

**BRICK MASONS'
HEALTH & WELFARE PLAN**

SUMMARY PLAN DESCRIPTION

Effective September 1, 2015

BRICK MASONS' HEALTH & WELFARE PLAN

Administrator

BeneSys, Inc.

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BRICK MASONS' HEALTH & WELFARE PLAN

1050 Lakes Drive, Suite 120

West Covina, CA 91790

(626) 646-1090 To All Eligible Members:

This new booklet has been prepared to provide you with a summary of the benefits available to you and your family as of September 1, 2015. This material replaces any previously issued benefit material.

All Fee-For-Service Medical, Fee-For-Service Dental, Loss of Time and Hearing Aid Benefits are paid directly out of the Brick Masons' Health & Welfare Trust Fund's assets. Your Life Insurance and Accidental Death and Dismemberment Benefits are insured by Prudential Insurance Company of America, Vision Care Benefits are provided through Vision Service Plan, Health Maintenance Organization (HMO) programs are provided through Kaiser and United Healthcare, and Dental HMO benefits are provided through United Concordia.

This booklet is only a summary. For a more complete description of your benefits, please refer to the Rules and Regulations for the Brick Masons' Health & Welfare Trust Fund, the Prudential Insurance Company of America certificate of insurance, and the contracts with Vision Service Plan, Kaiser, United Healthcare, and United Concordia.

We encourage you to review the schedule of benefits in order to become acquainted with the benefits that apply to you. You should retain this booklet for reference purposes since the payments of benefits will be based on the latest information issued to you for insertion in this booklet.

Please note that any word used in the male gender applies equally to the female gender unless a distinction is specified.

Please do not hesitate to contact the Administrative Office if you have any questions.

PLEASE NOTE: YOU MUST INFORM THE ADMINISTRATIVE OFFICE IN WRITING OF ALL CHANGES IN ADDRESS, MARITAL STATUS AND DEPENDENT STATUS.

Sincerely,

BOARD OF TRUSTEES

AUTHORIZED SOURCE OF INFORMATION

The only source of authorized information is the benefit booklet and booklet inserts, if any, the Trust Agreement, the Rules and Regulations Providing Health and Welfare Benefits of the Brick Masons' Health and Welfare Trust Fund and amendments, if any, and the written statements of the Fund Administrator, his authorized representatives and the Trust's legal representatives located in Los Angeles, California. Oral statements or representations made by individuals other than those designated personnel are not authoritative sources of information. Questions as to eligibility, benefits and other matters should be submitted in writing to the Administrative Office located at:

**1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090**

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I. SUMMARY OF BENEFITS FOR ACTIVE EMPLOYEE, NON-MEDICARE RETIREES AND DEPENDENTS

BRICK MASONS' HEALTH AND WELFARE TRUST FUND COMPARISON OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	KAISER – YOU PAY	UNITED HEALTHCARE – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Annual Deductible	None	None	PPO: \$250 per person; Non-PPO: \$250 per person; No family maximum
Hospital & Medical Maximum –			
Calendar Year	Unlimited	Unlimited	Unlimited
Lifetime	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum	\$1,500 per person, \$3,000 per family	\$2,000 per person, maximum \$6,000 per family	\$2,000 per person, maximum \$6,000 per family
Inpatient Hospital			
Room and Board	\$250 copay per admission	\$250 deductible per admission plus 20% of charges	PPO: 20% coinsurance Non-PPO: 40% of semi-private room rate or 40% of 2 times the semi-private room rate for ICU
Physician/Surgeon	No charge	No charge	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Extended Care Facility	No charge, limited to 100 days per Calendar Year	20% of charges for skilled nursing or Hospice care plus per admit Deductible; limited to 100 consecutive days from the first treatment per disability. This applies to Skilled Nursing only.	PPO: 20% coinsurance; Non-PPO: 40% coinsurance Confinement must begin within 7 days after a period of at least 5 days in the Hospital. Limited to 60 covered days per disability.

BRICK MASONS’ HEALTH AND WELFARE TRUST FUND COMPARISON OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	KAISER – YOU PAY	UNITED HEALTHCARE – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Outpatient Services			
Surgeon	No charge	No charge	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Room and Board	\$25 per visit	\$50 copay per visit	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Assistant Surgeon	No charge	No charge	20% of the Surgeon’s benefit
Office Visits	\$25 per visit	\$20 per visit	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Home visits	No charge	No charge, limited to 100 visits per year	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Rehabilitation Services	\$25 per day	\$20 copay, limited to Physical Therapy, Occupational Therapy, and speech therapy	PPO: 20% coinsurance Non-PPO: 40% coinsurance Physical Therapy, Chiropractic and Acupuncture services are limited to 20 visits combined per Calendar Year.
Habilitation Services	\$25 per day	Not covered	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Hospice Services	No charge	\$250 copay per admission and 20% coinsurance	PPO: 20% coinsurance Non-PPO: 40% coinsurance
Diagnostic X-ray and Laboratory	No charge	No charge	PPO: 20% coinsurance Non-PPO: 40% coinsurance

BRICK MASONS’ HEALTH AND WELFARE TRUST FUND COMPARISON OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	KAISER – YOU PAY	UNITED HEALTHCARE – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Maternity	Inpatient: \$250 per admission Outpatient: No charge for prenatal and postnatal care	Covered as any other Sickness; Prenatal and postnatal care paid in full	Covered as any other Sickness; no benefits for Dependent children except for Complications Of Pregnancy
Durable Medical Equipment Corrective Appliances & Artificial Aids	No charge	No charge	PPO: 20 coinsurance Non-PPO: 40% coinsurance
Chiropractor	Not covered	Not covered	PPO: 20% coinsurance, Non-PPO: 40% coinsurance (Plan pays up \$35 per visit) Limited to 20 visits combined with Chiropractic and Physical Therapy visits per Calendar Year
Acupuncture	\$25 copay per visit	Not covered	PPO: 20% coinsurance, Non-PPO: 40% coinsurance Limited to 20 visits combined with Chiropractic and Physical Therapy visits per Calendar Year

BRICK MASONS’ HEALTH AND WELFARE TRUST FUND COMPARISON OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	KAISER – YOU PAY	UNITED HEALTHCARE – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Substance Use Disorder - Inpatient Outpatient	Covered as any other Sickness \$25 copay per individual visit; \$5 copay per group visit	No charge No charge	Covered as any other Sickness Covered as any other Sickness
Mental/ Behavioral Health - Inpatient Outpatient	Covered as any other Sickness \$25 copay per individual visit; \$12 copay per group visit	\$250 per inpatient admission SMI benefits - \$250 per inpatient admission \$20 per visit SMI benefits \$20 per visit	Covered as any other Sickness Covered as any other Sickness
Residential Treatment Facility	\$100 copay per admit	\$250 deductible per admission plus 20% of charges	PPO: 20% coinsurance; Non-PPO: 40% coinsurance Confinement must begin within 7 days after a period of at least 5 days in the Hospital. Limited to 60 covered days per disability.
Emergency Care	PPO: \$50 copay per visit Non-PPO: \$50 copay per visit	\$100 copay (waived if admitted)	PPO: 20% coinsurance Non-PPO: 20% coinsurance
Urgent Care	PPO: \$25 copay per visit Non-PPO: \$25 copay per visit	\$50 copay per visit	PPO: 20% coinsurance Non-PPO: 40% coinsurance

BRICK MASONS’ HEALTH AND WELFARE TRUST FUND COMPARISON OF MEDICAL BENEFITS			
DESCRIPTION OF BENEFITS	KAISER – YOU PAY	UNITED HEALTHCARE – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Emergency Transportation	No charge	No charge	PPO: 20% coinsurance Non-PPO: 20% coinsurance
Prescription Drugs – Retail	\$15 copay for generic, \$30 for formulary and non-formulary brand prescription at Kaiser pharmacies for up to a 30-day supply	\$10 copay for generic, \$25 copay for formulary brand, and \$40 copay for non-formulary brand prescription at participating pharmacies for a 30-day supply	\$10 copay for generic, \$20 copay for formulary brand and 20% coinsurance for non-formulary brand and specialty prescription for a 30-day supply
Mail Order	Usually two times the cost of retail drug for up to 100-day supply	\$20 copay for generic, \$50 copay for formulary brand, and \$80 copay for non-formulary brand prescription for a 90-day supply	\$15 copay for generic, \$30 copay for formulary brand, \$45 copay for non-formulary brand, and 20% coinsurance for specialty prescription for a 90-day supply

**BRICK MASONS'
HEALTH AND WELFARE TRUST FUND
COMPARISON OF DENTAL BENEFITS**

SERVICE/TREATMENT	UNITED CONCORDIA – YOU PAY	FEE-FOR-SERVICE PLAN – YOU PAY
Annual Deductible	None	None
Annual Maximum Benefit	No maximum	\$1,000 per person
DIAGNOSTIC/PREVENTIVE X-rays, intra-oral, bitewing X-rays Complete mouth X-rays Teeth cleaning	No charge No charge No charge – one per six consecutive months	20% of fixed scheduled allowance once every 6 months 20% of fixed scheduled allowance once every 2 years, unless additional X-rays are necessary 20% of fixed scheduled allowance once every 6 months
RESTORATIVE DENTISTRY Fillings (amalgam) Crowns	No charge \$20 - \$40	20% of fixed scheduled allowance 20% of fixed scheduled allowance
PERIODONTICS (Treatment of the Gums) Gingivectomy per quadrant Osseous Surgery Specialist consultation	No charge No charge No charge	20% of fixed scheduled allowance 20% of fixed scheduled allowance 20% of fixed scheduled allowance
ENDODONTICS Root Canal Apicoectomy	\$20 - \$40 No charge	20% of fixed scheduled allowance 20% of fixed scheduled allowance
ORTHODONTIA Up to age 19 Age 19 and older	\$1,500 (24-months of banding) \$2,000 (24-months of banding)	Not covered Not covered

II. ELIGIBILITY RULES

A. ACTIVE EMPLOYEES

- (1) Establishment and Maintenance of Eligibility
 - (a) Any Active Employee working for Employers who contribute to the Brick Masons' Health and Welfare Trust Fund shall be eligible for Plan benefits on the first day of the second calendar month next following any consecutive period of four calendar months or less during which the number of hours for which contributions are made on your behalf by an Employer total at least 400 hours.
- (2) A reserve account has been established by the Fund for each Active Employee and is comprised of hours in excess of 120 hours worked by the Active Employee, while in an eligible class, with one or more contributing Employers during a month.

Such hours credited to the reserve account of the Active Employee under the Fund shall be carried over to his credit for continued eligibility for benefits. The maximum number of hours credited to the Active Employee's reserve account at any time shall in no event exceed 600 hours after the deduction has been made for the current month's coverage.

All hours credited to an Active Employee's reserve account shall be cancelled if the Active Employee does not satisfy the requirements for becoming eligible for benefits under the Fund for four consecutive calendar months.

When an Active Employee loses eligibility he or she has hours remaining in his or her reserve account and elects to self-pay for coverage through COBRA, the first month's self-pay amount will be prorated (reduced) by the hours remaining in the reserve account.

- (3) If an Active Employee has at least one hour in his or her Hour Bank, he or she may purchase additional hours, up to 120 hours, at a rate per hour as determined by the Trustees to maintain coverage. He or she will be allowed to purchase additional hours twice per fiscal plan year for maintaining eligibility, so long as there is at least one hour in his or her hour bank.
- (4) An Active Employee's Dependent becomes eligible on the date the Active Employee's eligibility is effective, or on the date the Active Employee acquires the Dependent, whichever is later.
- (5) Individuals who are employed by an Employer as a supervisor or estimator, as well as shareholders or Corporate Officers who hold less than 100% of the shares in an incorporated Employer, may participate in the Fund, provided that their Employers pay current

contributions to the Health and Welfare, Pension, and Apprentice Funds on their behalf on the greater of 160 hours or actual hours worked per month. The Employer(s) must notify the Fund of the individual's participation and sign a participation agreement with each of the above-listed Funds. The individuals are subject to the same initial eligibility rules that apply to Active Employees as set forth in Article I, Section 1, Subsections (a)(1), (a)(2) and (a)(3). Sole proprietors are not eligible to participate in the Fund.

B. RULES FOR SPECIAL CATEGORIES OF PARTICIPANTS

(1) Supervisors, Estimators and Shareholders

Individuals who are employed by an Employer as a supervisor or estimator, as well as shareholders or corporate officers who hold less than 100% of the shares in an incorporated Employer, may participate in the Fund, provided that their Employers pay current contributions to the Health and Welfare, Pension, and Apprentice Funds on their behalf on the greater of 160 hours or actual hours worked per month. The Employer must notify the Fund of the individual's participation and sign a participation agreement with the Fund. The individuals are subject to the same initial eligibility rules that apply to Active Employees as set forth under "Establishment and Maintenance of Eligibility" in Section I.A. Sole proprietors are not eligible to participate in this Plan.

