Washington, D.C. Cement Masons Welfare Fund

SUMMARY PLAN DESCRIPTION

November 2017

WASHINGTON, D.C. CEMENT MASONS WELFARE FUND
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500 or toll free (888) 490-8800

Nota: Este documento está disponible en español a petición del Fondo.

Dear Participant:

We are pleased to provide you with this updated Summary Plan Description and Plan Document so that you may become familiar with the benefits available to you and your family. Please read it and keep it available for easy reference.

The Washington, D.C. Cement Masons Welfare Fund (the "Fund") is a self-insured, labor-management trust fund, established pursuant to the Taft-Hartley Act and the Employee Retirement Income Security Act ("ERISA"). The Board of Trustees, half of which is designated by Employer representatives and half by the Cement Masons Local Union No. 891 (the "Union"), is the Plan Administrator. The Board, in turn, hires a third-party administrator for the Fund's day-to-day administration. The third-party administrator is Carday Associates, Inc.

The Board of Trustees meets as needed and typically at least once each quarter. The Fund is audited once each year by a Certified Public Accountant selected by the Board. A report is filed annually with the Internal Revenue Service and the U.S. Department of Labor.

In recent years, the cost of health care has risen by leaps and bounds. As a result, everyone must take an active part in controlling health care costs. If we work together to spend our benefit dollars wisely, we anticipate that the Fund will continue to prosper and provide important protection for years to come. In closing, we wish you good health and happiness in the coming months and years. However, if the need for coverage arises, we believe you will share with us the satisfaction of knowing you have the protection of the Fund.

Sincerely,

THE BOARD OF TRUSTEES

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SECTION 1
DEFINITION OF TERMS IN THIS BOOKLET

Co-insurance

The percentage of the Usual, Customary, and Reasonable charges for Covered Expenses that you must pay after the Deductible has been met each calendar year. For example, if the Plan will pay 70% of the Usual, Customary, and Reasonable charges for Covered Expenses, then you must pay the remaining 30% until you reach the Out-of-Pocket maximum. You must also pay any balance that exceeds the Usual, Customary, and Reasonable charges.

Collective Bargaining Agreement

The labor agreement(s) between the Cement Masons Local Union No. 891 and participating Employers, which provides for contributions to this Fund.

Covered Expense

A charge that is not more than the Usual, Customary, and Reasonable amount allowable under the Plan for a service or supply. An expense is not a Covered Expense unless it is Medically Necessary for diagnosis, treatment, mitigation, or cure of an illness or injury to a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply is a Covered Expense.

Covered Person

The Participant or the Participant’s eligible Dependent who has enrolled in the Plan.

Custodial Care

Services and supplies, including room and board and other institutional services, which are provided primarily to assist you in the activities of daily living whether or not you are disabled. These services and supplies are Custodial Care without regard to the practitioner or provider who prescribed, recommended, or performed them. Room and board and skilled nursing services, when provided in a Hospital or other institution for which coverage is specifically provided, are not Custodial Care when those services: (a) must be combined with other Medically Necessary services and supplies; (b) are provided in accordance with generally accepted program of medical treatment that can reasonably be expected to contribute substantially to the improvement of the individual's medical condition; and (c) are not merely for the maintenance or stabilization of such individual's medical condition.

Deductible

The initial Covered Expenses that you must pay each year before the Plan pays a Covered Expense. The Deductible is taken from the first Covered Expenses you incur during a calendar year. If you satisfy the individual Deductible, then the Plan will begin paying your Covered Expenses. Once the family Deductible is satisfied, the Plan will pay Covered Expenses for all family members regardless of whether the Covered Person satisfied his or her individual Deductible.

Delinquent Employer

An Employer who has not made timely required contributions to the Fund.

Dependent

Your eligible Dependents will include your Spouse and certain Children, as defined below:

> The term "**Spouse**" means your lawful spouse, as recognized under federal tax law, including a same-sex spouse.
>
> The term "**Child**" or "**Children**" shall include the following: (1) the Participant's natural children; (2) the Participant's legally adopted children; (3) children lawfully placed in the Participant's home in anticipation of adoption; (4) the Participant's legal stepchildren; and (5) eligible foster children lawfully placed in the Participant's home by an authorized placement agency or by judgment, decree or other order of any court or administrative agency of competent jurisdiction.
>
> Dependent status shall continue for a Child until the end of the month in which the Child's 26th birthday occurs.
>
> Dependent status shall also continue for a Child beyond his or her 26th birthday if the Child is disabled due to physical or mental incapacity that prevents self-support, the disability began while the Child was eligible for benefits as a Dependent, and the Child either: (a) is permanently and totally disabled, lives with the Participant for more than one-half of the year and does not provide more than one-half of his/her own support (including federal disability benefits), or (b) depends on the Participant for more than one-half of his/her financial support.
>
> The term Dependent does not include a previous Spouse from whom you are divorced or a Spouse from whom you are legally separated.

Effective Date

The Effective Date of this Summary Plan Description and Plan Document is November 1, 2016.

Emergency Services

Medical screening examinations for an emergency medical condition within the capability of a Hospital's emergency department, including ancillary services routinely available to evaluate an emergency medical condition, as well as further examination and treatment required to stabilize the patient. An emergency medical condition is evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts.

Employee

A person who is currently or was recently employed by an Employer.

Employer or Contributing Employer

An Employer who has agreed to make contributions to this Fund in accordance with the terms and conditions of the applicable Collective Bargaining Agreement or other written agreement accepted by the Board of Trustees.

ERISA

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

Fund or Plan

The Washington, D.C. Cement Masons Welfare Fund.

Hospital

An institution that is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations. A licensed facility that is set up, equipped, and operated under the direction of a Physician solely as a birthing center for prenatal care, delivery, and immediate postpartum care is a "hospital." Hospital does not include rest or nursing homes, convalescent homes, institutions, sanatoriums, or similar institutions which primarily operate training schools for patients or primarily provide custodial or institutional care. To be considered a Hospital, a Hospital must regularly keep patients overnight, have full diagnostic, surgical, and therapeutic facilities under the supervision of a staff of legally qualified Physicians; and regularly provide 24-hour nursing service by registered graduate nurses.

Illness

A medical disorder or sickness resulting in an unsound condition of the mind or body, and which causes a loss that begins while the benefits of the Covered Person are in force.

In-Network

For medical benefits, a provider who participates in the CareFirst BlueCross BlueShield Preferred Provider Organization network. For prescription drug benefits, a pharmacy that participates in the CVSHealth network.

Injury

A wound or damage to the body that is sustained accidentally and by external force, which occurs directly and is independent of all other causes, and which causes a loss that begins while the benefits of the Covered Person are in force.

Medically Necessary

Services or supplies that are:

- furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected illness or injury;
- consistent with the diagnosis and treatment of the patient's condition; in accordance with standards of good medical practice;
- generally accepted by the medical profession as safe, effective, and appropriate treatment of the patient's medical condition;
- required for reasons other than the convenience of the patient, Physician, or other licensed provider; and
- the most appropriate level of service or supply that can be provided safely for the Covered Person.

When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that your medical symptoms and condition are such that the service or supply cannot be provided safely on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

Out-of-Network

For medical benefits, a provider who *does not* participate in the CareFirst BlueCross BlueShield Preferred Provider Organization network. For prescription drug benefits, a pharmacy that *does not* participate in the CVSHealth network.

Out-of-Pocket Expenses

Co-insurance that a Covered Person must pay for Covered Expenses plus, if applicable, the payments toward the Deductible for the calendar year. For example, a Covered Person submits claims for medical services in the amount of $1,500. That Covered Person has a $500 "In-Network" individual Deductible and 70% "In-Network" coverage,

so the plan pays 70% of $1,000 ($1,500 less the $500 Deductible) or $700. The individual's Out-of-Pocket Expense is $800 ($500 Deductible plus $300 co-insurance not paid by the Plan). Out-of-Pocket Expenses apply to each Covered Person. However, the Plan pays 100% of expenses once a Covered Person meets the individual Out-of-Pocket Expense maximum. In addition, the Plan will pay 100% of expenses for a Covered Person after the family Out-of-Pocket Expense maximum is met even if the Covered Person has not met his or her individual Out-of-Pocket Expense maximum.

Outpatient Facility

A clinic or other establishment that provides surgery, diagnosis, and treatment on an outpatient basis. The facility must have an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist under the supervision of a Physician). Outpatient Facilities include alternative care facilities such as stand-alone surgical centers or 24-hour clinics. The following are not Outpatient Facilities: Convalescent homes, nursing homes, homes for the needy, homes for nursing and domiciliary care, infirmaries or orphanages, sanatoriums, maternity homes for prenatal or postnatal care, or other homes or institutions primarily providing Custodial Care.

Participant

An Employee or a Retired Employee who has satisfied the Plan's eligibility rules and is covered for benefits provided by the Fund.

Plan

Individually or together, the plans of benefits and eligibility rules maintained by Washington, D.C. Cement Masons Welfare Fund, and described in this booklet, as amended from time to time.

Physician

A duly licensed doctor of medicine (M.D.); a duly licensed doctor of osteopathy (D.O.); a duly licensed dentist for dental services that are Covered Expenses; and, a duly licensed podiatrist for purposes of treating covered conditions of the feet. A physician may also include a health care provider who is recognized by the Plan Administrator and is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices, which might include clinical nurse specialists, nurse practitioners, and physician assistants.

Retired Employee

A former Employee who has satisfied the Plan's eligibility rules for "Retired Employee Medical Coverage".

Room and Board

Room, board, general duty nursing, and any other services regularly furnished by a Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of a Physician nor intensive nursing, regardless of the terminology used.

Third-Party Administrator

The person or firm retained by the Board of Trustees to administer the Plan on a day-to-day basis. Carday Associates, Inc. is the Third-Party Administrator.

Union or Local Union

Cement Masons Local Union No. 891.

Usual, Customary, and Reasonable Charges (Out-of-Network)

Charges for Covered Expenses by a service provider which are reasonable and do not exceed the prevailing amount generally charged by providers in the locality for like or comparable services or supplies. "Locality" means a geographical area that includes a cross-section of person or entities regularly furnishing the type of treatment, services, or supplies for which the charge is made. Benefits are payable according to the Fund's Usual, Customary, and Reasonable scale, as determined and changed from time to time by the Trustees. Where appropriate, the Usual, Customary, and Reasonable charge is based upon the scale issued by the Health Insurance Association of America also known as FAIR Health, Inc. However, other industry sources are used if the FAIR Health, Inc. scale is not available or appropriate. Charges covered by the Plan cannot exceed the actual amount charged for a service or supply, up to the Usual, Customary, and Reasonable amount. Before imposing any cost sharing that would apply in-network, the Plan will reimburse Covered Expenses for out-of-network Emergency Services in an amount equal to the greatest of the following: (1) the median amount negotiated with in-network providers for the Emergency Service; (2) the amount for the Emergency Service calculated using the same method the Plan generally uses to determine payment for out-of-network services; or (3) the amount that would be paid under Medicare's minimum payment standards for the emergency service. However, the amount the Plan pays for out-of-network Emergency Services will never exceed the amount billed minus any cost-sharing that applies to in-network Emergency Services.

SECTION 2
BASIC INFORMATION ABOUT THE PLAN

Plan Name

The Plan name is the "Washington, D.C. Cement Masons Welfare Fund".

