund coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- The month after your employment ends; or

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Fund may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning the Fund or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Fund informed of address changes
To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Plan Administrator
Bricklayers and Masons' Local Union No. 5
Ohio Health & Welfare Fund
9525 Sweet Valley Drive
Valley View, OH 44125
Telephone: (216) 520-1644

However, COBRA also provides that your continuation coverage may be cut short for any of the following five reasons:

1. The Plan no longer provides group health coverage to any of the Members;

2. The premium for your continuation coverage is not timely paid (for this purpose, payment is timely if made within 30 days after the premium due date);

3. You or the family member become covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition you or the family member may have or is prohibited from enforcing the exclusion or limitation;

4. You or the family member become entitled to Medicare; or

5. The family member's coverage was extended to 29 months due to disability and there has been a final determination that you or he or she is no longer disabled. In such cases, continuation coverage will end on the first day of the month that begins more than 30 days after the date of the final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. COBRA also states that, at the end of the 18-month or three-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the Plan.

Appendix 3

IMPORTANT NOTICE REGARDING
Rights Under the Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Appendix 4

IMPORTANT NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed.

2. Surgery and reconstruction of the other breast to present a symmetrical appearance.

3. Prostheses and treatment of physical complications at all stages of the mastectomy procedure, including lymphedemas (swelling of the hand and arm on the operated side).

If you have any questions about this or other healthcare benefits, please contact the Fund's Office or call the Medical Mutual Customer Service number listed on your identification card.

Appendix 5

IMPORTANT NOTICE REGARDING MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Gender Affirming Surgery

The Plan, through Medical Mutual, will cover Medically Necessary services for gender affirming Surgery, subject to accepted medical clinical guidelines and corporate medical policies.

Autism Spectrum Disorders

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders.

Covered Services include:

- Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist.
- Clinical therapeutic intervention which includes, but is not limited to, applied behavior analysis. The intervention must be provided by, or be under the supervision of, a Professional who is licensed, certified, or registered by an appropriate state agency to perform such services in accordance with a treatment plan.
- Mental/behavioral health Outpatient services performed by a licensed Psychologist, psychiatrist, or Physician providing consultation, assessment, development, or oversight treatment plans
- Prescription Drugs.

Treatment for autism spectrum disorders means evidence-based care and related equipment prescribed or ordered for a Covered Person diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary.

All Covered Services must be prescribed or ordered by either a developmental pediatrician or a Psychologist trained in autism spectrum disorders and require Preauthorization.

"Medically Necessary" or **"Medical Necessity"** means a covered service, supply, and/or Prescription Drug that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational; and
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

Appendix 6
NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND YOUR COVERED DEPENDENTS MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Effective Date: The effective date of this Notice is January 1, 2023.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Official, Bricklayers and Masons' Local Union No. 5, Ohio Health & Welfare Fund, 9525 Sweet Valley Drive, Valley View, Ohio 44125, or calling (216) 520-1644.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

We will not use or disclose psychotherapy notes about you from your therapist without your written permission. However, we may use and disclose such notes when needed to defend against litigation filed by you.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many

conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

For Information on or to Exercise Your Individual Privacy Rights

For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
Bricklayers and Masons' Local Union No. 5, Ohio Health & Welfare Fund
9525 Sweet Valley Drive
Valley View, Ohio 44125
Telephone: (216) 520-1644

Appendix 7
NO SURPRISES ACT
(Effective March 1, 2022)

I. Network Cost Sharing for Non-Network Services

You may only be responsible for Network Cost Sharing for certain services, even if a Non-Network Provider provided those services.

"**Network Cost Sharing**" means:

- The amount you pay out-of-pocket (including amounts paid toward the Deductible, Coinsurance payments, and Copayments) will not be more than it would be if a Network Provider provided the services. In addition, the Plan will apply the amount you pay for the services to your Network Deductible and Network Out-of-Pocket Maximum in the same manner it would apply the amount you would have paid if a Network Provider provided those services.

"Qualifying Payment Amount ("QPA") means:

- QPA is used to calculate your Network Cost Sharing for items and services covered by the balance-billing protections of the No Surprises Act. In general, your Network Cost Sharing for emergency items and services, air ambulance services, and non-emergency items and services furnished by Non-Network providers in a Network facility, will be the lesser of the billed charges or the QPA.

II. Surprise Billing Situations

You will only be responsible for Network Cost Sharing for Surprise Billing Situations.

"**Surprise Billing Situation**" refers to:

- Non-Network Emergency Care;
- Non-Network air ambulance services; and
- Non-Network Non-Emergency Care at a Network Facility where there is no Notice and Consent. However, Ancillary Services are not subject to balance billing even in the absence of Notice and Consent.