(2) Mason Finisher Apprentices

A Mason Finisher Apprentice, as defined under the Collective Bargaining Agreement, will be covered when he or she meets the eligibility requirements set forth above. Coverage, however, will be limited as follows:

Unlike Active Employees, a Mason Finisher Apprentice may only enroll in the Fee-For-Service Medical and Fee-For-Service Dental Plans; and

If a Mason Finisher Apprentice wishes to cover their Dependent child(ren), they must elect this coverage by contacting the Trust Administrative Office. The Fund will not cover spouses of a Mason Finishers Apprentice under any circumstances.

Upon completion of the Mason Finisher Apprenticeship program (or the transitioning into the Bricklayer Apprenticeship program) a Mason Finisher Apprentice will be entitled to the same benefit options as Active Employees and any remaining hours earned as a Mason Finisher Apprentice will be fully credited into his or her reserve account as an Active Employee. The Mason Finisher Apprentice will be eligible as an Active Employee the month following the 1st contributions received at the Active Employee rate.

C. EFFECTIVE DATE

The effective date of all coverages for any Employee shall be the date on which he qualified for coverage in accordance with the rules set forth in Section I.A., above, except that no payments are to be made for days of hospitalization which occurred prior to his effective date, or for medical or surgical services rendered prior to that date.

D. HOUR-BANK PLAN

Hours worked* for Participating Employers by each Employee will be credited to the individuals "reserve account." 120 hours of work credit will be deducted from each Employee's reserve account for each month of coverage, and the Employee will continue to remain covered as long as his reserve account contains at least 120 hours of work credit.

Whenever you work more than the 120 hours for Participating Employers during a month (which is required to furnish one month's coverage), then such excess hours will be added to your reserve account.

You will be allowed to accumulate excess hours in your reserve account up to a maximum of 600 hours, after the deduction of the current month's coverage.

E. TERMINATION OF ELIGIBILITY

An Active Employee's eligibility will terminate on whichever of the following dates is applicable:

- (1) on the last day of the calendar month for which he does not qualify as an Active Employee, except as provided in Sections II and XVII.
- (2) On the date an Active Employee starts performing work that is not pursuant to a recognized Collective Bargaining Agreement in the area covered by the Plan. All contributions credited to the Employee's reserve account will be forfeited if eligibility is lost under this provision.
- (3) On the date of entrance into full-time active duty with the Armed Forces of the United States; but all hours accumulated shall remain in your account and may be used upon your return and re-entry into employment with a Participating Employer. Please see "Self-

* "Hours" and "hours worked" mean only those hours which Participating Employers are required to report.

Payment Under USERRA” for information about continuing eligibility while in military service.

- (4) benefits for a Dependent shall terminate when he no longer meets the definition of a Dependent.
- (5) On the date the Plan is terminated by the Board of Trustees.

F. REINSTATEMENT OF ELIGIBILITY

- (1) An Active Employee’s eligibility will be reinstated if his reserve account reflects a total of at least 400 hours within the four-month period following the termination of his previous eligibility. Such reinstatement will be effective on the first day of the second calendar month, which follows the month in which this requirement is met.

If the Active Employee is not reinstated within a four-month period, any hours remaining in his reserve account at the time of termination of his eligibility will be cancelled, and his eligibility can only be reinstated by satisfying the eligibility requirements, set forth in Section I.A., above.

- (2) If an Active Employee enters full-time active duty with the Armed Forces of the United States, and subsequently returns to work for an Employer within 90 days from his discharge date, he will be eligible on the first day of such reemployment, and he is to be credited with any hours held in his reserve account at the time of entrance to active duty.

If work is not commenced for an Employer within 90 days after his discharge date, his eligibility can only be reinstated by satisfying the eligibility requirements as outlined in Section I.A above.

G. SELF-PAYMENT UNDER USERRA

If an Active Employee enters full-time active service in the Armed Forces and takes a military leave from work with an Employer, a federal law known as the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) governs eligibility under the Plan as follows:

- (1) If the Active Employee takes leave for 30 days or less, the Active Employee and any eligible dependents will continue to be eligible under this Plan.
- (2) If the Active Employee is on military leave for longer than 30 days:

- (a) The Active Employee may self-pay for continuation coverage for himself or herself and any eligible Dependents for up to 24 months of coverage during active service provided:
 - (i) The Active Employee gives his or her Employer advanced notice of the military leave; and
 - (ii) When the total length of the military leave, when added to any prior periods of military leave, does not exceed 5 years.
- (b) The Active Employee's eligibility will be reinstated on the day he or she returns to work for a contributing Employer or registers for work with the Union, provided that this occurs within 90 days of discharge from active duty.

H. RECIPROCITY

The Fund is a party to the International Reciprocal Agreement for Bricklayers and Allied Craftworkers Health and Welfare Funds. Under this agreement, if an Active Employee is working temporarily under the jurisdiction of another union local that is a party to the reciprocity agreement, any contributions made on the Active Employee's behalf to the Trust Fund covering that local will be transferred to the Active Employee's Home Trust Fund, in order to maintain eligibility for benefits.

- (1) In order to participate in the reciprocity program, the Active Employee must, before he begins working in the jurisdiction of another union local, obtain a health and welfare transfer authorization.
- (2) The health and welfare transfer authorization must be submitted to the union local in whose jurisdiction the Active Employee is now working within thirty-five (35) days of the date he began work in that jurisdiction.
- (3) If an Active Employee has already established eligibility and incurred claims under this Trust Fund, he may not designate another Trust Fund as his Home Fund, unless he transfers his union membership to a local not covered by the Home Fund.

III. ELIGIBILITY RULES FOR RETIREES

A Non-Medicare individual who retires on or after May 1, 1988, and was eligible for benefits during all of the six months prior to his retirement, and receives a Regular Pension or Disability Pension as defined in the Rules and Regulations of the Brick Masons' Pension Trust, or who retires on or after November 1, 2007 and is eligible for benefits under any retirement plan sponsored by the Bricklayers and Allied Craftworkers Local #4, will be eligible to continue health care benefits under the "COBRA Coverage" described in the Section XVII, provided he was covered under the Active Plan at retirement, or he may elect to be covered under the Retiree Benefit Plan as described below. After the individual retires, and upon the exhaustion of his reserve account, he will be asked to elect one of the aforementioned plans. Once he has made his selection, he may not change to the other Plan.

The Retiree Plan consists of the medical and prescription drug benefits provided by Kaiser as well as the Hearing Aid Benefit, both described in this booklet. It does not include life insurance, accidental death and dismemberment, loss of time, dental or vision benefits. If the individual selects the Retiree Plan, coverage will start as of the date your pension benefits start, or after the number of hours in his reserve account falls below 120, whichever is later. The Retired Employee will maintain coverage under the Retiree Plan by remitting self-payment premiums by the 15th day of the month before the month for which coverage is desired. Individuals who select the Retiree Plan and have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of retiree self-payment premiums. The amount of the subsidy will be:

$$\frac{(\text{residual hours}) \times (\text{retiree monthly self-payment premium rate})}{(\text{monthly reserve account deduction})}$$

Coverage under the Retiree Plan will cease on the earliest of the following dates:

- (1) The date you cease to be eligible for pension benefits.
- (2) The date the Fund ceases to provide such coverage.
- (3) The first day of the month following the date you cease to pay premiums when due.
- (4) The date you become covered under another group health plan.

The Retired Employee may also continue his Dependents' benefits, if they are eligible under the Retiree Plan, or they may elect the special continuation coverage. Dependent benefits will terminate on the earliest of the following dates:

- (1) The date the Fund ceases to provide such coverage.
- (2) The date the Dependent becomes covered under another group health plan.
- (3) The date the Dependent ceases to qualify as a Dependent.
- (4) The date the Retired Employee's coverage terminates.

If the benefits of a Dependent covered under the Retiree Plan terminate due to one of the qualifying events listed in Section XVII, that Dependent will then be eligible to continue Retiree Plan benefits under the "COBRA Coverage;" see Section XVII.

IV. ELIGIBILITY RULES FOR DEPENDENTS

Dependents are defined as an Employee's or Retiree's (a) lawful spouse, (b) children from the date of birth to 26 years. Dependent children include natural children, stepchildren, foster children and children legally adopted or placed for adoption. Health Maintenance Organizations (HMO) such as Kaiser, United Healthcare, United Concordia and the Fund's vision carrier Vision Service Plan are mandated to recognize and provide coverage to those domestic partners that meet the criteria adopted by the Trust Fund. Contact the Administrative Office for information on enrolling a domestic partner.

In addition, unmarried Dependent children whose coverage would otherwise terminate due to turning age 26 shall continue to be covered while they are incapable of self-sustaining employment by reason of mental or physical disability, provided such children were so disabled prior to age 19 and provided written evidence of incapability is furnished to the Fund no later than: (a) the thirty-first day after attainment of the age limit, or (b) the thirty-first day after the child becomes eligible. Proof of continued incapability should be furnished to the Fund on request.

A Dependent will become eligible for benefits on the later of (a) the date the Employee satisfies the eligibility requirements stated herein or (b) the date he acquires Dependent status.

A. SPECIAL ENROLLMENT RIGHTS

Other Health Coverage. If a Covered Employee declines enrollment for an eligible Dependent(s) because the Dependent is covered under another group health plan, the Dependent may be eligible to be enrolled in this Plan in the future, provided that enrollment in this Plan is requested within 30 days after the other coverage ends.

New Dependent. If a Covered Employee acquires a new Dependent as a result of marriage, birth, adoption or placement for adoption, the new Dependent may be eligible to enroll in this Plan provided that enrollment in this Plan is requested within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage will become effective as of:

- (1) In the case of marriage, the first day of the month following the completed request for enrollment.
- (2) In the case of birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption.

- (a) The Covered Employee must pay any required contribution for a Dependent child's coverage.
- (b) A child is placed for adoption on the date the Covered Employee first become legally obligated to provide full or partial support of the child. A child who is placed for adoption with you a Covered Employee within 30 days after the child was born will be covered from birth if the Covered Employee complies with the Plan's requirements for obtaining coverage for a newborn Dependent child. If the child is placed for adoption and the adoption does not become final, coverage for that child will terminate as of the date the Covered Employee no longer has a legal obligation to support that child.

B. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Dependent child(ren) will be recognized as eligible Dependents if a divorce decree or other order of the court stipulates that the Covered Employee is responsible for the child's medical bills or must maintain health coverage for the child. The decree or order must satisfy the legal requirements pertaining to Qualified Medical Child Support Orders (QMCSO). The Plan has procedures to determine whether the order or other document is a QMCSO. These procedures are available to you at no charge when you request them. A copy of the divorce decree and/or support order must be on file in the Trust Office and the child must be enrolled as a Dependent in the Plan. Pursuant to the QMCSO, a child may be enrolled in the Plan by the non-Employee parent or appropriate state agency.

V. SUMMARY OF BENEFITS

A. ACTIVE EMPLOYEES, DEPENDENTS OF ACTIVE EMPLOYEES, AND COBRA PARTICIPANTS

(1) Fee-For-Service Medical Benefits (Provided by the Trust)

Medically Necessary Covered Expenses: The Plan pays 80% of the Contracted rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider. Non-PPO covered expenses for anesthesiology claims are based on the 85th percentile of HIAA.

Physical Therapy, acupuncture, and chiropractic care: The plan pays 80% of the contracted rate for covered expenses for Physical Therapy, acupuncture, and chiropractic care provided by a PPO Provider or 60% of the Non-PPO schedule for covered expenses provided by a Non-PPO Provider up to a maximum payable amount of \$35 per visit. Benefits are limited to 20 combined visits per year.

Inpatient and Outpatient Mental Health and Substance Use Disorder Services: Covered as any other Injury or Sickness.

Immunizations: The Plan will cover adult and children immunizations recommended by the US Preventative Care Task Force Guidelines. The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 60% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider.

Emergency Services: The Plan pays 80% of the Contracted Rate for Covered Expenses provided by a PPO Provider or 80% of the Non-PPO Schedule for Covered Expenses provided by a Non-PPO Provider.
Hospital Daily Rate:

Other than Intensive Care80% of PPO contracted rate or
60% of
Non-PPO schedule, but not to
exceed the Hospital's most
common charge for its
standard semi-private room
accommodations.

Intensive Care Unit80% of PPO contracted rate or
60% of Non-PPO schedule, but
not to exceed two times the
Hospital's most common
charge for its standard semi-
private room accommodations.