Plan Administrator

The Plan Administrator responsible for maintaining the Plan is the:

Board of Trustees
Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Third-Party Administrator

The Third-Party Administrator responsible for the Plan's day-to-day administration is Carday Associates, Inc. You must file medical and disability claims with Carday Associates, Inc., which administers those claims. Their address and phone numbers are:

Carday Associates, Inc.
Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (410) 872-9500 or toll free (888) 490-8800

Fund Office

The Fund Office is located at:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (410) 872-9500 or toll free (888) 490-8800

Participants and Dependents may receive from the Fund Office, upon written request, information about whether a particular Employer or employee organization contributes to the Plan and, if the Employer or employee organization contributes to the Plan, its address.

Employer Identification Number ("EIN")

The Fund's Employer Identification Number ("EIN") assigned by the Internal Revenue Service is: 52-6038505.

Plan Number

The Plan number assigned by the Board of Trustees is: 501.

This Plan is a **group health plan**, which generally provides disability income and coverage for hospitalization, Physician's care, and prescription drug expenses.

Legal Process

The name and address of the persons designated as **agents for the service of legal process** are:

President
Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Service of legal process may also be made upon an individual Trustee of the Fund.

The name, title, and address of the principal place of business of each Trustee of the Fund are as follows:

UNION TRUSTEES	EMPLOYER TRUSTEES
Carl Carson Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	George Maloney c/o Carday Associates, Inc. 7130 Columbia Gateway Drive, Suite A Columbia, MD 21046
Richard Bailey Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Dennis Carlisle Buch Construction 11292 Buch Way Laurel, MD 20723
Juan C. Jimenez Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Cherie Pleasant Construction Contractors Council 3033 Wilson Blvd., Suite 700 Arlington, VA 22201

Named Fiduciary

The Named Fiduciary of the Plan, which is the entity with the authority to control and manage Plan operation and administration, is the Board of Trustees of the Fund.

Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements and a copy of any such agreement may be obtained by Participants or Dependents by making a written request to the Plan Administrator.

Any Participant or Dependent who makes a request for copies of the Collective Bargaining Agreements, the trust agreement, the latest updated Summary Plan Description, the latest annual report, or other instruments under which the Plan is established or operated shall pay the Plan's reasonable costs of furnishing these materials. Information about the cost of copies of the above described materials can be obtained by contacting the Fund Office. The above described materials are also available for examination by Participants and Dependents at all times at the Fund Office and, within ten (10) calendar days after written request to the Plan Administrator, at the principal office of the employee organization:

Cement Masons Local Union No. 891
1517 Kenilworth Avenue, NE
Washington, DC 20019

These materials can also be obtained at each Employer where at least 50 Participants covered under the Plan usually work.

Disqualification or Loss of Benefits

Certain circumstances may result in disqualification, ineligibility, denial, loss, forfeiture, or suspension of benefits. The following are common examples of when coverage might be lost. However, the Trustees may terminate coverage for other reasons, as well:

(1) Loss of Participant eligibility (for example, a reduction in hours of work for which your Employer(s) contribute on your behalf to the Fund);

(2) Loss of Dependent eligibility (for example, reaching age 26);

(3) Failure to file forms required to support a claim or Plan eligibility;

(4) Failure to file claims within the Plan's specified time limit (one-year);

(5) Filing false claims or false information in support of a claim or Plan eligibility;

(6) Your Employer's failure to make contributions to this Fund on your behalf;

(7) Your Employer's failure to comply with its responsibilities under the Fund's Agreement and Declaration of Trust;

(8) Your failure to repay amounts you owe to the Fund;

(9) Termination of the Plan;

(10) Your failure to submit requested documentation of dependent status to verify dependent status; or

(11) Fraud or intentional misrepresentation by you and/or your Dependents.

From time to time, you must provide documentation to prove your Spouse's and/or Child's eligibility. The Trustees will determine the information you must provide in their sole discretion. Examples of information the Trustees might require include your marriage certificate, your Child's birth certificate, and/or adoption papers. Failure to provide sufficient documentation, as determined by the Trustees in their sole discretion, may result in termination of coverage for the affected individual(s). Please note that COBRA ***will not*** be provided to individuals whose coverage is terminated because the Plan did not receive sufficient documentation.

Coverage of ineligible dependents is in violation of the Fund's policy. Employees identified as covering ineligible dependents may be subject to legal action and have their Plan coverage terminated.

Fund Financing

The Fund is financed by contributions made by individual Employers under the provisions of Collective Bargaining Agreements or participation agreements, by active Employees (in certain situations), and by Retired Employees and their Spouses. The Fund is also financed by income earned from the investment of these contributions. All monies are used exclusively for the purpose of providing benefits to eligible Employees, Retired Employees and/or their eligible Dependents, and the paying of expenses incurred with respect to the operation of the Plan. The assets of the Fund are held in trust by the Board of Trustees. All benefits are provided directly from Fund assets. The Fund has entered into contracts with CareFirst and American Health Holding, Inc. for pre-admission review, large case management, and preferred provider organization ("PPO") services.

Plan Year

The Plan Year is November 1 to October 31.

QMCSOs

The Fund will honor Qualified Medical Child Support Orders ("QMCSOs") that satisfy the requirements of ERISA. Generally, a QMCSO is a medical child support order that creates or recognizes a child's right to receive benefits from the Fund and meets certain ERISA requirements. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent's group health plan as "alternate recipients." Both you and your beneficiaries can obtain, without a charge, a copy of the Plan's QMCSO procedures from the Plan administrator.

Whenever a child support order is issued by a court or administrative agency, it must be sent to the Fund Office, which will, in turn, determine whether the order is in fact "qualified" under ERISA. When you submit an order to the Fund Office, you will receive a copy of the Fund's procedures for determining whether the order is qualified. The Fund Office will promptly notify you and each alternate recipient within a reasonable period of time whether the order is qualified. A representative of a child may be delegated to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Support Order, the child will be considered a Covered Person.

Authority of the Trustees

The Fund's ability to provide benefits is dependent upon a number of factors that may vary from year-to-year or even month-to-month. Accordingly, the Trustees reserve the right to change, eliminate, or reduce the benefits provided to Employees, Retired Employees, and their Dependents. The Trustees also reserve the right to terminate, suspend, amend, or modify the Plan, in whole or in part at any time, by a written document adopted by the Board of Trustees or its designee, and to adopt new Fund rules and regulations or to modify the existing rules and regulations. Nothing in this book or elsewhere should be construed to mean the Fund's benefits, including contribution rates, are guaranteed or "vested." The Fund's Trust Agreement allows the Plan to be terminated, suspended, amended, or modified by a majority vote of the Trustees. Any of these changes in the Plan shall be reflected in the meeting minutes, Summary of Material Modifications, or a writing retained in the Fund Office. If the Plan is terminated, all funds in the Trust must be used exclusively on behalf of Plan Participants and to defray the cost of reasonable administration and termination expenses, or as otherwise permitted by law. In no event will any of the assets revert to any Employer or the Union.

Only the Board of Trustees (or its delegate) is authorized to interpret the rules, regulations, and plan of benefits set forth herein. Its interpretation is final and binding on all individuals or entities dealing with or claiming a benefit from the Fund. No representative of any Employer, the Union, or the Third-Party Administrator, has authority to speak on behalf of the Board of Trustees, and any statements from any of these parties will not change the Plan's terms. If you have questions about your eligibility, or you want other information, contact the Third-Party Administrator. Matters that require interpretation will be referred to the Board of Trustees.

Except to the extent delegated by the Trustees, the Trustees have the exclusive power to verify claims for the payment of benefits and to determine whether the conditions for the payment of benefits have been fulfilled. The Trustees also reserve the exclusive discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

The Board of Trustees may delegate certain of its Plan duties to other persons and may seek such advice as the Board deems reasonably necessary with respect to the Plan. The Board of Trustees shall be entitled to rely on the information and advice furnished by such delegates and experts, unless it knows such information or advice to be inaccurate or unlawful.

How You Can Do Your Part to Help Maintain the Plan

The benefits for medical care described in this booklet have been designed to pay the charges for a broad range of Medically Necessary services, treatments, and supplies.

Like any good tool, the Plan must be used properly to survive. Accordingly, Plan costs must remain reasonable. And, as you undoubtedly know, the costs of the Plan are governed, in large part, by the claims submitted by Participants and Dependents.

When arranging for Hospital, medical, and related services, discuss the charges that your doctor, the Hospital, or others expect to assess. Generally, your health care provider or Hospital will be pleased to discuss this with you. In fact, most medical societies encourage patients to discuss charges with their health care providers before treatment.

Please satisfy yourself that the charges will not be more than you would pay if you paid the entire amount yourself, nor more than that which is generally charged in your area for similar services. ***Remember, the Plan does not pay charges in excess of Usual, Customary, and Reasonable Charges for out of network claims. Amounts exceeding the Usual, Customary, and Reasonable Charges are your responsibility.***

Also, try to make sure that your health care provider only orders necessary services. In this way, you will be doing your part to maintain the Plan's benefits and help reduce your own Out-of-Pocket Expenses.

SECTION 3
ELIGIBILITY RULES

ELIGIBILITY RULES FOR ACTIVE EMPLOYEE MEDICAL COVERAGE

Initial Eligibility

An Employee who works under a Collective Bargaining Agreement that: (1) requires an Employer to make contributions on his or her behalf to the Fund, and (2) has been accepted by the Board of Trustees, will become eligible for "Active Employee Medical Coverage" on the first day of the second calendar quarter following a period not to exceed four consecutive calendar quarters during which he or she worked at least 550 hours in no more than three out of the four calendar quarters in this period.

Let's look at some examples to see what this means. As you know, the calendar year has four (4) calendar quarters, like this:

(1) January, February, and March

(2) April, May, and June

(3) July, August, and September

(4) October, November, and December

Eligibility is computed as of the last day of each calendar quarter.

Example #1:

Let's say that you work at least 100 hours in each of the six months of January, February, March, April, May, and June, which is two consecutive calendar quarters. You have worked a total of 600 hours in two consecutive quarters so that you become eligible on October 1 which is the first day of the second calendar quarter following a period not to exceed four consecutive calendar quarters during which you worked at least 550 hours in no more than three out of the four calendar quarters.

As you can see, to become eligible you must work a total of at least 550 hours in one, two, or three out of four consecutive calendar quarters and then you must wait one calendar quarter before receiving your eligibility. Once you are eligible, you then remain eligible for a complete calendar quarter.

Now, let's look at one more example.

Example #2:

Suppose you work 200 hours in the quarter January, February, and March, another 250 hours in the quarter April, May, and June, and another 275 hours in the quarter October, November, and December. That gives you 725 hours in three out of four consecutive quarters. After waiting the one quarter of January, February, and March, you then become eligible on April 1 and you are eligible for April, May, and June.

Please note that the Employer's contributions on your behalf must be received by the Fund Office before for your hours will count toward eligibility under the Plan. However, your Employer pays for your coverage and you are not required to make contributions as an active Employee unless required by the Collective Bargaining Agreement with your Employer.

Employee Enrollment

Each eligible Participant must complete and submit to the Fund Office an Enrollment Form, which may be obtained from the Local Union Business Manager or the Fund Office. The Plan Administrator or its delegate has discretion to permit enrollment by other means, including electronically, as it sees fit in its sole discretion.

Dependent Eligibility

Employees can also obtain coverage for eligible Dependents. Generally, your Dependents include your Spouse and Child(ren). See the Definitions section for more information on eligible Dependents.