"Ancillary Services" mean the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and

- Items and services provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

"**Emergency Care**" means:

- Services in an emergency department of a hospital or an independent freestanding emergency department as well as post-stabilization services in certain instances. The Plan will not require prior authorization for Emergency Care in an emergency department of a hospital or an independent freestanding emergency department. The Plan will not impose any administrative requirement or limitation on Non-Network Emergency Care that is more restrictive than for Network Emergency Care.

"**Notice and Consent**" means that:

- 72 hours before providing the services, the Provider sent you (through postal mail or email) notice of its network status and an estimate of charges; and
- You consented in writing to receiving Non-Network services.

III. **Continuing Care Patients**

If, while you are a Network Provider's Continuing Care Patient, the Provider's Network status changes (for example, the Provider no longer participates in the Plan's Network), you will only be responsible for Network Cost Sharing for that Provider's services (if those services are related to the reason you are classified as a Continuing Care Patient) for the period ending on the earlier of:

- The 90-day period beginning on the date the Provider's network status changed; or
- The date on which you are no longer a Continuing Care Patient.

A "**Continuing Care Patient**" is, with respect to a Provider:

- Undergoing treatment for a Serious and Complex Condition;
- Undergoing institutional or inpatient care;
- Scheduled to undergo nonelective surgery, including postoperative care;
- Pregnant and undergoing pregnancy treatment; or
- Terminally ill (as defined by the Social Security Act) and receiving treatment for such illness.

A "**Serious and Complex Condition**" is:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that—
    - Is life-threatening, degenerative, potentially disabling, or congenital; and
    - Requires specialized medical care over a prolonged period of time.

IV. Plan Payment of No Surprises Act Claims

When the Plan receives a "clean claim" which generally means receipt of the information needed to decide a claim for payment for services by a Non-Network provider or facility, the Plan will send an initial payment or a notice of denial of payment not later than thirty (30) calendar days after the Non-Network provider or facility submits a bill related to items and services that fall within the scope of the No Surprises Act balance billing protections.

V. Provider Directory Information

The Plan will verify and update the provider directory information included on its public website database (or the website of Medical Mutual) that contains a list of each health care provider and health care facility with which the Plan has a direct or indirect contractual relationship for furnishing items and services under the Plan. The Plan will provide for the removal of such a provider or facility when it has been unable to verify information during a period specified by the Plan. Notification will be provided that the information contained in the directory was accurate as of the date of publication of such directory and that an individual enrolled under the Plan should consult the database or contact the Plan to obtain the most current provider directory information.

In the case of an individual enrolled under the Plan who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under the Plan, the Plan will follow a protocol under which, in the case such request is made through a telephone call— (A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and (B) retains such communication in such individual's file for at least 2 years following such response.

VI. External Claims Review

An adverse determination that involves consideration of whether the Plan complied with the surprise billing and cost-sharing protections of the No Surprises Act is eligible for external review.

Appendix 8
Claims Procedure

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 full and absolute authority and discretion. 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.

Initial Claims Processing

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.

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 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.

Content of Notice

(1) The Claimant shall be provided with the notice of adverse benefit determination. That notice shall set forth, in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(v) One of the following:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, 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 explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) **Disability Claims:** In the case of an adverse benefit determination with respect to disability benefits, the notice shall set forth, in a manner calculated to be understood by the Claimant and in a culturally and linguistically appropriate manner:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

(v) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by health professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(B) The views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination by the Social Security Administration

(vi) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, 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 explanation will be provided free of charge upon request;

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(viii) A statement 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.

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.

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.

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.

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.

Review Process: If an appeal is filed within the requisite number of days as described above, the Trustees 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 review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. No deference will be will be afforded to the initial adverse benefit determination.

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.

The Plan Administrator will provide the Claimant, 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.

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.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate

training and experience in the field of medicine involved in the medical judgment. The health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

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.

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 these procedures. 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, 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.

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

(4) 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;

(5) 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 and a statement of the applicable contractual limitation period that applies to the Claimant's right to bring such as action, including the calendar date on which the contractual limitations period expires for the claim;

(6) 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;

(7) 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.";

(8) 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;

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

(10) In the case of adverse benefit decision with respect to disability benefits, the notice will also include, in a culturally and linguistically appropriate manner:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by health professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(B) The views of medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination by the Social Security Administration

(ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

Limitations Period: No action at law or equity based on an adverse determination under the Plan shall be brought after the expiration of three (3) years from the date of the final appeal denial.

Restriction on Venue: A Participant or Beneficiary shall only bring an action in connection with the Plan in the Northern District of Ohio.

External Review

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, these provisions shall apply to the request for External Review.

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.

Decision on Appeal to Be Final

All decisions by the Trustees and/or their designees shall be final, binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious.

The claims' review process must be exhausted before any legal action is brought.

Limitations Period: No action at law or equity based on an adverse determination under the Plan shall be brought after the expiration of three (3) years from the date of the final appeal denial.

Restriction on Venue: A Participant or Beneficiary shall only bring an action in connection with the Plan in the Northern District of Ohio.

NOTES