Most prescription drugs are covered after a required co-payment purchased at an Express Scripts network pharmacy. You only pay a \$15 co-payment for a 90-day supply of medication purchased through the Express Scripts mail order program. See Section VI.B for further details.

Maximum Amount Payable:

Calendar Year..... Unlimited for Essential Health Benefits
Lifetime..... Unlimited for Essential Health Benefits

Annual Deductible (per person):

PPO Providers.....\$250
Non-PPO Providers.....\$250

If two or more covered family members are injured in the same accident, only one Deductible will apply to the Covered Expense incurred for treatment received due to such accident for the remainder of the Calendar Year.

Accumulation Period: The Calendar Year, except that Covered Expenses incurred by an individual in the last three months of the preceding Calendar Year and applied toward the Annual Deductible for that Calendar Year may be applied toward such person’s Deductible amount for the current Calendar Year.

Physical Examination Benefit (Provided by the Trust) For Individuals Covered Under the Fee-For-Service Medical Plan

Active Employees and their spouse only are eligible for a routine physical exam and any routine diagnostic x-ray and laboratory tests run in conjunction with the exam provided that such services are medically appropriate based on age and gender. This benefit will be paid once a year for Eligible Individuals age 35 and over and once every two years for Eligible Individuals under age 35.

This benefit is not available to those individuals enrolled in an HMO plan.

(2) HMO Medical Benefits (Provided by Kaiser and United Healthcare)

See Section VII for a description of these benefits.

(3) Fee for Service Dental Expense Benefits (Provided by the Trust)

Dental Deductible None
Percentage Payable 80% of Covered Dental Expense incurred

Orthodontics..... Not Covered
Calendar Year Maximum \$1,000 per individual

The Trust allows you to opt out of the self-funded Fee for Service Dental Expense plan and Vision plan. However, there is no advantage to you to opt out. Should you decide to opt out anyway, you must first request the form from the Administrative Office. Please call the Administrative Office if you have questions regarding this.

(4) Prepaid Dental Benefits (Provided by United Concordia Companies)

See Section IX for a description of these benefits.

(5) Vision Care Benefits (Provided by Vision Service Plan)

If you select a VSP optometrist, you will be entitled to an eye exam and lenses (if required) every twelve months, and frames every twenty-four months at no cost except a \$5.00 co-payment per eligible person. See Section X for further details.

B. NON-MEDICARE RETIRED EMPLOYEES AND THEIR DEPENDENTS MEDICAL BENEFITS

Benefits are provided by Kaiser. See Section VII, for a description of these benefits.

C. ALL COVERED INDIVIDUALS (Except COBRA Participants)

The Hearing Aid Benefit that is provided by the Trust. See Section XI for a description of this benefit.

VI. CHOICE OF PLANS

A. MEDICAL

Active Employees may elect to be covered under the Fee-For-Service Medical Plan described in this booklet, or under one of the two Health Maintenance Organization (HMO) options offered by the Trust, which are also described herein. Non-Medicare Retirees may elect coverage under the HMO program provided by Kaiser.

B. DENTAL

Active Employees may elect to be covered under the Fee-For-Service Dental Plan or under the pre-paid dental plan provided by United Concordia Companies. Both dental options are described in this booklet.

C. CHOOSING YOUR HEALTH CARE PLANS

Upon initial eligibility, you must enroll in the Fee-For-Service Medical Plan for the first twelve (12) months of coverage. Once satisfied, you may change to another medical plan at the earlier of the next open enrollment period (May 1 of each year) or through self-directed enrollment. If you change plans through self-directed enrollment, the change will go into effect on the first day of the following month. All covered family members must have the same plans. If you were covered under Kaiser as an Active Employee, you will be eligible for Kaiser Senior Advantage coverage when you attain Medicare eligibility. The Kaiser HMO is described in Section VII.

D. REQUIRED ENROLLMENT IN FEE-FOR-SERVICE PLAN

Upon initial eligibility, the Covered Employee and his Dependents, if any, are required to enroll in the Fee-For-Service Medical Plan for the first twelve (12) months of coverage. Once satisfied, the Covered Employee and his Dependents, if any, may change to another medical plan at the earlier of the next open enrollment period (May 1 of each year) or through self-directed enrollment. If the Covered Employee changes plans through self-directed enrollment, the change will go into effect on the first day of the following month.

However, if the eligibility of the Covered Employee and his Dependents are terminated, but he otherwise re-enrolls in the Medical Plan within twelve (12) months of being so terminated, he and his Dependents can enroll in the Medical Plan they were in immediately before his eligibility was terminated.

If no dental plan selection is made at the time of initial eligibility or reinstatement of eligibility, Covered Employees, and their Dependents, if any, will be enrolled in the Fee-For-Service Dental Plan. After twelve (12) months of consecutive enrollment in the Fee-For-Service Plan or at the next open enrollment period (May 1 of each year), you can change to another dental plan.

**VII. FEE-FOR-SERVICE MEDICAL BENEFITS PROVIDED BY THE
TRUST FOR ACTIVE EMPLOYEES, THEIR DEPENDENTS, AND
COBRA PARTICIPANTS**

Comprehensive coverage for Covered Expenses incurred by you and your eligible Dependents is provided in connection with an Injury or Sickness.

The Fee-For-Service Medical plan pays benefits as follows:

	HealthSmart Providers	Non-HealthSmart Providers
Calendar Year Deductible: Per Person	\$250	\$250
Lifetime Maximum	Unlimited for Essential Health Benefits	Unlimited for Essential Health Benefits
Calendar Year Maximum	Unlimited for Essential Health Benefits	Unlimited for Essential Health Benefits
Medically Necessary Covered Services	80% of contracted rate; pregnancy benefits for Dependent children are limited to Complications Of Pregnancy; no Hospital related benefits if HealthSmart is not notified	60% of schedule; pregnancy benefits for Dependent children are limited to Complications Of Pregnancy; no Hospital related benefits if HealthSmart is not notified
Psychiatric Services (outpatient)	80% of contracted rate	60% of schedule

Note: “The Schedule” for Medically Necessary covered services is based on a fixed schedule of allowances that is, in general, considerably less than billed charges. You are responsible for 40% plus any amount over the schedule after your deductible has been satisfied.

FOR EXAMPLE:

Assume you are hospitalized for three days in a semi-private room and the Hospital charged \$2,000 per day. If you used a non-HealthSmart Hospital, the Fund would pay 60% of \$2,000 per day after your deductible (or \$1,200 per day) and you would be responsible for \$2,400. On the other hand, if you used a HealthSmart Hospital, the Fund would pay 80% of the negotiated charges and the most you would be responsible for is 20% of \$6,000 or \$1,200. By using the HealthSmart Hospital, you could have saved at least \$1,200.

A. COST CONTAINMENT PROGRAMS PROVIDED THROUGH HEALTHSMART

In an effort to reduce claims costs, the Trust has contracted with HealthSmart to provide various cost containment programs in conjunction with the Fee-For-Service Medical Plan. The following is a brief description of those programs and how they work.

(1) Provider Network

HealthSmart has established an extensive Preferred Provider Organization (PPO) network. This means that certain Hospitals and Physicians – “preferred providers” – have agreed to offer their services to you and your family at a reduced fee. Therefore, if you receive medical care from a HealthSmart provider, your medical bills may be 40% lower. You may continue to go to providers who are not members of the HealthSmart network, but the portion of your medical bills that you yourself have to pay will be higher.

We strongly encourage use of the HealthSmart program. It saves money for both you and the Fund.

Additional information about HealthSmart, including lists of participating Hospitals and Physicians, are available at the Administrative Office. If you have any questions concerning the HealthSmart programs, contact the Administrative Office, or call HealthSmart directly at (866) 511-4757.

(2) Second Surgical Opinion

- (a) If an elective surgery (surgery that is not Medically Necessary to save the life, or is not in response to an urgent medical condition of an Eligible Individual) is recommended by a Physician, a second opinion may be obtained through the Health Management Organization.
- (b) The Plan will pay for all expenses incurred in connection with obtaining a second surgical opinion.
- (c) No benefit reduction will apply if an Eligible Individual is hospitalized on a non-emergency basis without obtaining a second opinion.

(3) Pre-Admission Review

- (a) If an Eligible Individual is going to schedule an elective, non-emergency hospitalization due to surgery or Sickness, including pregnancy and Complications Of Pregnancy, the hospitalization must be approved by the Care Management company prior to admission.
- (b) The Eligible Individual or his or her Physician will contact a Coordinator with the Care Management Company to work out an appropriate treatment plan.
- (c) Emergency hospitalization does not require pre-admission review. However, the, Care Management Company must be notified within 48 hours of an emergency admission.

(4) Concurrent Review and Discharge Planning

- (a) While an Eligible Individual is hospitalized, the Care Management Company will monitor his or her progress.
- (b) Requests for additional days of hospitalization and other types of services will be evaluated.
- (c) In the event of catastrophic Injury or Sickness, the Care Management Company will help to coordinate post-hospitalization care and suggest alternative treatment where appropriate.

B. PRESCRIPTION DRUG COVERAGE

The Plan also covers most prescription drugs when purchased through Express Scripts retail network pharmacy or the Express Scripts mail order program.

To purchase retail prescriptions, you may call (800) 467-2006 to find a network pharmacy near you. Take your prescription to a participating pharmacy and have it filled. Show the pharmacist your Express Scripts I.D. card. You will pay the required co-payment, as described below.

RETAIL

Generic	\$10
Preferred Brand Name	\$20
Non-Preferred Brand Name	20%
Specialty	20%

MAIL ORDER

Generic	\$15
Preferred Brand Name	\$30
Non-Preferred Brand Name	\$45
Specialty	20%

If you fail to show your I.D. card, no benefits will be payable. If you go to a non-network pharmacy, no benefits will be payable except injectable drugs, covered at 60%.

If you use a medication regularly (a maintenance medication), you may save money by purchasing your prescription through the mail order program. Simply have your Doctor write your prescription for up to a 90-day supply, mail the prescription, along with your \$15 co-payment* and order form to Express Scripts, P.O. Box 52112, Phoenix, AZ 85072-2112. You should receive your order in approximately 2-3 weeks.

To effectively begin using the mail order program, ask your Doctor for two prescriptions. The first for a 30-day supply of medication to be filled at a retail pharmacy. The second, a 90-day supply with up to 3 refills to be mailed in (starting with the second prescription, it is mandatory to use mail order). Have your retail prescription filled and mail in your other prescription along with your co-payment. Before you are finished with your 30-day supply, you should receive your mail order. From then on, just call to refill your medication. Be sure to order your refill 14-21 days prior to running out of medicine.

C. CALENDAR YEAR DEDUCTIBLE

Each eligible person must satisfy the following Calendar Year Deductible:

	HealthSmart Providers	Non-HealthSmart Providers
Calendar Year Deductible:		
Per Person	\$250	\$250

* Your co-payment will be higher if you elect to have a brand name drug when a generic drug is available. In this case, your co-payment will be \$15 plus the difference in cost between the brand and generic drug.

Any Covered Expenses applied to the Deductible in the last three months of the Calendar Year will be applied to the following Calendar Year's Deductible as well.

Common Accident. If two or more covered family members are injured in the same accident before the Deductible amount has been satisfied, only one deductible will apply to the covered expense incurred for treatment received by all family members due to that accident for the remainder of the Calendar Year.

D. COVERED EXPENSES

Covered Expenses include charges for the following services, supplies, and treatments, which are certified by a licensed Doctor to be Medically Necessary, and are within generally acceptable medical care treatment protocols:

Hospital Care:

- (1) Daily room charge in a licensed Hospital for:
 - (a) Semi-private room;
 - (b) Private room, not to exceed the Hospital's average charge for semi-private room accommodations; and,
 - (c) Intensive Care or Coronary Care Unit, not to exceed two times the Hospital's most common charge for semi-private room accommodations; and.
- (2) General nursing care and charges for other Hospital services and supplies necessary for treatment of Injury or Sickness.
- (3) Extended Care Facility. Extended Care Facility room, board and general nursing care which commences within seven days after a period of at least five days confinement in a Hospital, excluding that part of the Extended Care Facility's daily charge in excess of the charge for its most prevalent semi-private room rate and any charges incurred after the 60th day of confinement during any disability.
- (4) Treatment by a licensed Physician or podiatrist, including Assistant Surgeon and anesthetist, charges for the services of an Assistant Surgeon will be paid at a maximum of 20% of the amount paid to the primary Surgeon. An Assistant Surgeon is considered Medically Necessary when a procedure is at a level of technical surgical complexity that the assistance of another Surgeon is required. An Assistant Surgeon is not considered Medically Necessary when the assistance required is of a manual nature, and can be provided by non-Surgeon, paramedical personnel.

Paramedical personnel include R.N.'s, L.P.N.'s, operating room technicians, and Physician assistants. Services of surgical assistants (paramedical personnel) are included in the operating room facility charges and are not eligible for separate benefits.