Coverage for Dependents ends on the earliest of the following dates or as otherwise provided by the Trustees on a uniform and nondiscriminatory basis:

1. the date Employee coverage terminates;

2. for your Spouse and any stepchildren, the date you and your Spouse divorce or legally separate;

3. the date your Dependent becomes eligible for benefits under this Plan as an Employee; or

4. On the last day of the month in which a Child turns age 26;

Notification Requirement upon Divorce

In addition to the notice requirements under COBRA, you have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced Spouse and children of the divorced Spouse (stepchildren of the Participant) become ineligible for benefits upon the divorce. **If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to someone who does not qualify as a Dependent, the Trustees may decide to recover those**

benefits by initiating legal action and/or treating such benefits as an advance to you, and deducting such amounts from benefits which become otherwise payable for you and your Dependents until the entire amount of benefits erroneously paid is recovered. Also, if notice of divorce is not provided to the Fund office within 60 days, your Spouse and children of your divorced Spouse will lose their right to elect COBRA Continuation Coverage.

Termination of Eligibility

You and your Dependent's eligibility will terminate when you fail to work at least 550 hours in three (3) out of four (4) consecutive calendar quarters. Eligibility for coverage will terminate on the last day of the first calendar quarter following such period. (See below for exceptions during certain leaves of absence or military leave).

If an Employee dies while eligible for coverage, the eligibility of the Employee's Dependents will terminate on the date the Employee's eligibility would have terminated if the Employee had simply stopped working on the date of the Employee's death. However, a Dependent who loses eligibility solely due to age will continue through the end of the month when they turn 26.

See the COBRA section for more information about any right you or your Dependents may have to continuation coverage under COBRA, after your coverage terminates.

Reinstatement of Eligibility

If an Employee's eligibility terminates, and he or she thereafter returns to work in Covered Employment for an Employer, eligibility can be reinstated by satisfying the provisions for initial eligibility.

Reinstatement of Eligibility after Military Leave

If you enter the uniformed services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time national guard or public health service duty, or fitness-for-duty examination, and you otherwise meet the requirements of USERRA (see below), coverage for you and your eligible Dependents will terminate under the rules for active employees.

If you are discharged other than dishonorably from Uniformed Service and you otherwise meet the requirements of USERRA (see below), Plan coverage for you and your eligible dependents will be reinstated on the day you return to work for an Employer as an Employee. To be reinstated, USERRA generally requires that:

- You (or an appropriate military officer) give advance written or oral notice to your Employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable, or precluded by military necessity);

- You not be dishonorably discharged from uniformed service;

- The cumulative length of all of your absences with the Employer due to uniformed service must generally be no longer than five years; and

- Upon leaving the uniformed service, you must report back to your pre-service Employer for re-employment and/or report to your local union for a referral to covered employment within the following specified periods of time:

    - Uniformed service of less than 31 days, or for any length for a fitness for duty examination – you must generally report for work on the first regularly scheduled workday at least 8 hours after you arrive home from service, or

    - Uniformed service of more than 30 days, but less than 181 days – you must generally report for work within 14 days after completion of service.

If you meet USERRA's requirements, you and your eligible Dependents will be eligible for a period after your return that would be the same as the period of eligibility after the date that you left your Employer. If you have not yet worked sufficient hours in covered employment to again meet the requirements for continuing eligibility at the end of that period, you may be able to elect COBRA continuation coverage. You must elect COBRA within 60 days of the date your coverage terminates. You may continue at the COBRA rate until you meet the eligibility requirements again or your maximum COBRA period expires, whichever first occurs.

TEMPORARY ELIGIBILITY CREDIT FOR EMPLOYEES OF A DELINQUENT EMPLOYER

If you are an Employee of a Delinquent Employer who is in jeopardy of losing your eligibility due to your Employer's non-payment of contributions, the Fund will provide you with credit for hours actually worked, up to a ***maximum*** of one quarter (three months), while the Fund pursues collection of the Employer's delinquency. The hours credited will be the oldest hours, in the event of a delinquency spanning several months.

In the event that the Delinquent Employer has also failed to submit the hours worked for its employees, it may be necessary for you to provide proof of your hours worked (for example, pay stubs) in order to provide you with this temporary credit.

ELIGIBILITY RULES FOR NEWLY ORGANIZED GROUPS' MEDICAL COVERAGE

If you are an Employee in a Newly Organized Group, you will become eligible for benefits on the first day of the month following the completion of at least 550 hours of contributions being reported to the Fund on your behalf, in the immediately preceding six months.

Initial Eligibility

If you are an Employee in a Newly Organized Group, you will become eligible for benefits on the first day of the month following the completion of at least 550 hours of work in Covered Employment in the immediately preceding six (6) calendar months for

which the Fund receives contributions. The names of the new Employees covered under this provision must be received in the Fund Office prior to the first day of the first month of coverage.

Which Employees Qualify For These Special Rules?

The Welfare Fund has established special eligibility rules for “Employees in Newly Organized Groups”. Employees who qualify for these special rules are individuals who are not Participants in the Plan and who currently have Employer-provided coverage. They may be current employees of a newly organized company that signs a Collective Bargaining Agreement with the Union or newly organized employees represented by the Union who are then employed by an Employer already contributing to the Fund. The purpose of these special eligibility rules is to encourage the addition of new Participants to the Plan. These special eligibility rules are not available for current Employees represented by the Union.

To What Period Do These Special Rules Apply?

The Collective Bargaining Agreement describes the eligibility requirements and benefits that are applicable to Employees in Newly Organized Groups for a limited period before an Employee establishes eligibility under the regular Initial Eligibility rules of the Plan.

After an Employee in a Newly Organized Group has maintained eligibility for one year, all of the rules and benefits of the Plan apply as described in this SPD and these special rules are no longer applicable. In addition, if an Employee in a Newly Organized Group loses eligibility under the special Continuing Eligibility Rules described in this SPD, these special rules are no longer applicable unless otherwise provided in the Collective Bargaining Agreement and previously agreed to by the Board of Trustees. In this circumstance, the Employee can then become eligible for benefits only by meeting the regular Initial Eligibility rules of the Plan as described on Section 3 of this SPD and Plan Document.

OTHER TIMES YOU MAY ENROLL YOURSELF OR DEPENDENTS IN COVERAGE

If you decline enrollment for yourself or your Dependents because of other health insurance coverage there are three categories of "special enrollment" events under the Health Insurance Portability and Accountability Act ("HIPAA") that may allow you to change your election and enroll in medical coverage under the Plan.

First, when you marry, give birth to a Child, adopt a Child or a Child is placed with you for adoption, the Plan allows you to enroll yourself, your eligible Spouse, and your newly born/adopted Child within 30 days of the date of the event.

Second, if you refused coverage for yourself, your Spouse, or your Child because of other coverage and your Dependent(s) experience a “loss of eligibility” for that other coverage, then you can enroll yourself, your Spouse, and/or your Children who lose eligibility within 30 days of the event.

A "loss of eligibility" results if any of the following occurs:

- Loss of eligibility for reasons other than failure to pay premiums or fraud;
- Cessation of all employer contributions;
- Moving out of an HMO service area if the other plan does not offer other coverage; or
- Ceasing to be a "dependent," as defined in the other plan.

Third, if you request enrollment within 60 days, you may enroll yourself and an eligible Child if either of the following conditions is satisfied:

- You or your eligible Child loses eligibility for Medicaid or a state child health plan; or

- You or your eligible Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state child health plan.

HIPAA special enrollment is generally prospective. However, if a newborn or a child who is adopted or placed for adoption is enrolled within the special enrollment period, then the child's coverage (and the coverage of any others who can be added under HIPAA's requirements, such as the Employee's Spouse) is retroactive to the date of birth, adoption, or placement for adoption if you request enrollment within 30 days.

COVERAGE FOR EMPLOYEES ON LEAVE

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent; the birth or placement of a child with the employee in the case of adoption or foster care or a “qualifying” exigency” as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12 month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Generally, employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75 mile radius of that employee equals or is greater than 50. Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to report the period of your absence. In addition, if you have any questions about the FMLA, you should contact your employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under U. S. Government, Department of Labor, Employment Standards Administration.

QUALIFIED MILITARY SERVICE

If you leave employment for full-time Qualified Military Service, as defined by federal law, you and your eligible Dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under federal law. This coverage, subject to the provisions of the Plan, must last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter Qualified Military Service and are discharged earlier and failed to make a timely application for re-employment upon discharge (see "Reinstatement of Eligibility after Military Leave" above).

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty (30) days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium to the Plan, which will be based on the average cost that the Plan incurs annually per Participant plus a two percent (2%) administrative charge.

ELIGIBILITY RULES FOR RETIRED EMPLOYEE MEDICAL COVERAGE

Initial Eligibility

A retired cement mason shall be eligible for Retired Employee benefits under the Fund if he or she:

- Elects Retired Employee Medical Coverage within 90 calendar days from the Retiree's benefit commencement date under the Washington, D.C. Cement Masons Pension Trust Fund Pension and Retirement Plan;

- is not eligible for Medicare (e.g., is under the age of 65 and not disabled);

- is retired from active employment; and

- Either:

    (a) met the requirements for retirement status under the Washington, D.C. Cement Masons Welfare Fund prior to 1970, or

    (b) is a participant receiving benefits under the Washington, D.C. Cement Masons Pension Fund and was eligible for health benefits under this Fund for five (5) out of the seven (7) years immediately before the effective date of his pension benefit from the Washington, D.C. Cement Masons Pension Fund; and

- makes the monthly premium payment in advance to the Fund Office in an amount established from time to time by the Trustees.

Dependent Eligibility

Only the Spouses of eligible Retired Employees qualify as Dependents under the "Retired Employee Medical Coverage" provisions of the Plan. Premium payments for coverage of Spouses must be made in advance of each month to the Fund Office, in an amount established from time-to-time by the Trustees.

Termination of Eligibility

A Retired Employee loses eligibility if he or she:

- becomes eligible for Medicare (i.e. reaches age 65 or becomes totally or permanently disabled); or

- fails to make the monthly premium payment in advance to the Fund Office.

The Spouse of a Retired Employee loses benefit eligibility by reason of:

- the Spouse becoming eligible for Medicare (i.e. reaches age 65 or becomes totally and permanently disabled);

- divorce or legal separation from the Retired Employee;

- the monthly premium payment for the Spouse is not made in advance to the Fund Office.

Under some circumstances, Spouses of Retired Employees may have rights to continue coverage under COBRA. See the Section 9, Continuation Coverage Under COBRA, for more information.

SECTION 4
SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEE COVERAGE

Comprehensive Major Medical Benefits (Employees and Dependents)*

Percentage of Covered Expenses Paid by Plan	70%
Percentage of Covered Expenses Paid by Employee/Dependent	30% (after deductible)
Percentage of Covered Expenses Paid by Plan – Preventive Services (In Network)	100%
Percentage of Covered Expenses Paid by Plan – Preventive Services (Out-of-Network)	0% (no deductible) ***
Individual Deductible (includes prescription costs)	$500
Family Deductible (includes prescription costs)	$1,000
Individual Out-of-Pocket Expense Maximum for Medical	$5,000
Family Out-of-Pocket Maximum for Medical	$10,200
Maximum Benefit Paid by Plan (Per Individual)	The Plan does not have a monetary limit on essential health benefits, as defined under the ACA. **

* In Network and Out of Network Benefits, unless otherwise specified.
** Determined in accordance with applicable guidance from the Department of Health and Human Services.
***Except when required by law.

Prescription Drug Benefits (Employees and Dependents)

Individual Deductible (includes medical costs)	$500
Family Deductible (includes medical costs)	$1,000
Individual Out-of-Pocket Expense Maximum for Prescription	$1,600
Family Out-of-Pocket Maximum for Prescription	$3,200
Maximum Benefit Paid by Plan (Per Individual)	The Plan does not have a monetary limit on essential health benefits, as defined under the ACA.**

Type of Drug	Retail (30 days)	Mail Order or CVS Pharmacy (90 days)
Generics *(except Preferred Preventive)*	$10	$20
Preferred Brands *(when there is no generic)*	30% up to $50	30% up to $100
Preferred Preventive* *(Affordable Care Act)*	No Cost	No Cost
Non-Preferred Brands *(with prior authorization)*	30% up to $100	30% up to $200
Specialty drugs	Not Covered	Not Covered

**A Preferred Preventive Drug (not subject to any copay and deductible) is a medication or item on CVSHealth's Preferred Preventive Drug List that is prescribed under certain medical criteria by a provider under a written prescription for – Aspirin, Folic Acid, Fluoride, Iron Supplements, Smoking Cessation Products, and FDA approved contraceptives for women.*

Please note the following about the Prescription Drug Program:

- The Prescription Benefit Manager is CVSHealth (formerly Caremark). This means that you can have your prescription(s) filled at any CVS Pharmacy or any other pharmacy that participates in the CVSHealth network (for example, Giant, Safeway, Rite Aid, Target, Walgreens).

- The Prescription Drug Program only provides benefits for generic drugs and certain brand name drugs when a generic is not available.

- If you request a brand name drug when a generic is available, you are responsible for paying the difference in the cost between the Generic drug and the Brand name drug. Generally, you must pay the difference between the brand name and generic even if your health care provider says the prescription must be dispensed as written.

- For contraceptives considered preventive care, the Plan will accommodate anyone for whom a generic drug (or a brand-name drug) would be medically inappropriate, as determined by the individual's health care provider, by waiving the cost-sharing for the brand version. Also, if a generic version is not available, or would not be medically appropriate as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then the Plan will cover the brand name drug without cost-sharing, subject to reasonable medical management.

- Specialty Drugs are not covered.

- A separate prescription out-of-pocket limit applies. The out-of-pocket maximum is $1,600 per person or $3,200 per family. Once out-of-pocket limit is met, you pay nothing for covered prescriptions except for the difference between a Brand-name drug and its Generic equivalent.

- Prescriptions up to a 30-day supply (retail) or up to a 90 day supply (mail order or CVS Pharmacy) are covered.

- Maintenance medications must be filled through the mail order program or at a CVS Pharmacy.

If you request a name brand medication when a generic version is available, then you must pay the full difference in cost between the generic and name brand. Likewise, if a health care provider prescribes a drug that has a generic equivalent, the Plan will reimburse only up to the cost of the generic equivalent, even if your health care provider says the prescription must be dispensed as written. In addition, the difference in cost between the generic and name brand will not count toward your deductible or out of pocket maximum.

As described below, the Plan covers preventive care required under the ACA at no cost. This includes certain prescription and non-prescription drugs. For contraceptives that are preventive care under the ACA, the Plan will accommodate anyone for whom a generic drug (or a brand-name drug) covered under the plan would be medically inappropriate, as determined by the individual's health care provider, by either waiving the cost-sharing for the preferred or non-preferred brand version. Also, if a generic version is not available, or would not be medically appropriate as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then the Plan will cover the brand name drug without cost-sharing, subject to reasonable medical management.

Weekly Accident & Sickness Benefit (Employees Only)

Benefit Paid by Plan	$200 per week
Maximum Payment Schedule	26 weeks per disability

Please see the descriptions of Covered Expenses and information in Section 6 of this booklet for more details on the benefits that the Plan covers.

SECTION 5
SCHEDULE OF BENEFITS FOR RETIRED EMPLOYEE MEDICAL COVERAGE

(For Retired Employees and their Spouses)

Benefits are based on the Schedule of Benefits provided to Active Employees, except:

1. No weekly accident & sickness benefits;

2. Benefits are provided only to non-Medicare eligible Retired Employees (and their Spouses);

3. Retirees and/or their Spouses eligible for Medicare (either by age or disability) are not eligible for this portion of the Plan; and

4. A monthly per person premium payment is required.

SECTION 6
DESCRIPTION OF PLAN BENEFITS

WEEKLY ACCIDENT AND SICKNESS BENEFITS

(Active Employees Only)

General

A weekly benefit is payable to an Employee while disabled and prevented from working as a result of a non-occupational accident or an Injury or Illness for which benefits are not payable under a Workers' Compensation Law.

It is not necessary for an Employee to be confined to home to collect benefits but he or she must be under the care of a licensed Physician and may not engage in any other work for cash or other remuneration during the period of disability.

Once an Employee has begun to receive these benefits, he or she will be required from time to time to have a doctor complete a supplemental form indicating whether or not the Employee is still disabled. This form will be sent to the Employee from the Fund Office and must be returned to the Fund Office within two weeks of receipt.

Period of Coverage

The $200 weekly benefit to which an Employee is entitled will commence on the first day of disability resulting from an accident or if hospitalized, or on the eighth day of disability if the disability did not result from an accident or did not require hospitalization, and will be payable as long as the disability lasts up to the maximum number of weeks specified in the Schedule of Benefits.

Payment will be made for as many separate and distinct periods of disability as may occur, not to exceed payment for the maximum number of weeks as specified in the Schedule of Benefits. No payments will be made if you are receiving a pension or Social Security disability payments. If a disability ends during a work week, accident and sickness benefits shall be paid at the rate of $40 per day of disability during that work week with a maximum payment of $200.

Successive Periods of Disability

> ***Unrelated Causes****:* If an Employee returns to work following an absence for which weekly accident and sickness benefits have been paid and again becomes disabled, both periods of absence will be considered as one disability unless the subsequent disability is due to an injury or illness entirely unrelated to the cause(s) of the previous disability and commences after the employee returns to full active employment with an Employer.

The Same or Related Causes*:* In the event of a subsequent disability for the same or a related cause, the Employee must have recovered completely and completed at least two weeks of full time active employment with an Employer after the first disability in order for the second absence to be considered a second disability for which weekly accident and sickness benefits are payable. In addition, the Employee's Physician must confirm that the Employee recovered completely and returned to work with the Physician's permission.

In all cases, the Trustees, in their discretion, may require that the Employee who is claiming entitlement to benefits be examined by a Physician selected by the Trustees.

MEDICAL BENEFITS

Preferred Provider Organization (PPO)

The Trustees have retained the services of the "OneNet" Preferred Provider Organizations (PPO) – groups of Physicians, specialists, and Hospitals, which have agreed to provide their services to Fund Participants at discounted rates.

It is not mandatory to use the PPO network. However, by using the PPO, there is considerable savings to both you and the Fund. Remember, under this Plan, you are responsible for paying 30% of the charges after the deductible. The higher the charges, the more you have to pay.

The CareFirst BlueCross BlueShield PPO Directory lists the participating Physicians and Hospitals. It is a guide to assist you in identifying providers and is organized by specialty and geographical location. Please contact the Fund Office for a copy of the directory.

As you might expect, the list of health care providers participating in the PPO changes periodically. The list in the directory is as complete as our procedures allow at the time of issue. However, because some listed providers may no longer participate in the PPO, you must check with your provider each time you request health care services. This will ensure that your provider is still participating so that you and the Fund will be afforded the appropriate discounts.

Designation of Primary Care Providers and/or OB/GYN

You have the right to select any primary care provider who participates in the Fund's network and who is available to accept you or your family members. For children, you may select a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CareFirst at 1-800-235-5160 or online at www.carefirst.com.

You do not need prior authorization from the Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CareFirst at 1-800-235-5160 or online at www.carefirst.com.

Pre-Admission Hospital Review Requirements

When a Covered Person needs to be hospitalized, the Plan will cover many of the Hospital charges. However, all Covered Persons must follow these pre-admission review procedures to help insure that the charges for the Hospital stay are necessary and appropriate:

(1) At least 7 to 10 days before a scheduled Hospital stay, you or your doctor must call American Health Holding, Inc. (the Fund's Pre-Admission Review and PPO provider) at 1-800-641-5566 (If the Hospital admission occurs after receiving Emergency Services, the call must be made within 48 hours of your admission).

(2) The doctors and nurses at American Health Holding, Inc. will discuss the proposed length of stay with your doctor. They will either approve it or recommend an alternative, such as outpatient treatment. You and your doctor will receive confirmation of the decision.

(3) American Health Holding, Inc. will monitor the Hospital stay and, if necessary, approve additional days for benefit coverage.

(4) As the Pre-Admission Review provider, American Health Holding, Inc. acts as an advisor to the Fund for the purpose of recommending the number of Hospital days that the Fund should pay for under your Schedule of Benefits.

Please note that the pre-admission hospital review helps you determine if a particular expense will be covered under the Plan and, if so, at what reimbursement rate. If precertification is requested and denied, the denial means only that the expense will not be covered or will be covered at a lower reimbursement rate under the Plan. It does not represent a medical judgment as to whether you should have the medical treatment or procedure; that decision is yours alone in consultation with your chosen providers. The fact that a particular medical treatment or procedure may not be covered under the Plan, or may be reimbursable at a lower rate, is simply a matter of plan design – providing the greatest benefit to the greatest number of people at an affordable cost.

Medical Case Management

If a Hospital confinement is expected to be unusually long and costly, a “case manager” at American Health Holding, Inc. may be assigned to help determine the most appropriate and cost effective way to provide the necessary care. The Fund will cover its share of the charges for such alternative care recommended by the case manager.

The case manager will work with your doctor to develop a treatment plan and make the necessary arrangements. He or she will continue to monitor the case until specialized treatment is no longer necessary.

Please note that medical case management is a procedure which helps you determine if expenses will be covered under the Plan and, if so, at what reimbursement rate. If a service or supply is requested and denied, the denial means only that its expense will not be covered or will be covered at a lower reimbursement rate under the Plan. It does not represent a medical judgment as to whether you should have the medical treatment or procedure; that decision is yours alone in consultation with your chosen providers. The fact that a particular medical treatment or procedure may not be covered under the Plan, or may be reimbursable at a lower rate, is simply a matter of plan design – providing the greatest benefit to the greatest number of people at an affordable cost.

Description of Covered Medical Expense Benefits

As shown on the Schedule of Benefits, the Fund provides coverage pursuant to a “comprehensive major medical plan,” where many Covered Expenses are paid 70% by the Fund and 30% by you. This coverage is designed to reimburse you, to a large extent, for expenses incurred as a result of non-occupational Injuries or Illnesses.