- (5) Treatment by a licensed chiropractor, acupuncturist or physical therapist paid at the appropriate PPO/Non-PPO percentage to a maximum payable of \$35 per visit and limited to 20 combined visits per year.
- (6) Services of a Registered Nurse, provided that the services rendered require the skill or training of a Registered Nurse.
- (7) Services of a registered physiotherapist, licensed speech pathologist or laboratory technician.
- (8) Anesthesia and its administration.
- (9) Medical care by a Physician, Dentist or dental Surgeon for a fractured jaw or for Injury to natural teeth, including replacement of such teeth within six months after the date of the accident.
- (10) X-ray or radium treatment, and x-ray and laboratory examinations.
- (11) Professional ambulance service to the Hospital for confinement therein and from the Hospital immediately following such confinement.
- (12) Medical supplies as follows:
 - (a) Drugs and medicines which can be obtained only by a numbered prescription for the specific accident or Sickness for which the patient is being treated (through Express Scripts);
 - (b) Blood and blood plasma;
 - (c) Initial artificial limbs and eyes;
 - (d) Surgical dressings;
 - (e) Casts, splints, trusses, braces and crutches;
 - (f) Rental of wheel chairs, Hospital bed or iron lung or other Durable Medical Equipment used exclusively for treatment or Injury or Sickness, not to exceed the reasonable purchase price;
 - (g) Oxygen and rental of equipment for administration or oxygen; and,

- (h) Insulin and diabetic supplies and diagnostics (through the Prescription Drug Provider).
- (13) Mental Health and Substance Use Disorders: Covered as any other Injury or Sickness.
- (14) Residential Mental Health/Substance Abuse Facilities. Residential Mental Health/Substance Abuse facilities room, board, and general nursing care which commences within seven days after a period of at least five days confinement in a Hospital, excluding that part of the Residential Mental Health/Substance Abuse Facility's daily charge in excess of the charge for its most prevalent semi-private room rate and excluding any charges incurred after the 60th day of confinement during any disability.
- (15) Maternity care for female Employees and Dependent spouses only.
 - (a) Covered expenses will be covered as any other Sickness.
 - (b) Group health plans and health insurance issuers generally may not, under federal law known as the Newborns' and Mothers' Health Protection Act of 1996, 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 caesarian section. However, federal law generally does not prohibit the Doctor 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

E. LIMITATIONS AND EXCLUSIONS

Payment will **not** be made for:

- (1) Treatment of any Injury or Sickness for which the covered person is not under the care of a Physician;
- (2) Except in the case of an emergency, Hospital-related expenses which have not been preauthorized;
- (3) Medical examinations, services, or supplies not Medically Necessary for the treatment of an Injury or Sickness;

- (4) Expenses incurred for Experimental procedures, or treatment that is not within accepted medical practice;
- (5) Cosmetic surgery, except operations necessary to repair disfigurement due to an accident occurring while covered or surgical treatment after a mastectomy to assure a symmetrical appearance;
- (6) Any operation or treatment in connection with the fitting or wearing of dentures or for treatment of teeth or gums except: (a) tumors, (b) treatment rendered within six months of accidental Injury to natural teeth (including their replacement), and (c) fractures due to an accident occurring while covered under the Plan;
- (7) Treatment of Temporomandibular Joint Dysfunction (TMJ) will be limited to that which is Medically Necessary, according to accepted medical practice, to alleviate discomfort and/or restore function;
- (8) Charges in connection with conditions of pregnancy of other than the Employee or Dependent spouse;
- (9) Charges for routine nursery care; however, any expenses incurred due to the confinement of a newborn Dependent child that results from premature birth, abnormal congenital condition, or Injury or Sickness contracted or sustained after birth will be covered;
- (10) Expenses incurred for transplants;
- (11) No Plan benefits will be paid for any of the following elective surgeries:
 - (a) Uterine Suspension;
 - (b) Sympathectomy (Thoracic or Lumbar);
 - (c) Omentopexy;
 - (d) Renal Decapsulation;
 - (e) Perineal Insufflation;
 - (f) Hypogastric or Pre-sacral Neurectomy;
 - (g) Fascia lata stripping;
 - (h) Excision of Carotid Body;
 - (I) Ligation Femoral Vein;

- (j) Ligation Internal Mammary Artery;
 - (k) Female Circumcision.
-
- (12) Charges in connection with acupressure or massage therapy;
 - (13) Eye refractions, eyeglasses, and the fitting of eyeglasses;
 - (14) Vision therapy (orthoptics) unless it is in lieu of a surgical procedure;
 - (15) Any surgical procedure for the correction of visual refractive problems, including radial keratotomy;
 - (16) Charges in connection with orthotics;
 - (17) Transportation, except local ambulance services;
 - (18) Orthopedic shoes and items which also serve as wearing apparel;
 - (29) Charges for non-prescribed drugs and contraceptives;
 - (30) Charges for services or supplies paid for under any other benefits provided by this Plan;
 - (31) Custodial Care, whether received at home, in a skilled nursing facility or Hospital;
 - (32) Surgical procedures or treatment to alter a person's sex or reversals thereof;
 - (33) Any supplies or services (a) for which no charge is made or the Eligible Individual is not required to pay, or (b) furnished by or payable under any plan or law of any Government or furnished by a Federal, State, County, Parish or Municipal Hospital where there is no legal requirement to pay for such supplies or services, except when this Trust Fund is required by federal law to provide coverage;
 - (34) Expenses incurred for services rendered by a person related by blood or marriage to the Eligible Individual or who ordinarily resides in that person's home;
 - (35) Any Injury or Sickness arising out of or in the course of any occupation or employment for compensation, profit, or gain, or for which benefits are provided under any Workers' Compensation act or similar legislation;

- (36) Treatment of Injury or Sickness which is occasioned by war or act of war, declared or undeclared; and,
- (37) Hearing Aid Benefits, except as provided under Section XI.

F. EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Eligible Individual is totally disabled at the time his coverage terminates, medical benefits will be payable to the same extent as if the coverage had not been terminated for expenses incurred on account of the Injury or Sickness which caused such disability, until the earliest of:

- (1) the date on which the Total Disability ceases;
- (2) the date on which coverage for such person becomes effective, with no limitation as to the disabling condition, under any (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other pre-payment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, Employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs, (such as Medicare, Medi-Cal and Medicaid), and (v) any coverage required or provided by any statute; or,
- (3) the end of the period of 12 months following the date on which coverage on account of the person ceases.

G. MEDICAL REHABILITATION BENEFIT

- (1) Benefits

If an Active Employee or a Dependent, while eligible, suffers any one of the following non-work incurred injuries which requires extensive Hospital and/or medical care, the Plan will pay charges incurred for Covered Expenses, subject to the provisions of Section VI:

- (a) Spinal Cord Injury: Damage to the spinal cord causing paralysis from waist or neck down;
- (b) Head Trauma: Injury to the head causing fracture of the skull, paralysis or a long period of unconsciousness; and,
- (c) Major Burn Injury: Second and third degree burns over 20% of the body or on the face.

(2) Covered Expenses

Covered Expenses include charges for the following types of treatment which are certified by the attending Doctor to be necessary for medical rehabilitation treatment, to the extent that the charges do not exceed Reasonable Charges:

- (a) Treatment at a Neurological Training Center; and,
- (b) Treatment at a Rehabilitation Center.

(3) Limitations

Medical Rehabilitation Benefits are subject to the following:

- (a) The Eligible Individual must submit a Doctor's written opinion that he or she is totally disabled and unable to work; and,
- (b) Pre-authorization of treatment must be obtained from the Health Management organization.

H. ROUTINE PHYSICAL EXAMINATION BENEFIT

(1) Examination and Diagnostic Tests

The Plan will pay benefits for routine physical examinations for an Active Employee and Dependent spouse performed by a licensed Physician as follows:

(2) Routine Physical Exam Benefit

Once per Calendar Year for a Covered Employee or spouse of a Covered Employee once every two years under the age of 35.

Once per Calendar Year for a Covered Employee or spouse of a Covered Employee age 35 and over.

If any abnormality is discovered as a result of your physical examination, the benefits outlined in Section VI.E will be paid on the same basis as any Sickness.

The benefits covered under routine physical examinations are limited to those generally considered medically appropriate based on the age and gender of the person being examined.

(3) Covered Expenses

The Routine Physical Examination Benefit will cover:

- (a) Complete history and physical examination;
- (b) X-ray of chest;
- (c) Electrocardiogram;
- (d) Routine urine analysis;
- (e) CBC and differential;
- (f) Blood chemistry screen profile (SMA-26);
- (g) Serology and T4;
- (h) Pap smears; and,
- (i) Sigmoidoscopy, if recommended by the Doctor, for Eligible Individual s over age 40.

(4) Limitations and Exclusions

No benefits are payable for:

- (a) More than one examination per Calendar Year for Covered Employees or a Dependent spouse over the age of 35 or more than one examination every two years for Covered Employees or a Dependent spouse under the age of 35.
- (b) Expenses incurred as a result of diagnosed Injury or Sickness.
- (c) Any physical examination required for employment.
- (d) Any examination for which the Eligible Individual's Employer is required to pay.

VIII. HEALTH MAINTENANCE ORGANIZATIONS FOR ACTIVE EMPLOYEES, THEIR DEPENDENTS, COBRA PARTICIPANTS, AND NON-MEDICARE RETIREES

Health Maintenance Organization (HMO) health programs are provided through Kaiser and United Healthcare. There are no claim forms involved when you are enrolled in an HMO plan. Covered services and supplies are provided by the HMO's facilities either at no cost to you or at specified co-payment or co-insurance amounts.

A. PROVIDED BY KAISER PERMANENTE

Under the Kaiser Plan, most medical needs will be covered at no cost or at a specified co-payment. There are no claim forms to fill out. Except in certain medical emergencies, you must receive all medical care from Kaiser Hospitals and staff Physicians. **If medical care is received from a provider that is not a member of the Kaiser network, you will have to pay all the provider's charges.**

To be covered under the Kaiser plan, you must live in one of their service areas, which are determined by zip code. If you do not reside in a designated zip code, you will not be able to enroll in the Kaiser plan. A list of the Kaiser facilities and the service area zip codes is contained in a separate document and will be automatically furnished to you, free of charge, when you enroll in Kaiser.

Some of the benefits provided under the Kaiser Plan include Hospital, annual exams, maternity, chiropractor, and prescription drugs. For a complete description of benefits, please refer to the Evidence of Coverage and Disclosure Form provided by Kaiser or contact the Administrative Office for a free copy.

B. PROVIDED BY UNITED HEALTHCARE

United Healthcare, like Kaiser Permanente, is also an HMO, and provides the same type of coverage. There are some variations in co-payments, however. If you opt to be covered under the United Healthcare Plan, you will be asked to choose one of their contracted medical groups to take care of your basic health care needs. The United Healthcare medical groups are made up of Primary Care Physicians (PCP's) who will evaluate your medical problems and refer you to a United Healthcare affiliated Hospital or specialist, as required. All United Healthcare Physicians are in private practice, but have contracted to service United Healthcare participants. Similarly, all United Healthcare Hospitals are open to the public. Except for emergency situations, the United Healthcare network, as approved by your PCP or medical group must provide any medical treatment you receive. Listings of the medical groups that

are associated with United Healthcare will be automatically furnished to you, free of charge, when you enroll in United Healthcare.

Some of the benefits provided through United Healthcare include Hospital, annual exams, maternity, and prescription drugs. For a complete description of benefits, please refer to the Evidence of Coverage and Disclosure Form provided by United Healthcare or contact the Administrative Office for a free copy.

**IX. FEE-FOR-SERVICE DENTAL BENEFITS PROVIDED BY THE
TRUST
FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS**

A. COVERED DENTAL EXPENSES

The term “Covered Dental Expense” means only expenses incurred for Necessary Treatment which is received by an Active Employee or his Dependent from a Dentist or dental hygienist under the supervision of a Dentist and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount allowable as Covered Dental Expense will not exceed the amount specified in the Schedule of Dental Allowances for the procedure Reported on any attending Dentist’s statement. A covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

If an Active Employee or his Dependents incurs Covered Dental Expense, the plan will pay for treatment, examination or procedure, but not more than 80% of Covered Dental Expense or the Dentist’s Reasonable Charge, whichever is less.

The maximum amount payable hereunder for Covered Dental Expense incurred by each Active Employee or Dependent in any Calendar Year shall be \$1,000. This Calendar Year maximum does not apply to children under the age of 19.

The Trust allows you to opt out of the self-funded Fee for Service Dental Expense plan and Vision plan. However, there is no advantage to you to opt out. Should you decide to opt out anyway, you must first request the form from the Administrative Office. Please call the Administrative Office if you have questions regarding this.