The medical expenses that are Covered Expenses under the Plan are:

(1) Room and Board and any other charges which are made by the Hospital as a condition of occupancy on a regular or weekly basis. However, if a private Hospital room is used, any excess of daily Room and Board charges over the Hospital’s average, semi-private room charge will not be counted as a covered medical expense;

(2) Operating, delivery, recovery, and treatment room and equipment fees;

(3) Diagnostic laboratory and pathology tests when Medically Necessary and generally accepted as a standard or reasonable test for the condition, including x-ray examinations, electrocardiograms and electroencephalograms;

(4) Radiotherapy, including use of x-ray, radon, radium, cobalt, and other radioactive substances;

(5) Hospital provided services or supplies for treatment in the outpatient department, emergency room, or ambulatory surgical facility;

(6) Bandages and surgical dressings at a Hospital or Physician's office;

(7) Prescription drugs taken or administered during hospitalization;

(8) Whole blood, blood plasma, plasma extenders, and blood transfusions;

(9) Routine nursery care of a newborn child of a Covered Person;

(10) Inpatient treatment of a mental or nervous disorder;

(11) Confinement for medical complications of alcoholism or drug abuse, including cirrhosis, delirium tremens, hepatitis;

(12) General nursing care services of a licensed practitioner;

(13) An incision, excision, or electrocauterization of any organ or part of the body;

(14) Pre-surgical tests;

(15) Treatment of a fracture;

(16) Reduction of a dislocation;

(17) Endoscopic procedures;

(18) X-ray or radium therapy or laser therapy if used in lieu of a cutting operation;

(19) Anesthesia and its administration;

(20) Assistant surgeon fees not to exceed 20% of the covered surgical expense;

(21) The services of a legally qualified Physician (but not visits in the Hospital in connection with a surgical procedure or post-operative care unless the visit is by a Physician other than the surgeon performing the operation);

(22) The services of a nurse-midwife (for Employees and Spouses only) up to an amount that does not exceed the amount that would be payable if a Physician performed the services;

(23) The services of a registered, graduate nurse (R.N. – other than a nurse who ordinarily resides in your home or who is a member of you or your Spouse family);

(24) X-ray, radium, and radioactive isotope therapy;

(25) Anesthetics, including administration;

(26) Rental of an iron lung and other durable, medical, or surgical equipment, such as a wheelchair or hospital-type bed;

(27) Artificial limbs, orthopedic appliance implants, orthopedic braces and appliances, larynx and artificial eyes, but not hearing aids, eye examinations or eyeglasses;

(28) Services rendered by a licensed practitioner for physical therapy, hydro therapy, or occupational therapy;

(29) Speech therapy through the use of appropriate programs for treatment of developmental speech dysfunction resulting from injury or illness;

(30) Kidney dialysis when performed in a Medicare-approved facility;

(31) Oxygen;

(32) Local ambulance service when used to transport the individual from the place where he is injured by an accident or stricken by an Illness to the first Hospital where treatment is given. However, no other charges in connection with ambulance travel are included;

(33) Expenses incurred in connection with dental work or oral surgery when performed to repair damage to natural teeth or other bodily tissues resulting from a non-occupational, accidental Injury occurring while the individual is a Covered Person, provided the services are received within twelve (12) months of the accident, or for surgery directly related to cancer surgery of the mouth;

(34) Cosmetic surgery is covered only when necessary for the prompt repair of a non-occupational, accidental Injury occurring while the individual is eligible, for congenital defect or disfigurement, or disfigurement related to disease. No other expenses are provided for cosmetic surgery unless otherwise required by law;

(35) Casts, splints, trusses, leg braces, and crutches;

(36) Electronic heart pacemaker;

(37) In vitro fertilization benefits are available, to eligible Participants and Spouses (but not to other Dependents) if the following guidelines for outpatient and out-of-hospital expenses are followed:

(a) The patient’s eggs are fertilized with the sperm of the patient’s Spouse;

(b) The patient and the patient's Spouse have a history of infertility of at least five (5) years duration or the infertility is associated with one or more of the following medical conditions:

i. endometriosis;

ii. exposure in utero to diethylstilbestrol (DES); or

iii. blockage of, or surgical removal of, one or both fallopian tubes.

(c) The patient has been unable to attain a successful pregnancy through any less costly, applicable infertility treatments for which coverage is available under the Plan, if any.

(d) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society's minimal standards for programs of in vitro fertilization.

(38) Preventive medical care is provided as follows:

The term "Preventive Services" generally includes routine health care such as screenings, check-ups, and patient counseling to prevent illness, disease, or other health problems. The Plan covers a comprehensive range of Preventive Services that are required under the ACA without cost-sharing (in other words, without charges such as co-payment, co-insurance, or deductibles) when the services are provided by an in-network provider. Specifically, the covered Preventive Services include the following:

- Evidence-based preventive services: Evidence-based items or services with a "grade" of A or B by the U.S. Preventive Services Task Force, such as breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling.

- Routine vaccines: Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Prevention for children: Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents, such as regular pediatrician visits, vision

and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

- Prevention for women: Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women, contraceptives, breastfeeding support and supplies, and screening and counseling for interpersonal and domestic violence.

As new services are approved, the Plan will cover them with no cost-sharing for Plan years beginning one year later. A list of the covered services is available at:

- https://www.healthcare.gov/preventive-care-benefits/
- https://www.healthcare.gov/preventive-care-benefits/women/
- https://www.healthcare.gov/preventive-care-benefits/children/

Sometimes Preventive Services are included with other services as part of an office visit. The Plan may impose cost-sharing to an office visit: (a) if the Preventive Service is billed separately (or is tracked as individual encounter data separately) from the office visit, or (b) if the recommended Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, the primary purpose of the office visit is something other than the delivery of recommended Preventive Service. In such a case, the Plan may still impose a co-payment, co-insurance, or a deductible.

Consistent with applicable law and administrative agency guidance, the Plan imposes cost-sharing for these Preventive Services when provided by an out-of-network provider unless the Preventive Service is not available In-Network. In addition, prescription drugs that are Preventive Services are only available In-Network unless they are not available In-Network.

Be sure to check the General Plan Exclusions and Limitations Section of this booklet (Section 7) before you seek any medical treatment.

Description of Covered Prescription Drugs

The Plan pays eligible prescription drug benefits as shown on the Schedule of Benefits. This coverage is designed to reimburse you, to a large extent, for expenses incurred as a result of non-occupational Injuries or Illnesses. Covered Expenses under this part of the Plan include:

- Legend drugs

- DESI drugs – DESI drugs are determined by the FDA as lacking substantial evidence of effectiveness. DESI drugs do not have studies to support the drugs' uses, but continue to be used in today's marketplace because they have been used and accepted for many years without any safety problems

- Controlled substance 5 (CV) Over-the-Counter ("OTC") (e.g., Robitussin AC syrup and Naldecon-CX) – Although designated OTC under federal law, these are legend drugs in some states, so are all covered

- Prescribed single entity vitamins – Vitamins that have indications in addition to use as nutritional supplements for treatment of specific vitamin deficiency diseases. For example, vitamin B12 (cyanocobalamin) for anemia and degeneration of the nervous system, vitamin K (phytonadione) for hypoprothrombinemia or hemorrhage, and folic acid for megaloblastic and macrocytic anemias

- Prescribed prenatal vitamins

- Pediatric vitamins that require a prescription (to the extent required under the ACA as preventive care)

- Nail fungal treatments

Covered Expenses under the prescription drug program do not include:

- Non-legend, patent or proprietary drug, medicine or medication not requiring a prescription, except insulin (except when specifically provided otherwise in this SPD), unless the drug, medicine, or medication is a compounding of two or more drugs, medicines, or medication, which compounding, by law, must be prescribed

- Separate charges for medication, legend or non-legend, that is consumed or administered, in whole or in part, at the place where it is dispensed

- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use

- Over-the-counter medicine, unless otherwise specified above

- Blood products or blood serum

- Experimental medicines

- Drugs for treatment of ADHD/Narcolepsy after attaining age 18

- Anorexiants (diet aids)

- Differin, Tazorac, Fabior, Tretinoin (Retin-A, Retin-A Micro, Avita, Ziana, Atralin) after attaining age 18
- Anti-smoking aid unless they qualify as Preventive Services under the ACA
- Contraceptives not required as Preventive Services under the ACA
- Cosmetic drugs, including hair loss drug, anti-wrinkle creams, hair removal creams and others even if prescribed (for example Botox Cosmetic & Dysport)
- Alcohol swabs
- Oral Glucose
- Blood Glucose Monitors
- Insulin Pumps
- Insulin Pump Supplies
- Prescribed multivitamins
- Allergy serums
- Nutritional supplements even if prescribed
- Respiratory therapy supplies, including spacers, peak flow meters, and nebulizers
- Fertility agents
- Biotech/specialty medications (including products on the CVSHealth specialty drug list)
- Growth hormones
- Topical analgesics
- Convenience kits (for example, two or more products to be used separately)

Annual and Lifetime Limits

The Fund does not impose annual or lifetime limits on Essential Health Benefits (as defined in guidance and regulations issued by the Department of Health and Human Services).

Women's Health and Cancer Rights Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstruction surgery as part of a mastectomy procedure. Breast reconstruction surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

Newborns' and Mothers' 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, 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket Expenses, you may be required to obtain precertification. For more information on precertification, contact American Health Holding, Inc. at 1-800-641-5566.

Medicare Benefits For Actively Working Employees

The Fund serves as the primary payor of benefits for actively working Employees and their Spouses, age 65 and over. Medicare coverage, if available, will generally be secondary. This means your benefits will first be paid under this Fund. If there are any medical expenses not paid by the Fund, Medicare may reimburse you if those expenses are covered by Medicare. In order to obtain reimbursement from Medicare, you must enroll in Medicare. Also, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium. Contact your local Social Security Administrative Office for information about enrollment procedures. Employees and their Spouses are urged to enroll in Medicare so this coverage is available when needed. Please note that if you do not enroll in Medicare Part B when you are first eligible, you **might have a late enrollment penalty** for every year you did not enroll in Medicare Part B, and you may have to wait to sign up. Typically, that penalty is 10% per year that you did not enroll in Medicare Part B. You will pay a higher premium due to this penalty for as long as you have Medicare Part B. Penalties also apply if you did not get automatically enrolled or sign up during your Medicare Part A initial enrollment period.

Medicare is complex and this is only a brief summary. You should not and cannot rely on this summary. Instead, you should visit https://www.medicare.gov to ensure that you timely enroll in all Medicare programs, particularly if you will turn age 65 in the next few years, become disabled, or have end stage renal disease. You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 prohibits the Plan from using Employees' and family members' genetic information in deciding eligibility and contributions for group health plan benefits. In addition, the Plan cannot use genetic information for underwriting purposes.

SECTION 7
GENERAL PLAN EXCLUSIONS AND LIMITATIONS

No benefits are available under this Plan for the charges listed below, and the amount of any such charges will be not be included when the Plan calculates the portion of the Covered Person's expenses it will pay.

(1) Charges that a Covered Person would not be required to pay if he was not a covered person;

(2) Charges for services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service in the armed forces of a government, except to the extent prohibited by law;

(3) Charges for services or supplies that are paid by a government agency or program, unless required by law;

(4) Charges for services or supplies received as a result of an act of war occurring while covered;

(5) Charges for services and supplies which are not Medically Necessary for treatment of the Injury or Illness;

(6) Charges that are not recommended and approved by the Covered Person's Physician;

(7) Charges incurred in connection with an occupational Injury or Illness, including: (a) an Injury arising out of, or in the course of, any employment for wage or profit; or (b) Illness covered, with respect to such employment, by any Workers' Compensation Law, occupational Illness law or similar legislation;

(8) Charge in excess of the Usual, Customary, and Reasonable Charge;

(9) Charges for Physician's services in connection with eye refractions or hearing problems or any other examinations to determine the need for, or the proper adjustment of eye glasses or hearing aids;

(10) Charges for the fitting or cost of hearing aids;

(11) Charges for X-Ray examinations made without film;

(12) Charges for treatment of periodontal or periapical Illness or any condition involving teeth, surrounding tissue, or structure, except as described herein for dental treatment due to accident;

(13) Charges for dental work, dental x-rays and/or treatment, except as described herein for dental treatment due to accident;

(14) Charges for treatment of: (a) weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and, (b) corns, calluses, or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating metabolic or peripheral-vascular Illness;

(15) Charges for nursing, speech therapy, or physiotherapy rendered by yourself, Spouse, or a Child, brother, sister, or parent of yourself or Spouse;

(16) Charges for services or supplies furnished by someone who ordinarily resides in the patient's home or is related to the patient by blood or marriage;

(17) Charges incurred as the result of self-inflicted injuries, unless such injuries were inflicted as the result of a medical condition, mental health condition, or from an act of domestic violence;