If benefits are payable under this benefit and the Fee-For-Service Medical Plan, payment will be made only under the plan which allows the greater payment.

Subject to the limitations and exclusions of Section VIII, the Plan uses a Schedule of Dental Allowances which is updated periodically by the Board of Trustees. Copies of the current Schedule is available from the Trust Fund Office.

The following expenses are covered when rendered by a Dentist or a dental hygienist under the supervision of a Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice:

- (1) Routine examinations and/or prophylaxis, if performed by a Dentist or dental hygienist, once every six months;
- (2) Bitewing x-rays once every six months and complete mouth x-rays once every three years, unless additional x-rays are necessary;
- (3) Topical application of fluoride;
- (4) Space maintainers;
- (5) Restorative services:
 - (a) Amalgam, synthetic porcelain and plastic fillings; or
 - (b) Gold restorations, crowns and jackets when teeth cannot be restored with the above materials;
- (6) Root canal therapy;
- (7) Periodontal treatment (treatment of the tissues supporting the teeth);
- (8) Extractions and other oral surgery, including anesthesia and pre- and post-operative care.
- (9) Partial dentures and bridges;
- (10) Initial complete dentures; and,
- (11) Replacement of complete dentures.

For any claim submitted for a denture or partial denture that replaces natural teeth, the Plan will consider Covered Expenses to be the Reasonable And Customary Charges made for standard cast chrome or acrylic dentures. However, if the Eligible Individual wishes to acquire a more sophisticated appliance or implants, the Plan will allow the amount that would have been payable for standard dentures toward any non-standard device or procedure. However, no benefit will be payable for the surgical removal of implants.

B. DENTAL LIMITATIONS AND EXCLUSIONS

Payment will not be made for:

- (1) Service with respect to congenital or developmental malformations or cosmetic surgery or dentistry for cosmetic reasons, including but not limited to (a) cleft palate, (b) maxillary and mandibular malformations, (c) enamel hypoplasia, (d) fluorosis, and (e) anodontia;

- (2) Orthodontic services, including the correction of malocclusion; appliances or restoration necessary to increase vertical dimension;
- (3) Dietary planning, oral hygiene instruction or training in preventative dental care;
- (4) The replacement of any prosthodontic appliance (including partial and complete dentures, crowns and bridges) which was covered under these Dental Benefit provisions, either as an initial complete denture or as a replacement, if such replacement occurs within three years from the date expense was incurred for such denture, unless the replacement is made because the existing appliance is unsatisfactory and cannot be made satisfactory;
- (5) Services and supplies provided for the treatment of Temporomandibular Joint Dysfunction (TMJ);
- (6) Prescription drugs;
- (7) Treatment of any condition for which the covered person is not under the care of a Dentist;
- (8) Any procedure which commenced before the date the person became eligible under this Dental Benefit;
- (9) Expenses incurred for Experimental procedures, or treatment that is not within accepted dental practice;
- (10) Expenses incurred for services rendered by a person related by blood or marriage to the Eligible Individual or who ordinarily resides in that person's home;
- (11) Any condition rising out of or in the course of any occupation or employment for compensation, profit, or gain, or for which benefits are provided under any Workers' Compensation act or similar legislation;
- (12) Treatment of any condition which is occasioned by war or act of war, declared or undeclared;
- (13) Any supplies or services (a) for which no charge is made or the Eligible Individual is not required to pay, or (b) furnished by or payable under any plan or law of any Government or furnished by a Federal, State, County, Parish or Municipal Hospital where there is no legal requirement to pay for such supplies or services, except when this Trust Fund is required by federal law to provide coverage;

- (14) Treatment of any condition that results from non-therapeutic release of nuclear energy;
- (15) Claims not submitted within one year of the date they were incurred, except in the absence of legal capacity. Additional information requested by the Administrative Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment;
- (16) Replacement of a prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth, or (b) the prosthesis is a stayplate or similar temporary partial prosthesis, and is being replaced by a permanent prosthesis, while in the oral cavity, has been damaged beyond repair as a result of Injury while covered; and,
- (17) Procedures which are necessary solely to increase vertical dimension, or restore the occlusion.

If benefits are also payable under the Fee-For Service Medical Benefit Plan, payment will be made only under the Plan that allows the greater payment.

C. EXTENDED DENTAL BENEFITS

If an Eligible Individual is receiving treatment for services required for the completion of a procedure which is considered a Covered Dental Expense at the time his coverage hereunder terminates, Dental Benefits will be payable for such expense, but not beyond 30 days after termination of coverage.

**X. PREPAID DENTAL BENEFITS PROVIDED BY UNITED
CONCORDIA COMPANIES FOR ACTIVE EMPLOYEES
AND THEIR DEPENDENTS**

If you enroll in the United Concordia Companies plan, you and your eligible Dependents will receive dental care at no cost or at a specified co-payment, as long as you receive treatment from a United Concordia Companies DHMO Dentist. Co-payments are the same for both Specialists and General Dentists. However, you must have a referral from your General Dentist in order to be treated by a Specialist. If services are received from a Specialist without presenting the United Concordia referral form, or if services are from a non-panel specialist, you will be responsible for the full, usual fees. In order to be eligible to enroll in the United Concordia Companies plan, you must live within the service area of a DHMO dental office. Each member of your family may choose a different dental office.

For a complete list of covered dental procedures and applicable co-payments under the United Concordia Companies plan, please refer to the Evidence of Coverage and Disclosure Form provided by United Concordia or contact the Administrative Office for a free copy.

The dental services of the United Concordia Plan are provided only when performed or authorized by the United Concordia Dentist you have selected. Listings of United Concordia Dentists will be automatically furnished to you, free of charge when you enroll in the United Concordia Plan.

**XI. VISION CARE BENEFITS PROVIDED BY VISION SERVICE PLAN
FOR ALL ACTIVE EMPLOYEES AND THEIR DEPENDENTS**

Vision Care benefits are available for Active Employees and their Dependents through Vision Service Plan (VSP). VSP has a panel of Doctors who will provide appropriate eye care at pre-established fees. If you select a VSP optometrist, you will be entitled to an eye exam and lenses (if required) every 12 months, and frames every 24 months at no cost except a \$5 co-payment per Eligible Individual.

In order to use the VSP plan, simply call VSP at (800) 877-7195 or see your VSP provider. Once the examination has been completed, you will pay your \$5 co-payment directly to the Doctor and sign the benefit form, which the Doctor will then submit to VSP for payment of the balance of the pre-established fee.

If you receive vision care from a Doctor who is not a VSP panel member, submit your receipts along with an itemized bill to VSP. You will be reimbursed according to the VSP schedule. There is no guarantee that the reimbursement will cover the incurred charges. Send your benefit form and itemized bill to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

Phone: (800) 877-7195 No vision care benefits will be paid under any other portion of the Trust Fund's medical plan.

A free list of VSP providers will be automatically furnished to you as a separate document.

(1) Your Coverage from a VSP Doctor

YOUR COVERAGE FROM A VSP DOCTOR	
Exam covered in full	every 12 months
Prescription Glasses	
Lenses covered in full.....	every 12 months
– Single vision, lined bifocal and lined trifocal lenses	
– Polycarbonate lenses for Dependent children.	
Frame	every 24 months
– Frame of your choice covered up to \$120	
– Plus 20% off any out-of-pocket costs.	
~ OR ~	
Contact Lens Care	every 12 months

YOUR COVERAGE FROM A VSP DOCTOR

When you choose contacts instead of glasses, your \$120.00 allowance applies to the cost of your contacts & the contact lens exam (fitting & evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contact lenses you will be eligible for a frame 24 months from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your Doctor or vsp.com.

(2) Vision Care Benefits Provided by Vision Service Plan for All Active Employees and Their Dependents

YOUR COPAYS

Exam & Prescription

Glasses\$5.00
Contacts No co-pay applies

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network Doctor. If you decide not to see a VSP Doctor, co-pays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim within six months to VSP for partial reimbursement. If you decide to see a non-VSP provider, call us first at (800) 877-7195.

Out-of-Network Reimbursement Amounts:

Exam.....\$45.00
Lenses:
 – Single Vision\$45.00
 – Lined Bifocal\$65.00
 – Lined Trifocal.....\$85.00
 – Frame\$47.00
Contacts\$105.00

(3) Extra Discounts and Savings

EXTRA DISCOUNTS AND SAVINGS

Laser Vision Correction Discounts

Glasses and Sunglasses

- Average 30% savings on lens options such as scratch-resistant and anti-reflective coatings and progressives
- 20% off additional glasses and sunglasses, including lens options*

Contacts*

- 15% off cost of contact lens exam (fitting and evaluation)

* Available from any VSP Doctor within 12 months of your last eye exam

XII. HEARING AID BENEFITS PROVIDED BY THE TRUST FOR ALL ACTIVE AND RETIRED EMPLOYEES AND THEIR DEPENDENTS

The Hearing Aid benefits are available to all eligible Active Employees, Retirees, and Dependents, regardless of which medical plan is chosen.

How Does the Hearing Aid Benefit Work?

If an Eligible Individual incurs expenses for one or more hearing aids that are certified by a Doctor to be necessary, the Fund will pay for the hearing aid(s), up to a maximum of \$1,200 per three year period, with a \$50 deductible. The three-year period begins on the day a covered hearing aid claim is incurred.

Exclusions. No benefits are payable for:

- (1) Cleaning, repair and maintenance of a hearing aid;
- (2) Batteries; and,
- (3) Replacement of a lost, stolen or broken hearing aid for which payment was made under this benefit.

XIII. LIFE INSURANCE BENEFITS PROVIDED BY PRUDENTIAL INSURANCE COMPANY OF AMERICA FOR ACTIVE EMPLOYEES

\$10,000 will be payable to your beneficiary in the event of your death from any cause, whether on or off the job, while eligible.

A. BENEFICIARY

You may designate anyone as the beneficiary of your life insurance benefits. You can change your beneficiary designation at any time by written request. The consent of any previously designated beneficiary is not required.

A beneficiary designation or change is effective on the date you sign the change form, but Prudential Insurance Company of America shall not be held liable for making payment to another person before such change form is received at Prudential Insurance Company's home office.

If you designate more than one beneficiary, any benefits will be paid equally to the beneficiaries who survive you, unless otherwise specified.

If you have not designated a beneficiary, or if no designated beneficiary survives you, benefits will be paid to the living persons who are the first in the following order: (a) spouse or registered Domestic Partner, (b) children, (c) parents, (d) brothers and sisters, or (e) your estate.

B. LIFE INSURANCE CONVERSION PRIVILEGE

If your life insurance coverage terminates because you cease to be eligible or your membership in an eligible class terminates, you are entitled to purchase an individual life insurance policy issued from Prudential Insurance Company of America. This policy will not provide disability or supplementary benefits. You will not have to provide evidence of insurability to be eligible for the policy. The amount cannot exceed the amount of your terminated life insurance.

To obtain this benefit, you must, within the conversion period, submit a written application and pay the first premium for the individual policy. The form of the policy may be any one of the forms, except term insurance, customarily issued by Prudential Insurance Company at the age and amount applied for. The premium for the policy will be Prudential Insurance Company's customary rate applicable (a) to the form and amount of the policy, (b) to your class of risk and (c) to your age on the effective date of the individual policy.

The converted policy will be in exchange for all your rights to benefits under your life insurance coverage. However, if within 12 months after the

termination of your employment or membership in an eligible class, proof is submitted that your life insurance benefits should be extended due to Total Disability, then coverage will be restored upon surrender of the converted policy for no claim other than the return of premiums paid.

You are entitled to this Life Conversion Privilege when the policy terminates if you are then totally disabled, if your Total Disability began while you were covered under the policy, and if you are ineligible for an extension of coverage. The requirements for conversion on termination of eligibility apply to this conversion, except that you cannot convert any amount of life insurance for which you become covered under any replacement plan. For the purposes of this paragraph, termination by your Employer of coverage for your Employee group under the policy is considered policy termination for that group.

Conversion Period: The 31-day period immediately following the termination of your eligibility for the life insurance provided to your eligible class.

Notice of Conversion Rights: If you have received notice of your right to convert 15 days before the end of the conversion period, you will have an additional 25 days from the date you are notified in which to convert. The life insurance will not be extended beyond the 31st day after the date your eligibility terminates or the life insurance terminates for your eligible class, and your right to convert will not be extended more than 60 days beyond your initial 31 day conversion period.

Death Benefit During Conversion Period: If you should die during the conversion period, the amount of life insurance you were entitled to convert will be paid as a claim under the policy.

C. ACCELERATED DEATH BENEFIT

If you become a terminally ill Participant whose life expectancy is 6 months or less while insured under the Participant Term Life Insurance provision or while your death benefit protection is being extended under the Participant Term Life Coverage provision, you may elect to receive accelerated payment of death benefits.

D. BENEFITS DURING TOTAL DISABILITY

Your life insurance coverage will stay in effect without additional premiums if you become totally disabled while covered by the Plan before reaching the age of 60. The full amount of insurance will be paid to your beneficiary if your Total Disability continues until the date of your death. The waiver of premiums provision terminates at age 65.

YOU WILL BE REQUIRED, WITHIN ONE YEAR OF THE CESSATION OF PREMIUM PAYMENTS, TO SUBMIT PROOF THAT THE TOTAL DISABILITY BEGAN WHILE INSURED. PROOF OF CONTINUED DISABILITY WILL BE REQUIRED ON A YEAR TO YEAR BASIS.

**XIV. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
PROVIDED
BY PRUDENTIAL INSURANCE COMPANY OF AMERICA
FOR ACTIVE EMPLOYEES**

Accidental Death and Dismemberment Insurance will be paid as follows:

Death by Accidental Means\$10,000

Dismemberment by Accidental Means:

Loss of both hands, both feet, the sight of both eyes,
or any two of these\$10,000

Loss of one hand, one foot, or the sight of one eye\$ 5,000

Additional amount payable:

Loss of life as a result of an accident in a four wheel vehicle while
using a seat beltthe lesser of 10% of your amount of
insurance or \$10,000

Loss of life as a result of an accident in a four wheel vehicle
equipped with a supplemental restraint systemthe lesser of 10%
of your amount of insurance or \$10,000

The Injury, whether occurring on or off the job, must be sustained while you are insured and the loss must occur within 90 days after such Injury. Payment will be made regardless of any other benefits you may receive.

Accidental Death benefits will be paid to your beneficiary while Accidental Dismemberment benefits will be paid to you. Your beneficiary may be any person(s) you name. You may request a change of beneficiary at any time by submitting a new beneficiary card. If there is no designated beneficiary, or if no designated beneficiary survives you, benefits will be paid to the living persons in the following order: (a) spouse, (b) children, (c) parents, (d) brothers and sisters, or (e) your estate.

The payment for all losses caused by any one accident may not be more than the full amount of your insurance, but the benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents.

You are not covered for losses from: (a) intentionally self-inflicted Injury or suicide; (b) bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of bodily Injury for which accidental death and dismemberment benefits are payable); (c) bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment thereof; (d) commission of or the attempt to commit an assault or felony; (e) war, whether declared or undeclared, (f) travel or flight as a pilot or crew member in any kind of aircraft; or (g) travel or flight in any kind of aircraft owned, operated or leased by or on behalf of (i) the Policyholder.

An additional benefit may be payable for a loss for which a benefit is payable under the other terms of this coverage or would be payable except for the limitation per accident of those terms. Any such benefit is payable in addition to any other benefit payable under this coverage. Additional conditions that apply to an additional benefit are: (a) loss of life as a result of an accident in a four wheel vehicle equipped with a supplemental restraint system; (b) loss of life as a result of an accident in a four wheel vehicle while using a seatbelt. The additional benefit amounts are shown above.

**XV. LIFE INSURANCE BENEFITS PROVIDED BY PRUDENTIAL
INSURANCE COMPANY OF AMERICA FOR DEPENDENTS
OF ACTIVE EMPLOYEES**

If one of your eligible Dependents dies while insured under this benefit, the Fund will pay the applicable amount of Dependent Life Insurance specified below:

Life Insurance:

Spouse\$750

Children:

14 days but less than 6 months\$100

6 months but less than 3 years\$250

3 years or over.....\$500

Payment of Benefits will be made to the surviving person or persons in the first of the following order: (a) you, (b) your spouse, (c) your children, including legally adopted children, or (d) your estate. Two or more persons entitled to benefits will be paid equal shares.

XVI. LOSS OF TIME BENEFITS PROVIDED BY THE TRUST FOR ACTIVE EMPLOYEES

If an Active Employee, while eligible, become totally disabled and unable to work as a result of Sickness or accidental Injury occurring on or off the job, the Plan will pay (subject to the provisions hereinafter stated) to the Active Employee a weekly benefit of \$25 (subject to federal and state taxes). The payment of such benefit is contingent upon that the Employee's proof of entitlement to either California Unemployment Compensation Disability benefits or Workers' Compensation benefits, regardless of whether or not the Employee has insufficient earnings or has exhausted his U.C.D. or Workers' Compensation benefits.

A. PAYMENT OF BENEFITS

Payments begin with the first day of disability due to an accident and eighth day of disability due to Sickness. For each day during partial weeks of disability, payment will be one-fifth of the weekly benefit. The maximum number of weeks payable will be thirteen weeks per disability.

B. PERIOD OF DISABILITY

For purposes of this Section XV only, successive periods of disability will be considered one period of disability unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the causes of the previous disability and commences after return to active work for an Employer at least one full working day.

C. LIMITATIONS

- (1) The Loss of Time Benefit will not be provided unless the Active Employee is able to furnish proof of eligibility for Unemployment Compensation Disability or Workers' Compensation benefits, even if he has insufficient earnings or has previously exhausted these benefits.
- (2) A disability will be deemed to have begun on the date the Active Employee first became disabled, provided that treatment by a Doctor is received within three days of such date. If, however, treatment by a Doctor is not received in accordance with the foregoing, a disability will be deemed to have begun three days before such first treatment.

XVII. OTHER FACTS

A. MEDICAL EXAMINATION

No medical examination is required. Eligible Employees and their eligible Dependents will be covered regardless of their physical condition.

B. MEDICAL AND DENTAL COORDINATION OF BENEFITS

Medical and Dental Benefits are subject to the Coordination of Benefits provisions included in the Plan.

“Coordination” means that if the individual is entitled to benefits under any plan (as defined below) which will pay part or all of the expense incurred for medical services and medical supplies for treatment of an Injury or Sickness, the amount of Medical or Dental Benefits payable by our Plan, any other plans or a pre-paid plan, will be coordinated so that the aggregate amount paid will not exceed 100% of the necessary, reasonable, and customary medical expenses incurred. The Plan payment will not exceed the amount, which would have been paid if there were no other plan involved. When coordinating with a pre-paid plan, the Plan will pay its normal benefits for any expenses that you are legally obligated to pay.

The term “plan” means (a) group, blanket or franchise insurance, (b) service plan contracts, group practice, individual practice and other prepayment coverage; (c) labor-management trustee plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and (d) any coverage under governmental programs, and any coverage required or provided by any statute, except Medicare, which provides benefits or services for medical, or dental care or treatment.

If an individual covered under this Plan is also insured under another plan or plans and, as a result, has two or more coverages, and the other plan has a similar non-duplication of coverage provision, the rules set out in this paragraph establish the plan that will pay benefits first. The plan that covers the person as an Employee or Retiree will pay benefits before the plan that covers the person as a Dependent. The benefits of a Plan which covers the person on whose claim is based as an Active, laid-off, or Retired Employee shall be determined before the benefits of a Plan which covers such a person as a Dependent. The benefits of a Plan which covers the person on whose expense claim is based as a Dependent of an Active Employee shall be determined before the benefits of a plan which covers such person as a Dependent of a laid-off or Retired Employee. When both plans cover the person on whose expense

claim is based as a Dependent child of an Active Employee, or when both Plans cover the person on whose expense claim is based as a Dependent child of a laid-off or Retired Employee, the benefits of the plan which covers the parent whose birthday (month and day only) occurs first during a Calendar year shall be determined before the of the Plan which covers the parent whose birthday (month and day only) occurs late in the year, except that in the event a father and mother are legally separated or divorced, the following rules shall apply.

The benefits of a plan which covers the person on whose expense claim is based as a Dependent child of the parent with financial responsibility for the child's medical expenses by virtue of a court decree, shall be determined first. If there is no court decree, the benefits of a Plan which covers the person on whose expense claim is based as a Dependent child of the parent with legal custody shall be determined first. If there is no court decree and the parent with legal custody has remarried, the order of benefit determination shall be as follows: (a) the Plan which covers the parent with legal custody; (b) the plan which covers the step-parent with legal custody; and (c) the plan which covers the parent without legal custody.

When these rules do not establish an order of benefit determination, the benefits of the plan that has covered the person for the longer period of time will pay its benefits first. If the other plan has no Coordination of Benefits provision, that plan will pay benefits first.

C. COORDINATION WITH PRE-PAID PLANS (MEDICAL AND DENTAL)

If an Eligible Individual is covered under the Fee-For-Service Medical or Dental Plan provided by the Fund in addition to being covered as a Dependent under a pre-paid plan sponsored by the Employer of his or her spouse if the Eligible Individual is the Covered Employee, or the Employer of the parent who is the spouse of a Covered Employee if the Eligible Individual is a Dependent under this Plan, the Eligible Individual may receive treatment either from a provider or privately selected Hospital as part of the Fee-For-Service plan or from a provider or Hospital in the prepaid plan. If the Eligible Individual receives treatment through the pre-paid plan, the primary coverage under the Fee-For-Service Plan provided by the Fund will pay for all co-payments that the individual is legally obligated to pay not to exceed this Plan's normal benefit.

D. POLICY RULES AND REGULATIONS

If you are eligible for the Fund's benefits, your rights can only be determined by Prudential Insurance Company's Certificate of Insurance relating to the Life Insurance and Accidental Death and Dismemberment benefits, the contract between Vision Service Plan and the Plan, Kaiser Permanente and the Plan, United Healthcare and the Plan, United Concordia and the Plan and the Fund's complete Rules and Regulations relating to the loss of time, hearing aid, and Hospital-medical and dental benefits provided directly by the Plan, which can be obtained by contacting the Administrative Office.

E. BREAST RECONSTRUCTION AFTER MASTECTOMY

In accordance with the Women's Health and Cancer Rights Act of 1998, an Eligible Individual who is receiving benefits under the Plan in connection with a mastectomy will be provided coverage in a manner determined in consultation with the attending Physician and the patient for (subject to the terms and conditions of the Major Medical Plan.):

- (1) All stages of reconstruction of the breast on which the mastectomy was performed;
- (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) Prostheses; and,
- (4) Treatment of physical complications of the mastectomy, including lymphedemas.

This coverage is subject to the same annual deductibles and coinsurance/co-payment provisions applicable to other medical and surgical benefits provided under this Plan.

F. FINANCING

Benefits for Active Employees and their eligible Dependents are paid for by Employer contributions to the Fund as a result of the Collective Bargaining Agreements.

G. DISCLAIMER

THE LOSS OF TIME, HEARING AID, AND FEE-FOR-SERVICE MEDICAL AND DENTAL BENEFITS DESCRIBED IN THIS BOOKLET ARE NOT INSURED BY ANY CONTRACT OF INSURANCE AND THERE IS NO LIABILITY ON THE BOARD OF TRUSTEES OR ANY INDIVIDUAL OR ENTITY TO PROVIDE PAYMENT OVER AND BEYOND THE AMOUNTS IN THE FUND COLLECTED AND AVAILABLE FOR SUCH PURPOSE.

H. RIGHT OF EQUITABLE LIEN, REIMBURSEMENT AND SUBROGATION

Should you or your eligible Dependent be injured through the act or omission of a third party and payment is made by that person (or his insurance company), you will be required to reimburse the Fund up to the actual benefits paid by the Plan for medical expenses arising from the Injury.

If you or your Dependent's injury or illness is in any way caused by the act or omission of a third party who is or may be legally liable or responsible for the injury or illness, no benefits are payable or paid under this Plan unless you and/or your Dependent contractually agree in writing in a form satisfactory to the Trustees, to reimburse the Fund from any recovery received by you or your Dependent in an amount equal to the benefits paid by the Fund when a recovery is obtained from the third party or the third party's insurer. If you or your eligible Dependent receives a recovery from such third party or insurer whether by way of court judgement, settlement, arbitration award or other arrangement, or if a person covered under the Plans maintained by this Fund is injured and receives Workers' Compensation or insurance benefits, the Fund shall be entitled to a first right to recover for the amount of benefits paid by the Plan related to the injury or illness up to the full amount of the recovery.

The Fund will require the execution of an Assignment and Subrogation Agreement and Third Party Lien Form by you and/or your Dependent's attorney as a condition for payment of benefits; however, the Fund's lien on the recovery shall exist and shall be fully enforceable whether or not such form has been executed and

whether or not such form has been lost, destroyed or modified in any manner.

The Fund may also require the filing of periodic reports by you, your Dependents and/or attorneys regarding the status of the third party claim or action as a condition of continued eligibility for benefits from the Plan. The failure to furnish such reports may result in automatic termination of eligibility for benefits.