(18) Charges incurred for services in connection with the pregnancy, child birth, miscarriage, abortion, or related event incurred by a Dependent other than a Spouse, except to the extent covered as Preventive Services under the ACA);

(19) Charges by a hospital or a physician that does not satisfy the definition of Hospital or Physician in this booklet;

(20) Charges made by a sanatorium, rest home, nursing home, or any institution or part of one, used principally as a facility for convalescence, nursing, rest, or for the aged;

(21) Charges for Custodial Care or domiciliary care regardless of the facility where provided;

(22) Charges for transportation or travel other than local use of ambulance service (and as limited herein);

(23) Charges for cosmetic surgery or treatment, except when necessitated by an accidental bodily Injury, or congenital defect or disfigurement, or disfigurement related to disease or to the extent required by law;

(24) Charges for vision care services, except as required under the Affordable Care Act as pediatric Preventive Services;

(25) Charges incurred in connection with treatment to reverse a voluntary sterilization procedure, such as a vasectomy;

(26) Charges incurred in connection with gender reassignment surgery or any care or services associated with this type of operation;

(27) Charges for medical services or supplies used primarily for dietary control (unless covered as Preventive Services);

(28) The purchase or rental of air conditioners, humidifiers, dehumidifiers, vaporizers, or similar devices;

(29) Food or food supplements;

(30) Charges for services or supplies which are experimental or investigational, including:

- Any treatment, drug, or supply which is not generally recognized as acceptable medical practice in the United States;

- Any items requiring governmental approval which was not granted at the time the services were rendered;

- Any service or supply that is available only upon approval of an Institutional Review Board (as required by federal statute, including ones that require completion of an Informed Consent For Experimentation on Human Subjects) as required by federal regulations;

- Any treatment that involves drugs which are not approved by the FDA, including dosages, combinations, and uses that are not approved;

- Any new drug or device for which investigational application has been filed with the FDA;

- Any service or supply that has protocols or consent documents describing it as an alternative to more conventional therapies; and/or

- Any treatment that is only available through participation in a clinical trial, unless:

- The Covered Person is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition that is likely to result in death unless the disease or condition is interrupted and either:

- the referring health care provider is a participating provider and has concluded that the Covered Person's participation in the clinical trial is appropriate; or

- the Covered Person provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate;

- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements;

- The costs are routine patient costs that the Plan typically provides to Covered Persons not enrolled in a clinical trial, but not including: (a) the investigational item, devise or service itself; (b) items and services not included in the direct clinical management of the Covered Person, but instead provided in connection with data collection and analysis; or (c) a service not consistent with widely accepted and established standards of care for the particular diagnosis; and

- The Affordable Care Act requires the Plan to pay the cost;

(31) Charges for vitamins, minerals, dietary supplements, dietary drugs, medications which can be legally purchased over-the-counter without a prescription, even if prescribed by a Physician, unless covered as Preventive Services;

(32) Medications whose primary purpose is cosmetic in nature, fertility medications, serums or vaccines, and medications to promote hair growth, unless covered as Preventive Services;

(33) Charges resulting from any injuries, including, but not limited to, vehicular accidents, which resulted from the consumption of alcohol beyond the legal blood alcohol limit in the jurisdiction where the injury occurred, from the use of illegal substances (as defined under federal law or state law), or use of prescribed medication other than as directed by a health care provider by the Covered Person;

(34) Charges resulting from injuries which resulted from the Covered Person's use of a cellular telephone or any other telephonic or electronic device while operating a motor vehicle, if the use of such a device, or its manner of use, while operating a vehicle was illegal;

(35) Charges for failure to keep a scheduled appointment or for the completion of any form;

(36) Charges for an injury or illness caused by an act of war, or determined by the Secretary of Veterans' affairs to have been incurred in, or aggravated during, performance of services sustained while in the armed forces; and

(37) Charges for services not rendered, or in amount more than the amount billed.

SECTION 8
CLAIMS AND APPEALS PROCEDURE

Enrollment Forms

Each eligible Participant must complete and submit to the Fund Office an Enrollment Form, which may be obtained from the Local Union Business Manager or the Fund Office. Claims cannot be processed until the Enrollment Form is filed with the Fund Office. If you wish to add a Dependent, you must furnish satisfactory documented proof of dependent status.

Notify Fund Office of Important Changes

After a Participant becomes eligible for benefits, he or she must notify the Fund Office of any of the following changes:

(1) Changes in marital status (proof required);

(2) Names and birth dates of newborn Children (proof required);

(3) Change in address, or the address of your Spouse, and/or your Children.

To notify the Fund Office, complete and submit a new enrollment form.

Filing Claims

The Plan only covers prescriptions at pharmacies in the CVSHealth network (except in the unusual circumstance that a prescription required by the Affordable Care Act's Preventive Services requirement is not available in the CVSHealth network, in which case the Plan will cover the prescription out-of-network). When you obtain a prescription from a pharmacy in the CVSHealth network, the pharmacy will file your claim directly with CVSHealth.

However, all Participants and Dependents requesting medical or disability benefits under the Plan must file a written claim for benefits with the Third-Party Administrator at the Fund Office. In most cases, in-network claims will be submitted by your provider electronically. The Board of Trustees shall make available prescribed forms for claims applications at the Fund Office and, when possible, at the Local Union office.

Steps to Take

(1) Get your claim form from the Fund Office or your Local Union Office.

(2) Have the claim form completed by the Hospital and/or Physician.

(3) Attach all receipts and bills to the claim form.

(4) Complete your side of the Attending Physician Statement Form that requires information from you. The form must be signed by the Participant.

(5) Mail the claim form to the Fund Office as follows:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Filing the prescribed form of claim application shall be considered the normal manner of applying for benefits. However, any form of written claim for benefits filed with the Fund Office and reasonably calculated to notify the Fund Office of the claim and to provide all the necessary information required in order for the Fund Office to determine the eligibility of the applicant to receive benefits shall satisfy the requirements of filing a written claim.

Time Limit For Filing A Claim: *One Year*

In order for a claim to be considered, it must be received in the Fund Office within one year of the date the service was provided or the good was received. Failure to make a claim within this one year period shall constitute an absolute waiver of the claim in question and shall be grounds for denial of the claim (unless the Covered Person is incapacitated during this time, under which circumstances the Trustees may provide additional time to file the claim).

Processing of Prescription Drug Claims and Appeals

The Plan only covers prescriptions at pharmacies in the CVSHealth network, unless a prescription required by the Affordable Care Act is not available in the CVSHealth network (which is rare). When you obtain a prescription from a pharmacy in the CVSHealth network, the pharmacy will file your claim with CVSHealth directly. CVSHealth is the claims administrator for all prescription drug claims and appeals. If CVSHealth denies your claim, you can file an appeal with CVSHealth, which has final authority to decide your appeal. The Board of Trustees has delegated authority to decide appeals to CVSHealth and does not consider prescription drug appeals.

Please contact CVSHealth for more information on their claims and appeals process.

Processing of Medical Claims

This procedure applies only to claims submitted for medical benefits. In addition, it applies to any rescission (as defined under the Affordable Care Act ("ACA") and guidance thereunder) of medical or prescription drug coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals for medical benefits will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives, or other similar matters regarding any individual or organization making decisions in the claims an appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

In cases where the Department of Labor has indicated that there is a delayed enforcement deadline for a particular ACA requirement described in this section, the Plan Administrator or its delegate (the "Claims Administrator") may delay implementation of the particular delayed provision until the enforcement deadline.

The Third-Party Administrator shall examine all written claims for benefits filed with the Fund Office. The Third-Party Administrator shall have the right to require submission of all necessary information in addition to that filed with the claim application. No benefit payments will be made under the Plan until an application or written claim is made therefore to the Fund Office and all additional information required by the Third-Party Administrator to substantiate the claim has been submitted. The Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by the ACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

A Participant or Dependent may file a claim under this procedure through an attorney or any other authorized representative acting on the Participant's or Dependent's behalf.

The following terms are defined for purposes of this subsection:

> *Post-Service Claim* means any claim for a benefit which is not a Pre-Service Claim as defined below.
>
> *Pre-Service Claim* means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care (e.g., if the Plan requires precertification in order for a service to be covered).
>
> Urgent Care Claim means a claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
>
> - Could seriously jeopardize the Claimant's life or health or the ability of the Claimant to regain maximum function, or
>
> - In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care.

This claims procedure applies to the medical plan described in this SPD. Claims Administrator means the person or entity responsible for the relevant claims determination under the Plan. Appeals Unit means the group or individuals employed by the Claims Administrator assigned to review appeals of adverse benefit determinations. This claims and appeals procedure does not apply to prescription drug benefits. The Claims Administrator for claims and appeals regarding prescription drug benefits is the pharmacy benefit manager and network provider, CVSHealth.

If your claim for benefits from the Plan is denied, in whole or in part, you will be notified within a reasonable period of time, but not later than the following:

- *Post-Service Claims:* The Claims Administrator will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Claims Administrator expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's time frame for making a benefit determination is tolled from the date the Claims Administrator sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

- *Pre-Service Claims:* The Claims Administrator will notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the claim. This period may be extended for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification before the expiration of the initial 15-day period explaining the reason for the additional extension and when the Claims Administrator expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will

have at least 45 days to provide the requested information. In that case, the Plan's time frame for making benefits determination is tolled from the date the Claims Administrator sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Claims Administrator. In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within five days after the Claims Administrator initially receives the claim so that the Claimant can make proper adjustments.

- *Urgent Care Claims:* The Claims Administrator will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Administrator will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the claim. The Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim, unless the Claimant fails to submit information necessary to decide a claim. In this situation, the Claimant will be informed within 24 hours after submitting the claim the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Administrator will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Claims Administrator's receipt of the requested information or the end of the period the Claimant was given to supply the additional information. In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within 24 hours after the Claims Administrator initially receives the claim so that the Claimant can make proper adjustments. In order to expedite an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth below shall follow within three days.

- *Concurrent Care Decisions:* In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Administrator will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated. If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Administrator will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Claims Administrator will provide the Claimant, within the relevant time period described above, with a written notice of the denial. The notice will be written in a culturally and linguistically appropriate manner (as defined by applicable regulations) calculated to be understood by the Claimant and will include:

- The specific reason(s) for the denial;
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- References to the specific Plan provisions on which the benefit determination was based;
- A description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- A statement that Claimant is entitled to receive, upon request as soon as practicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (the Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review);
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- A description of the Plan's internal appeals procedures, any applicable external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- If the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- If the determination is based on 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 particular medical circumstances, or a statement that this will be provided free of charge upon request;

- Identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

- The denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim;

- The contact information for the Employee Benefits Security Administration, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act; and

- In the case of an adverse determination involving Urgent Care, a description of the expedited review process available to such claims.

Filing Medical Appeals

Every Claimant whose application for benefits has been denied in whole or in part shall have the opportunity to appeal the denial to the Board of Trustees. An appeal may be filed by a duly authorized representative acting on the Claimant's behalf.

In the event a Claimant desires to take advantage of the opportunity to appeal, he/she will be required to file a written request for review with the Board of Trustees at the Fund Office.

Time Limit For Filing An Appeal (other than Urgent Care Claim): *180 Days*

If the claim is denied in whole or in part, the Claimant may appeal the denied claim in writing to the Board of Trustees within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records, and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records, and information relevant to the claim free of charge. The Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his or her claim.

The written request for review (i.e., the appeal) must be received by the Board of Trustees within 180 days of the Participant's or Dependent's receipt of the Fund Office notification of denial of claim. A request for review shall be considered received by the Board of Trustees at the time it is actually received by the Fund Office.