The Fund shall have a lien on any recovery by you or your eligible Dependent for amounts paid in connection with the injury or illness, and may in its own name intervene in any administrative or judicial proceeding as a party thereto for the purpose of ensuring enforcement of its lien rights, but shall not be obligated to do so.

Upon settlement of the claims against the third party, the insurance company or the Workers' Compensation carrier, you, your Spouse, Dependent or you as the Employee-Parent, shall pay or cause to be paid to the Trust out of the proceeds of any recovery the amount of the lien, even if you or your Dependents are not made whole or have not recovered the full damages claimed before any amounts (including attorneys' fees) are deducted from the recovery.

If you as the covered Employee or your Dependent fails to execute an Assignment and Subrogation Agreement, Third Party Lien Form or other document required by the Fund or if you, your Dependent or your or Dependent's attorneys fail to provide such information as may be requested from time to time by the Fund or its representatives, the Trustees may offset all or any portion of the lien against any other benefits which may be owing at any time to, or on your behalf as the covered Employee or your eligible Dependent.

In the event reimbursement from a third party recovery is requested and is not received, in addition to any other remedy, the amount of the unreimbursed benefits will be deducted from all future medical benefits payable to, or on behalf of the covered Employee or any Dependent until the overpayment is resolved.

In the event the amount of the lien is not reimbursed and a legal action or proceeding is required to recover the amount of benefits paid by Fund, or it becomes necessary to enforce the lien or rights created thereunder, the Fund shall be entitled to recover all costs and reasonable attorneys' fees incurred in seeking reimbursement and/or enforcement of the lien.

Nothing herein shall require the Fund to make any payment which the Trustees in their sole discretion consider to be improper under the Plan.

I. FUND REIMBURSEMENT

In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of benefits to a participant or a beneficiary, the Trustees shall also have the general power to withhold and offset such benefits for claims incurred on behalf of any participant or beneficiary who: (1) owes money to the Trust because of any obligations imposed upon them by this Plan booklet or the rules and regulations of the Fund, or (2) owes money to the Fund because the Fund overpaid a participant or beneficiary, (3) or in any other circumstance in which a participant or beneficiary legally owes money to the Trust.

The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

The Trustees must ensure that all who benefit from the Plan do so appropriately, and only as they are entitled. For example, if the Trustees determine that a Participant, his Dependents, or health care provider has committed any fraud or made any intentional misrepresentation in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Participants and their Dependents restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Participant and his Dependents. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

XVIII. COBRA COVERAGE

A federal law known as “COBRA” (the Consolidated Omnibus Budget Reconciliation Act of 1985) gives you and your covered family members the right to temporarily extend your health coverage under the Plan (called “COBRA coverage”) following certain life events (called “qualifying events”) that would normally end your Plan coverage. Please be aware that you or your Dependent(s) must pay for COBRA coverage. This section of the booklet is a summary of your rights and obligations regarding COBRA coverage. For more information about COBRA, contact the Plan Administrator.

A. WHAT BENEFITS CAN BE CONTINUED UNDER COBRA?

Under COBRA, you may only continue the benefits that you have at the time of a qualifying event (discussed below in section B). You may not, however, continue your life, accidental death and dismemberment, hearing aid, or loss of time benefits under COBRA. This means that if you are covered under the Active Plan, you can continue the Hospital-medical, prescription drug, dental, and vision care benefits that you had at the time of the qualifying event. If you are a Dependent of a Retiree, you may continue your Hospital-medical and prescription drug benefits through Kaiser.

If you are covered under the Active Plan, and you elect COBRA coverage, you will be entitled to the same coverage that is provided to other Active Employees and their Dependents under the Trust. This means that you are entitled to make Plan changes at the earlier of twelve (12) months of consecutive enrollment or at the next Open Enrollment period (May 1 of each year). Similarly, if you are covered under the Retiree Plan, and you elect COBRA coverage, you will be entitled to the same coverage that is provided to Retirees and their Dependents under the Trust.

You do not have to show that you are insurable to obtain COBRA coverage.

B. WHAT ARE COBRA QUALIFYING EVENTS?

(1) **Active Employees.** If you are an Active Employee covered by the Plan, you have the right to choose COBRA coverage for yourself if you lose your group health coverage under the Plan for any of the following reasons:

- (a) Your hours of employment are reduced; or

- (b) Your employment ends for any reason other than your gross misconduct.

Even if you do not elect COBRA coverage for yourself, each of your covered Dependents will have a separate right to elect it. THEREFORE, IT IS IMPORTANT THAT YOU AND ALL OF YOUR DEPENDENTS READ THIS SECTION OF THE BOOKLET.

- (2) **Spouse.** If you are the spouse of a covered Active Employee or Retiree, you have the right to choose COBRA coverage for yourself if you lose your health coverage under the Plan for any of the following reasons:
 - (a) Your spouse's hours of employment are reduced;
 - (b) Your spouse's employment ends for any reason other than his or her gross misconduct;
 - (c) Divorce or legal separation from your spouse; or,
 - (d) The death of your spouse.
- (3) **Dependent Children.** A Dependent child of a covered Active Employee or Retiree has the right to choose COBRA coverage for him or herself if he or she loses health coverage under the Plan for any of the following reasons:
 - (a) The Employee parent's hours of employment are reduced;
 - (b) The Employee parent's employment ends for any reason other than his or her gross misconduct;
 - (d) The parents' divorce or legal separation;
 - (e) The child stops being eligible for coverage under the Plan as a "Dependent child" as defined in Section III; or
 - (f) The death of the Employee or Retiree parent.
- (4) **Bankruptcy as a Qualifying Event.** If a proceeding in bankruptcy is filed under title 11 of the United States Code with respect to an Employer, and that bankruptcy results in the loss of health coverage of any Retiree covered under the Plan, the Retiree, as well as his or her spouse, surviving spouse, and Dependent Children may be entitled to COBRA coverage.

C. WHEN DOES COBRA COVERAGE BEGIN?

Generally, COBRA coverage for you and your Dependents will begin on the date that Plan coverage is lost due to a qualifying event. This date depends on the type of qualifying event involved, as explained below.

If the qualifying event is termination of employment, reduction in hours, or death: You and your Dependents will lose Plan coverage at the end of the month in which you have less than 120 hours left in your reserve account.

Example 1: If you lose your job in January with 600 hours left in your reserve account, you and your Dependents will lose Plan coverage at the end of June. This is because the 600 hours in your reserve account will give you and your Dependents Plan coverage for an additional five (5) months, from February through June. COBRA coverage, if elected, will begin on July 1.

Example 2: If you die in January with 600 hours left in your reserve account, your Dependents will lose Plan coverage at the end of June. This is because the 600 hours in your reserve account will give your Dependents Plan coverage for an additional five (5) months, from February through June. COBRA coverage, if elected, will begin on July 1.

Example 3: If you lose your job in January with 75 hours left in your reserve account, you and your Dependents will lose Plan coverage at the end of that month. This is because the 75 hours in your reserve account is not enough to give you and your Dependents any additional Plan coverage. COBRA coverage, if elected, will begin on February 1.

If the qualifying event is divorce/legal separation, or the cessation of eligibility as a “Dependent Child.” Your Dependents will lose Plan coverage at the end of the month in which the qualifying event occurs. In these instances, it does not matter how many hours you have in your reserve account.

Example: If you and your spouse get divorced in January, your spouse will lose Plan coverage at the end of that month, and COBRA coverage (if elected) will begin on February 1.

D. HOW LONG DOES COBRA COVERAGE LAST?

The maximum COBRA coverage period for you and your Dependents is 36 months, unless coverage under the Plan is lost because of a termination of employment or a reduction in hours. In these instances, the maximum COBRA coverage period for you and your Dependents is eighteen (18) months. There are, however, three

ways to extend this 18-month period of COBRA coverage, which are described in detail below.

(1) Disability Extension

If you or your family member elects COBRA coverage, and then is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage or earlier, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage (at increased rates), for a total maximum of 29 months.

To be eligible for this extension, you or your Dependent must notify the Plan Administrator in writing of the Social Security Administration's determination within 60 days of the date you received the determination, but before the end of the 18-month period of COBRA coverage.

This extended period of COBRA coverage for disability will end on the earliest of the following: (i) the end of the 29-month period; (ii) 30 days after the last day of the month in which Social Security determines the disabled person is no longer disabled (this must be Reported to the Trust Office within 30 days after its date of issuance by Social Security); or (iii) pursuant to the applicable termination provisions of this section specifying when COBRA coverage ends.

(2) Second Qualifying Event

If, during the initial 18-month COBRA coverage period, the former Active Employee or Retiree dies, becomes divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, **the maximum COBRA coverage period for the affected spouse and/or child may be extended to 36 months from the date Plan coverage was lost due to termination of employment or reduction in hours. In all of these cases, you or your family member must notify the Plan Administrator in writing of the second qualifying event within 60 days of such event.**

Example: You lose your job (the first qualifying event), and you enroll yourself and your Dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 26 years old and is no longer eligible for Plan coverage. Your child can continue COBRA coverage for another 33 months, for a total of 36 months of COBRA coverage, provided you or another family member notifies the Plan Administrator in writing within 60 days of your child's 26th birthday.

This extended period of COBRA coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA coverage is

available to any child(ren) born to, adopted by, or placed for adoption with you (the Active Employee) during the initial 18-month period of COBRA coverage.

(3) Special Extension of COBRA Coverage under California Law

If you and/or your Dependents are enrolled in an HMO, and you and/or your Dependents are receiving COBRA coverage, you and/or your Dependents may be entitled to an 18-month extension of coverage under California law, up to a total of 36 months coverage from the date Plan coverage was lost due to your termination of employment or reduction of hours. The premium payments for such extended coverage (months 19 through 36) will be higher than the payments for standard COBRA coverage.

E. ADDING DEPENDENTS TO YOUR COBRA COVERAGE

(1) New Spouses and Children

If, while you are enrolled in COBRA coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for those five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, you must notify the Trust Office in writing within 30 days of acquiring the new Dependent. There may be a change in your COBRA premium amount in order to cover the new Dependent.

(2) Loss of Other Group Health Plan Coverage

If, while you are enrolled in COBRA coverage, your Dependent loses coverage under another group health plan, you may enroll that Dependent for coverage for the balance of your COBRA coverage period, provided that

- (a) The Dependent was previously offered enrollment in the Plan but declined Plan coverage due to coverage under another group health plan; and
- (b) The other coverage was (a) COBRA coverage that was exhausted or (b) other health plan coverage that was terminated due to loss of eligibility or termination of Employer contributions. (Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause).

You must enroll the Dependent **within 30 days** after the termination of the other coverage. Adding a Dependent may cause an increase in the amount you must pay for COBRA coverage

F. YOUR RESPONSIBILITY TO NOTIFY THE PLAN

The Plan will offer COBRA coverage to you and your family members only after the Plan Administrator has determined that a qualifying event has occurred. The Plan Administrator cannot make this determination unless is it properly notified.

When You Must Notify the Plan of a Qualifying Event (Very Important Information): In order to elect COBRA coverage after a divorce, legal separation, or a child ceasing to be a “Dependent child” under the Plan, you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs. That notice should be sent to the Administrative Office at the following address:

Brick Masons’ Health & Welfare Trust Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

IF SUCH A NOTICE IS NOT RECEIVED BY THE ADMINISTRATIVE OFFICE WITHIN THE 60-DAY PERIOD, YOUR FAMILY MEMBER(S) WILL NOT BE ENTITLED TO CHOOSE COBRA COVERAGE.

Your Employer is responsible for notifying the Administrative Office of your death, termination of employment, reduction in hours, or your Employer’s commencement of a bankruptcy proceeding. However, **you or your family member should also notify the Administrative Office promptly and in writing** if any such event occurs in order to avoid confusion over the status of your health care coverage in the event there is a delay or oversight in the Employer’s transmittal of information to the Administrative Office.