Failure to request in writing a review of the denial of a claim within the foregoing 180 days shall constitute a waiver of further review of the claim in question and a denial of the claim shall be binding and conclusive on all questions of fact or law.

Board of Trustees Review of Appeal

The Board of Trustees shall consider all timely filed appeals from denials of claims. In his/her written request for review, a Participant or Dependent shall submit in writing every issue, comment, argument, and all other evidence in support of the appeal. The

Board of Trustees will not have been involved in the initial benefit determination nor will the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination. If the initial adverse decision was based in whole or in part on a medical judgment, the Board of Trustees will consult a health care professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the health care professional who was consulted in the initial adverse benefit determination. If a health care professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

The Board may, in its discretion, conduct an informal hearing on the appeal. In such hearings, the formal rules of evidence will not apply. If the Board decides to conduct a hearing, it will provide the Participant or Dependent with notice of the time and place of the hearing. Such notice will also inform the Participant or Dependent of the specific issues to be determined at the hearing and the matter on which findings will be made and a decision rendered. The Board of Trustees shall make its determination with respect to the appeal after examination of the evidence presented by the appealing Participant or Dependent. The decision of the Board shall be final and binding upon all parties.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Board of Trustee's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

The time that the Board of Trustees has to respond is based on the underlying claim for benefits:

- *Post-Service Claims:* the next Board meeting. However, for appeals filed within 30 days before the meeting, a determination shall be made at the second meeting following receipt of the appeal. If special circumstances require a further extension of time, a determination will be made at the third meeting after receiving the request for review.

- *Pre-Service Claims:* within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving appeal request.

- *Urgent Care Claims:* as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving Claimant's appeal request.

Notification of Appeal Decision

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the denial;

- Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;

- References to the specific Plan provisions on which the benefit determination was based;

- A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

- A description of any voluntary review procedures, internal appeals, and the external review process, including information on how to initiate an appeal and applicable time limits;

- If the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;

- If the determination is based on 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 particular medical circumstances, or a statement that this will be provided free of charge upon request;

- Identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

- A statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

External Review

Two types of external review are available for health claims: standard and expedited.

Requests for Standard External Review

A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following

the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. External review is only available for:

- A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and

- Medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer.

An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);

- Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);

- Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;

- The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;

- Whether a Participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;

- The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and

- Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

Preliminary Review of Standard External Review

Within five (5) business days after the date of receipt of the external review request, the Claims Administrator will review the request to determine whether:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

- The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);

- The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and

- The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Administrator will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

Referral of Standard External Review to Independent Review Organization

The Claims Administrator will assign an independent review organization (IRO) accredited by a nationally recognized accrediting organization to conduct the external review. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- The IRO will use legal experts where appropriate to make coverage determinations under the Plan;

- The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review;

- The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review; and

- The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.

Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Administrator may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Administrator will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Administrator.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The Claimant's medical records;

- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider; the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;

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

- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and

- The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Notice of Standard External Review Decision

The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:

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

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;

- A statement that judicial review may be available to the Claimant; and

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

Reversal of Plan's Decision after Standard External Review

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision

without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

Request for Expedited External Review

When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or

- A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Preliminary Review of Expedited Review

Immediately upon receipt of the request for expedited external review, the Claims Administrator will review the request to determine whether the request meets the reviewability requirements above for *Preliminary Review of Standard External Review*. The Plan must immediately send a notice to the Claimant of its eligibility determination.

Referral of Expedited Review to Independent Review Organization

Upon determination that a request is eligible for expedited external review following preliminary review, the Claims Administrator will assign an independent review organization (IRO) in accordance with the requirements described in above for *Referral of Standard External Review to Independent Review Organization*. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the IRO will review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Expedited External Review Decision

The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements for *Notice of Standard External Review Decision*, except that the notice will be provided as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

IRO Recordkeeping Requirements

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Claims and Appeals Procedures for Weekly Accident and Sickness Benefits

You must report your absence to initiate your claim for disability benefits. When reporting your absence, the Claims Administrator will ask you to provide some basic information including:

- Personal information**:** Name, address, telephone number, Social Security Number, and job title;

- Job information**:** Employer, workplace location and address, work schedule, supervisor's name and telephone number, and date of hire;

- Sickness/Injury Information**:** Last day worked, nature of illness, how, when, and where the injury occurred, and when disability commenced;

- Physician information**:** Name, address, telephone number, and fax number for each treating physician.

The Claims Administrator will provide you with written or electronic notification of any adverse benefit determination within 45 days (although it may take up to two thirty-day extensions for matters outside of its control, if it provides you with prior notice of the delay). The notification will set forth:

- The specific reason or reasons for the adverse determination;

- Reference to the specific plan provisions on which the determination is based; and

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

Alternatively, if the claim you filed was incomplete, the Claims Administrator may let you know that it needs more information to decide the claim. In that case, you will have 45 days to respond with the necessary information, and the Claims Administrator will make a decision on your claim within 30 days of receipt of this information.

If you dispute the response to your request for benefits, you must submit the disputed claim to the Claims Administrator. You or your authorized representative may appeal a denied claim within 180 days after you receive the notice of denial. You have the right to:

- Submit for review, written comments, documents, records, and other information relating to the claim;

- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

- A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

- A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person’s subordinate;

- If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and

- The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision. The Claims Administrator will make a full and fair review of your appeal and may require additional documents, as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless the Claims Administrator determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which the Claims Administrator expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period. The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

The Claims Administrator's notice of denial will be provided within 45 days and shall include:

- The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

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

- A statement describing any voluntary appeal procedures offered by the Claims Administrator and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

- If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or statement that such explanation will be provided free of charge upon request.

If there are special circumstances in the consideration of your appeal, the Third Party Administrator may extend the timeframe for deciding your appeal, for up to 45 days.

Statute of Limitations and Exhaustion of Administrative Remedies (All Claims and Appeals)

The Claimant may not commence a judicial proceeding against any person, including the Plan, the Board of Trustees, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, Claims Administrator, or any other person, with respect to a claim for benefits under the Plan, without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the decision on appeal, but only if the action is commenced no later than the earlier of: (1) three years after the date the service or treatment was provided, or the event giving rise the benefit occurred, or (2) the first anniversary of the final decision on appeal.

Notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for medical claims or rescissions of medical coverage, then to the extent mandated by the ACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) three years after the date the service or treatment was provided, or the event giving rise to the benefit occurred, or (2) the first anniversary of the Claims Administrator's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. *De minimis*;

2. Not likely to cause prejudice or harm to the Claimant;

3. Attributable to good cause or matters beyond the Plan's control;

4. In the context of an ongoing good-faith exchange of information; and

5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed 10 days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

Notices

Whenever notice is required to be made by these claims and appeals procedures, the notice shall be in writing and signed by the person sending the notice. The notice may be sent by first class mail or hand-delivered, at the option of the sender. Notices to a Claimant shall be sent to him or her at the last known address, as indicated by the files at the Fund Office.

Notice to the Fund shall be sent to the Fund Office at the following address:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

SECTION 9
CONTINUATION COVERAGE UNDER COBRA

If coverage (eligibility) under the Fund terminates at the result of a "qualifying event," Covered Persons may purchase a temporary extension of Fund coverage (called "continuation coverage") at a group rate that amounts to 102% of Plan costs. An Employee, Spouse, or Child who is a Covered Person could become "qualified beneficiaries" if coverage under the Plan is lost because of the qualifying event. This continuation coverage is sometimes referred to as "COBRA" coverage.

You May Have Other Options When You Lose Group Health Coverage

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov or call 1-800-318-2596.

If you enroll in COBRA, you can only enroll in the Marketplace at specific times.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a Child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

"Qualifying Events" for Continuation Coverage

If you are an Employee, Spouse, or Child covered by the Fund, you have a right to purchase this continuation coverage for a period up to 18 months, if you lose your coverage because of a reduction in the Employee's hours of employment or the termination of the Employee's employment (for reasons other than gross misconduct).

If you are the Spouse of an Employee covered by the Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Employee;

(2) divorce or legal separation from the Employee; or

(3) your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are a Child of an Employee covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Employee parent;

(2) parents' divorce or legal separation;

(3) the Employee parent becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(4) the Dependent ceases to satisfy the definition of "Dependent" under the rules of the Plan.

If you are the Spouse of a Retired Employee covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

(1) the death of the Retired Employee;

(2) divorce or legal separation from the Retired Employee; or

(3) the Employee parent becomes entitled to Medicare benefits (under Part A, Part B, or both).

Disability Extension to Twenty-Nine (29) Months

This extension will apply when any qualified beneficiary is determined by the Social Security Administration (SSA) to have been disabled at any time prior to the end of the first sixty (60) days of COBRA coverage (resulting from a termination of employment or reduction of work hours), and continues to be disabled at the end of the initial 18 month period of coverage. For the disability extension to apply, you must provide a copy of the SSA Determination of Disability letter issued to your disabled family member within the 18 month COBRA period and no later than 60 days after the latest of: (1) the date of the SSA Determination of disability; (2) the date on which the qualifying event occurs; or (3) the date on which the Qualified Beneficiary loses coverage.

Your Reporting Responsibilities

The Employee or Retired Employee or his or her family members have the initial responsibility to inform the Board of Trustees of a divorce, legal separation, a child losing Dependent status under the Fund, the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), or the death of the Retired Employee. Written notice must be provided no later than sixty (60) days after the event or the date coverage terminates, whichever is later. Covered Persons may be required to provide additional information to support the qualifying event (e.g. a divorce decree).

The Employee's contributing Employer has the initial responsibility to notify the Board of Trustees of the Employee's death, termination of employment, or reduction in hours.

Electing Coverage

When the Board of Trustees is notified that one of these events has happened, the Board of Trustees will in turn notify Covered Persons that they have the right to elect continuation coverage. Covered Persons must inform the Board of Trustees that they want to purchase continuation coverage within sixty (60) days from the date they would lose coverage because of one of the events described above. Covered Persons who elect coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium during a disability extension. The first premium is due 45 days after the date of the election for coverage. All subsequent premiums are due the first day of the coverage period, which is the first day of each month (with a 30 day grace period).

Duration of Coverage

The time periods for continuation coverage include all months during which coverage continued after the qualifying event occurred, even if the Covered Persons were not required to self-pay for the coverage during those months. For example, if an Employee terminated employment on March 31, but his coverage under the Fund continued until June 30, he or she would be able to purchase fifteen (15) months of continuation coverage (through September of the next year) under these rules. This is a total of eighteen (18) months of continuation coverage.

If you lose coverage as a result of a qualifying event, you may elect to continue the same coverage that you had immediately preceding the qualifying event, however, that continuation coverage is subject to changes made by the Board of Trustees to the same coverage maintained by similarly situated Employees or Retired Employees (as applicable). You have the same right to change your coverage that similarly situated Employees or Retired Employees have (including any open enrollment rights to change coverage).

The premiums for continuation coverage are subject to modification by the Board of Trustees from time to time. Contact the Fund Office for information about continuation coverage premiums. If a Covered Person does not purchase continuation coverage, regular coverage under the Fund will end.

Ways In Which Continuation Coverage May Be Cut Short

Continuation coverage may be cut short for *any* of the following reasons:

(1) the Employee's or Retired Employee's Employer no longer contributes to the Fund for purposes of providing group health coverage to its Employees;

(2) the Covered Person does not pay the premium for continuation coverage on time;

(3) the Covered Person becomes covered under another group health plan, whether as an Employee or otherwise;

(4) the Covered Person becomes entitled to benefits under Medicare;

(5) in the case of eleven (11) month extensions due to certain disabilities, a final determination that the Covered Person is no longer disabled.

Qualified beneficiaries must pay all of the premium for continuation coverage.

Please note that if a Covered Person has changed marital status or addresses, please notify the Board of Trustees immediately.

SECTION 10
OTHER PLAN RULES AND REGULATIONS

Coordination of Benefits

The purpose of the "coordination of benefits" rules is to permit Covered Persons to receive benefits from one or more group plans, but in no event, to receive more than 100% of Covered Expenses.

Since most of the insurance industry has some form of "coordination of benefits," if this Plan did not include such a provision it would always be considered the "primary" plan, and therefore, would always pay benefits first. If that were the case, other plans would experience great savings at the expense of this Plan.

For purposes of this Plan's coordination of benefits rule, an "allowable expense" is any Medically Necessary, Usual, Customary, and Reasonable Charge covered, at least in part, by one of the plans. "Plans" mean medical or welfare benefit coverage provided: (a) under a governmental plan established specifically for the government's own civilian employees and their dependents, or (b) under a group insurance policy or group plan or other coverage for a group of individuals, including student coverage obtained through an educational institution.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

(1) A plan covering a person as an employee will pay benefits first. A plan covering a person as a dependent will pay second.

(2) If a dependent child is covered by both parents' plans, the benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined as primary. The benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined as secondary.

    If a plan containing the "birth-date" rule is coordinating with a plan which contains the gender-based rule and as a result the plans do not agree on the order of benefits, the gender-based rule will determine the order.

(3) When the parents are divorced or separated the order is:

    (a) The plan of the parent with custody pays first. The plan of the parent without custody pays second.

    (b) If the parent with custody has remarried, the order is:

(i) the plan of the parent with custody,

(ii) the plan of the step-parent,

(iii) the plan of the parent without custody.

If there is a court decree which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first. That order will supersede any order given in (a) or (b).

(4) If a person is covered under more than one plan, the plan he or she was covered under longer pays first. The exception to this rule is:

- A plan that covers a person other than as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid first. A plan that covers a person as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid second.

If this Fund is secondary under the above-stated rules, this Fund will pay the amount it would have paid if it had been primary, minus whatever the primary plan paid.

Third Party Recovery (Subrogation, Reimbursement, and Offset)

This Fund has subrogation, reimbursement, and offset rules that apply when a Covered Person is injured or becomes ill and someone else is potentially responsible for the Injury or Illness. Under such a circumstance, the Fund will advance the payment of benefits to cover the Covered Person's qualified claims, however, the Fund will retain a right to subrogation, reimbursement, and/or offset with respect to any such payment as further described below.

The Fund's subrogation, reimbursement, and offset rights are three distinct rights. The Fund may elect to pursue one or more of the rights in a particular matter. Moreover, the Fund's failure to pursue a given right does not constitute a waiver by the Fund with respect to any other right, nor shall such failure diminish or otherwise alter the extent of the Fund's remaining rights. For example, if the Fund chooses not to assert its subrogation interests in a particular case, the Fund will still have the right to full reimbursement and/or offset as further described below.

The subrogation, reimbursement, and offset rules are in place to assist Covered Persons by paying qualified claims while they proceed against the responsible third party. The rules also prevent a situation where a Covered Person is compensated twice for the same Injury or Illness once by the Fund when it pays the medical bills and a second time by the third party when it pays damages for the loss. The bottom line is that the rules help to ensure that assets are available for all of the Fund's Participant's and beneficiaries.

The Fund's rights of subrogation, reimbursement, and offset arise and will be exercised when any benefits are paid by the Fund to or on behalf of the Covered Person due to a loss, injury, or illness for which another person or entity is or may be legally responsible. This would include, but is not limited to, a loss, injury, or illness compensable under Social Security, the workers' compensation system, and/or due to medical malpractice, negligence, tortuous and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's payment of benefits in this context, the Covered Person is subject to the Fund's rights of subrogation, reimbursement, and offset, as follows:

- The Covered Person must sign and return the Fund's subrogation and reimbursement agreement as well as any other paperwork deemed necessary by the Fund or its agents to protect the Fund's subrogation, reimbursement, and/or offset interests. Benefits will not be paid unless the Fund Office receives a copy of all required documentation, including the subrogation and reimbursement agreement, signed by the Covered Person or, in the case of incapacitation, the Covered Person's authorized guardian. Notwithstanding anything to the contrary in the immediately preceding sentence, the Fund's rights to subrogation, reimbursement, and/or offset apply regardless of whether the required documentation, including the subrogation and reimbursement agreement, is actually signed by the Covered Person and received by the Fund Office. Thus, the payment of benefits by the Fund on behalf of a Covered Person absent the receipt of the required documentation, including the signed subrogation and reimbursement agreement, by the Fund Office does not constitute a waiver of the Fund's subrogation, reimbursement, and/or offset rights with respect to such payment.

- The Covered Person will do nothing to impair or negate the Fund's right of subrogation and will fully cooperate with the Fund. To this end, no settlement shall be made with or release given to a third party for claims arising out of the Covered Person's loss, injury, or illness for which benefits have been paid under the Fund without prior written consent of the Fund. If the Covered Person performs any act or fails to act, or otherwise compromises the Fund's rights, the Fund may immediately seek recovery of all benefit amounts paid by any available means, including legal action.

- The Fund shall be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Fund. The Fund shall receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the Covered Person, payment of attorneys' fees, and/or expenses. The Fund's right in first priority to full reimbursement shall not be subject to reduction for reasons including but not limited to the Covered Person's failure to recover the perceived full or actual value of his claim for whatever reason, attorneys' fees, expenses or other costs, and/or the Fund's failure to actively participate in the claim and/or recovery. Further, the Fund expressly rejects and otherwise prohibits application of the "make-whole" and "common fund" doctrines or any similar doctrines or common law rules with respect to its subrogation, reimbursement, and offset rights.

- The Fund shall be fully reimbursed from and/or granted a lien in any recovery that occurs or is available from any source, including but not limited to the person or entity that is or may, be responsible for such loss, injury, or illness, the insurer of such person or entity, the Covered Person's insurer including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance, Social Security, the workers' compensation system, or any other source. Such recovery includes but is not limited to court judgments, administrative or agency orders, private settlements, or any other payments.

- This repayment obligation applies to any recovery from a third party, regardless of whether the recovery is characterized as compensation for pain and suffering or something else.

- By way of example, if the Fund pays out $15,000 in medical claims on your behalf and you later recover $25,000 from a third party, you must reimburse the Fund for the $15,000 of medical benefits paid on your behalf.

- If a Covered Person recovers money, but refuses to repay the Fund, future health and welfare benefits will not be paid on the Covered Person's behalf until such time as the Fund offsets the full amount due to be reimbursed under these rules plus 10% per annum. These offset benefits shall be permanently forfeited by the Covered Person and the Covered Person shall be legally responsible to any provider for any unpaid claims.

The Fund may also choose to bring legal action against a Covered Person to collect monies due under these subrogation rules. If the Fund prevails, a Covered Person must also pay interest at the rate of 10% per annum and the Fund's reasonable attorney's fees.

Penalty for Falsifying Claims or Failing to Refund Overpayment

Any Participant or Dependent who through error, misrepresentation, or otherwise receives an incorrect payment from the Fund must make immediate repayment to the Fund. If the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Board of Trustees, Third-Party Administrator, or Claims Administrator (or their designee) may recover that incorrect payment, whether or not it was made due to the Plan's or its delegate's own error, from the person to whom it was made or from any other appropriate party. Failure to comply with the Fund's request for repayment within 30 days will result in imposition of the following penalties:

(1) Interest will be added to the amount due at the rate of 10% per annum or, if less, the maximum rate permitted under applicable law.

(2) Future benefits payable on the Participant's and his/her Dependents' behalf will be held in and used to offset (i.e., make up) the amount due the Fund plus interest at the rate specified in (1) above.

In addition, the Participant's and his/her Dependent's eligibility may be terminated by action of the Board of Trustees, and/or the Trustees may choose to file a lawsuit against the Participant, his/her Dependents, and/or other parties to recover the money due. In such a case, the Fund will also be entitled to recover its reasonable attorney's fees and costs.

Falsifying a claim for benefits is a serious offense. The Fund reserves the right to terminate a Participant and/or his/her Dependent's benefits, deny future benefits, take legal action against a Participant and/or his/her Dependents, and/or set off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, in the case of any Participant, Dependent, or other person who obtains benefits wrongfully due to intentional misrepresentation or fraud. The Fund may also notify legal authorities if a Participant, Dependent, or other person files a false claim.

Selection of Service Providers

Use of the services of any Hospital, clinic, Physician or other provider rendering health care is the voluntary act of the Participant or Dependent. Nothing in this booklet or elsewhere is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on the factors you deem appropriate. All providers are independent contractors, not employees of the Fund. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission by any provider in connection with Fund coverage. The provider is solely responsible for services and treatments rendered.

IRS Information Reporting and Medicare Secondary Payer Reporting

You may get a letter from the Fund or third-party administrator asking you to confirm or provide Social Security number information for your enrolled Dependents. Generally, Medicare requires the Plan's third-party administrator to provide this information electronically. To view the CMS (Centers for Medicare and Medicaid Services) ALERT, which provides information on the authority for requesting the Social Security number, visit www.cms.hhs.gov/MandatoryInsRep. Go to the Downloads section and select the June 23, 2008 ALERT.

In addition, the Fund must obtain Social Security numbers for all enrolled Dependents to comply with new IRS reporting required by the ACA.

Your failure to provide this information may result in your Dependent's termination of coverage.

No Guarantee of Employment

Nothing contained in this SPD/Plan Document shall be construed as a contract of employment between an Employer and any employee, or as a right of any employee to be continued in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of its employees, with or without cause.

Anti-Assignment Provision

Except for assignments to health care providers required in agreements with the Fund, your right to receive benefits under the Plan may not be assigned, voluntarily or involuntarily, to any other person. You cannot at any time assign your right to make a claim or sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which you might have against the Plan, its delegates, its fiduciaries, its Trustees, or any other person.

Misrepresentation or Fraud

To the extent permitted by law, the Plan Administrator, Third-party Administrators, and Claims Administrators reserve the right to terminate an Employee's or Dependent's benefits, deny future benefits, take legal action against an Employee or Dependent, and/or set off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, in the case of any person who obtains benefits wrongfully due to intentional misrepresentation or fraud.

SECTION 11
PRIVACY OF HEALTH INFORMATION

The Fund will comply with the Standards for Privacy and Security of Individually Identifiable Health Information promulgated by the Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under these standards, the Fund will protect the privacy of HIPAA protected health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only (1) to the extent authorized by the Covered Person; (2) as required to administer the plan, including the review and payment of claims and appeals; or (3) as otherwise allowed or required by law. You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Fund's use and disclosure of protected health information or your rights with regards to this information, you may request a copy of the Notice from the Fund Office.

SECTION 12
STATEMENT OF ERISA RIGHTS

The following statement of ERISA rights is required by federal law and regulation.

As a Participant in the Washington, D.C. Cement Masons Welfare Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse, or Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and Plan Document for more information on your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

- If your claim for benefits is denied in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You have the right to have the Plan 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 Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan'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.

Assistance with Questions

- If you have any questions about your Plan, you should contact the Third-Party Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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.

- Although this statement emphasizes your right to bring a lawsuit or to seek assistance from the Department of Labor Department, it is unlikely that disputes will require such action. The claims review procedure should be able to meet the needs of any Participant. In extreme cases, if legal action seems necessary, the Third-Party Administrator has been designated as the agent for service of legal process. Service of process can also be made on any Trustee.