G. DEADLINE TO ELECT COBRA COVERAGE

Once the Plan Administrator has determined that a qualifying event has occurred, you and/or your family members will be sent a COBRA election form, as well as other information regarding COBRA coverage. You will have at least sixty (60) days from the date your coverage ends or, if later, sixty (60) days from the date the Plan Administrator sends you the COBRA election form, to make your decision.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT ELECT COBRA COVERAGE WITHIN THIS 60-DAY PERIOD, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

H. PAYING FOR COBRA COVERAGE

You and/or your Dependents must pay for COBRA coverage on the following basis:

- (1) Any person with COBRA coverage must pay a monthly premium for such coverage. The amount of such premium will be established by the Board of Trustees from time to time and furnished to the eligible person with the COBRA election form.
- (2) All payments must be made by check, cashiers check, or money order.
- (3) The initial COBRA coverage payment should be received by the Plan Administrator no later than the 20th day of the month after the month for which coverage is desired, in order to avoid possible delays in claim payments and eligibility problems. However, this initial payment will be accepted up to 45 days from the date you elect COBRA coverage. The first payment must cover the number of months from the date COBRA coverage began, including the month in which the first payment is made.
- (4) After the first COBRA coverage payment is made, additional payments must be made every month to keep coverage. Monthly payments must be received by the 20th day of the month succeeding each coverage month to avoid possible delays in claim payments and eligibility problems. For example, if you want COBRA coverage for the month of February, payment should be received by March 20th. Failure to make a monthly payment within thirty (30) days of the beginning of the payment coverage month will result in termination of COBRA coverage as of the end of the period for which payment has been made.
- (5) Employees who have residual hours left in their reserve account, but not enough for a full month of eligibility under the Active Plan, will be able to use these residual hours to subsidize their first month of COBRA self-payment premiums. The amount of the subsidy will be:

(residual hours) x (COBRA monthly self-payment premium rate)
(monthly reserve account deduction)

In addition, life insurance benefits as outlined in Article XII will continue for one month if the Employee loses eligibility and he or she has residual hours left in his or her reserve account, regardless of whether the Employee chooses to self-pay through COBRA.

The Administrative Office will not send you monthly bills or warning notices. It is your responsibility to submit payments when due.

I. TERMINATION OF COBRA COVERAGE

Your COBRA coverage will end on the earliest of the following dates:

- (1) The date the maximum COBRA coverage period has been reached as described previously.
- (2) The date that the Trust Fund ceases to provide health care coverage to any active member;
- (3) The date you fail to make a timely premium payment for your COBRA coverage;
- (4) The date you first become eligible as an Employee, spouse or Dependent of an Employee for another group's health and welfare benefits; or
- (5) In the case of Total Disability, at the end of the month after the month in which Social Security determines that the disability no longer exists.

J. CONVERSION OPTION

At the end of the 18-, 29-, or 36-month maximum COBRA coverage period, you may be allowed to convert to an individual insurance policy if you are enrolled in the Kaiser or United Healthcare plan at that time. You should contact the HMO directly for more information.

K. IF YOU HAVE QUESTIONS ABOUT COBRA

If you have questions about your COBRA coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

L. KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

should also keep a copy, for your records, of any notices you send to the Plan Administrator.

M. CALIFORNIA INSURANCE MARKETPLACE (CALIFORNIA EXCHANGE)

In addition to COBRA continuation coverage, there may be other options for you and your family. The California Insurance Marketplace (California Exchange) offers many health plans to choose from. Open enrollments will be held from October 15 through December 7 for coverage effective the following year. After open enrollment ends, you may have special enrollment rights under certain circumstances. More information is available from the California Exchange website at www.coveredca.com. Also, you might be eligible for a tax credit that lowers your monthly premium if you are not eligible for coverage through the Fund.

Note: If you decide to enroll in COBRA coverage and then drop your COBRA coverage, you can only enroll in Exchange coverage during the Exchange open enrollment period.

XIX. NOTICE OF GRANDFATHERED STATUS

The Patient Protection and Affordable Care Act (“the Affordable Care Act”) distinguishes between grandfathered and non-grandfathered plans. For the Plan year starting May 1, 2015, all options provided to Active Employees and Retirees participating in the Brick Masons’ Health and Welfare Trust Fund will be grandfathered plans. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain parts of its health plan coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that the Trust will continue to apply Plan limitations on certain provisions, such as cost sharing for preventive health services. Grandfathered health plans will comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits and coverage of eligible children through age 25.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Administrative Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which Affordable Care Act provisions do and do not apply to grandfathered health plans.

XX. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

A law, known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy rules issued under the law, give you certain rights with respect to your health information. It is required that the Trust protect the privacy of your personal health information and establish a formal policy and procedures for maintaining the privacy of your Protected Health Information (PHI).

HIPAA regulations also allow special enrollment periods for you and eligible dependents

A. PROTECTED HEALTH INFORMATION AND NOTICE OF INFORMATION PRACTICES

HIPAA give you certain rights with respect to your health information. The Fund will protect the privacy of employees' and dependents' protected health information (PHI). The Fund will also require contracting providers and business associates such as the Trust's lawyers, accountants, and third party professionals to protect such PHI. PHI is health information that includes the name, Social Security number or other information that reveals the identity of the employees or dependent. Employees or dependents may generally see and receive copies of their PHI, correct or update their PHI, and ask the Administrative Office for an accounting of certain disclosures of PHI.

The fund may use or disclose PHI for treatment, payment and health care operations purposes, including health research and measuring the quality of care and medical services. The Fund is sometimes required by law to give PHI to government agencies or in judicial actions. In addition, the Employee's or Dependent's identifiable medical information is shared with employers only with specific authorization or as otherwise permitted by law.

The Fund will not use or disclose any person's PHI for any other purpose without his/her (or appropriate representative's) written authorization, except as provided in the Fund's Notice of Privacy Practices. Giving the Fund authorization is at the discretion of the employee or the dependent.

This is only a brief summary of some of the Fund's key privacy practices. The Fund's Notice of Privacy Practices describing the Fund's policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to the employee or

dependent upon his or her request. To obtain a copy of the Notice of Privacy Practices, please contact:

BeneSys, Inc.
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

B. COMPLAINTS

If you are concerned that the Plan has violated your privacy rights, or if you disagree with a decision the Plan has made about access to your records, you may contact the Trust Administrative Office. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer at the Trust Administrative Office can provide you with the appropriate address upon request.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. The Plan will not retaliate against you for filing a complaint.

C. SPECIAL ENROLLMENT PERIODS

Under the provisions of HIPAA an eligible individual and eligible dependents may be enrolled during special enrollment periods.

A special enrollment period applies when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption, or placement for adoption. The eligible individual or the eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions.

An eligible individual or an eligible dependent that loses other health coverage may be enrolled during a special enrollment period if all of the following requirements are met:

- (1) The eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when otherwise initially eligible for coverage under this Plan; and
- (2) Coverage in this Plan was declined; and
- (3) Coverage under the other group health plan or health insurance coverage was lost for one of the following reasons:

- (a) The other group health coverage is COBRA continuation coverage and the coverage has been exhausted;
 - (b) the other coverage is a group health plan or other health insurance coverage and has been terminated as a result of loss of eligibility, or employer contributions towards the other coverage have been terminated;
 - (c) Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
 - (d) Loss of eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or due to termination of coverage for cause; and
- (2) The eligible individual or eligible dependent enrolls within 31 days of the loss of coverage.

If you have been eligible but not otherwise enrolled and if you acquire a dependent through marriage, birth, adoption, or placement for adoption, you and the new eligible dependents may enroll during a special enrollment period.

The special enrollment period is 30 days, beginning on the date of the marriage, birth, adoption, or placement for adoption. If a completed request for enrollment is made during the 30-day period, the effective date of coverage will be:

- (1) In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received; or
- (2) In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

XXI. COVERAGE DURING FAMILY AND MEDICAL LEAVE

Under a federal law known as the Family and Medical Leave Act (FMLA), a Covered Employee may continue medical, prescription drug, dental and vision coverage (but not life insurance, accidental death and dismemberment insurance, and loss of time benefits) for the Covered Employee and any eligible dependents subject to the terms of the law.

Eligibility will continue for the Covered Employee and eligible Dependent's until the end of the leave, provided the Contributing Employer properly grants the leave under the FMLA and makes payment of the required contributions to the Plan.

Whether or not the Covered Employee keeps coverage while on FMLA leave, if he or she returns to work promptly at the end of that leave, coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your leave.

Any changes in the Plan's terms, rules or practices that went into effect during a FMLA leave will apply to the Covered Employee and Dependents.

XXII. MEDICARE

A. MEDICARE AND PLAN BENEFITS

The term “Medicare” means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

Medicare provides a broad program of health insurance for people 65 or older, people who have been totally disabled continuously for two years even if under age 65, and people with end-stage renal disease undergoing dialysis or kidney transplant.

Medicare Part A covers hospitalization and certain follow-up services. Medicare Part B helps pay Doctor and other medical bills. It is most important that you enroll promptly in this extensive program of health insurance.

B. HOW TO ENROLL IN MEDICARE

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and have established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits you must file a Medicare application during the three month period prior to the month in which you become age 65 in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65th birthday and request an application card.

C. COORDINATION WITH MEDICARE

When you or your Dependent is eligible for both Medicare benefits and benefits under this Plan, this Fund will coordinate benefits with Medicare. Submit your claims to the Trust Fund first. After it has acted on the claims, then submit them to Medicare.

XXIII. CLAIMS AND APPEALS PROCEDURES

The Trustees have the exclusive right, power and authority in their sole and absolute discretion, to administer, apply and interpret this Plan and all other documents that describe the Plan and the Fund. The Trustees have discretionary authority and power to decide all matters arising in connection with the operation or administration of the Plan, including but not limited to: making factual findings, fixing omissions, resolving ambiguities, construing the terms of the Plan, making eligibility determinations, and resolving other disputes under the Plan. Except as described in these procedures, all determinations made by the Trustees with respect to any matter arising with regard to Plan benefits will be final and binding on all concerned. Any judicial review of any Trustee decision must be done in deference to the Trustees decision.

A. APPLICABILITY

- (1) Only to claims for fee-for-service medical, fee-for-service dental, loss of time, and hearing aid benefits. These procedures also apply to appeals of any claims that were denied based on eligibility. These procedures do not apply to claims for life insurance, accidental death & dismemberment, HMO, prepaid dental, and vision care benefits. Please refer to the certificate of insurance for the Prudential Insurance Company of America and the evidences of coverage for Kaiser Permanente, United Healthcare, United Concordia, and Vision Service Plan for the procedures applicable to claims for benefits under those plans, which are incorporated herein by reference.

For example, if the HMO you selected claims you are no longer eligible, these procedures govern such an “eligibility” denial. If the HMO claims you have exhausted a certain benefit, such as the number of counseling sessions, these procedures do not govern, and you must use the HMO’s claim procedures.

B. TYPES OF CLAIMS

The Plan’s procedure for processing your claim varies depending on what type of claim you file. Your claim will fall into one of the following two categories:

- (1) Group Health Claim. Your claim will be considered a Group Health Claim if you are requesting fee-for-service medical, fee-for-service

dental, hearing aid or loss of time benefits. There are three kinds of Group Health Claims:

- (a) *Post-Service Claim.* A Post-Service Claim is a claim for which plan approval is not required prior to obtaining services and payment is being requested for care already rendered to an Eligible individual. This includes a request for hearing aid benefits.
 - (b) *Pre-Service Claim.* A Pre-Service Claim is a claim for which the plan conditions receipt of the benefit on approval of the benefit in advance of obtaining care (e.g., Medical Rehabilitation Benefit and Pre-Admission Review for elective Hospital stays). It also includes your request for an extension of an ongoing course of treatment that the Plan has already approved, such as increasing the number of treatments previously authorized.
 - (c). *Concurrent Claim.* A Concurrent Claim is when the Plan has approved an ongoing course of treatment to be provided over a period or a number of treatments, for example, approval of a hospitalization for three days (e.g., Concurrent Review).
- (2) Loss of Time Claim. Your claim will be considered a Loss of Time Claim if you are requesting Loss of Time Benefits.

C. FILING A CLAIM

All claims must be filed with the Trust Fund Office using the claim forms provided by the Plan. You must file your claim within ninety (90) days from the date on which you:

- (1) Receive medical or dental services (for Post-Service Claims under the fee-for-service medical or dental plans);
- (2) Purchase a hearing aid (for hearing aid benefits); or,
- (3) Become disabled (for loss of time Benefits).

The Plan may accept your claim after the 90-day period if you can show that it was not reasonably possible for you to file a claim within this time limit. In any event, the Plan will not accept claims that are filed beyond one year after the end of the 90-day period.

For Pre-Service Claims only: Please file your claim form sufficiently in advance of the date that you wish to receive services. This will allow the Plan enough time to process your claim. If you fail to properly file

a Pre-Service Claim, the Plan will notify you of the failure and the proper procedures for filing the claim within five days following the failure. This notification may be oral, unless you request written notice.

D. TIME PERIOD FOR REVIEWING CLAIMS

- (1) Post-Service Claim. The claimant must be notified in writing of a denial within 30 days after a claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Plan. If such an extension is necessary, the claimant must be notified in writing, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Plan expects to render a decision, which will not be more than 45 days from the date the claim was filed. If the extension is due to the claimant's failure to submit the information necessary to decide the claim, and the extension notice specifically describes the required information, the claimant must be given at least 45 days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the claimant to the earlier of: (i) the date on which the Plan receives the claimant's response; or (ii) the due date established by the Plan for the furnishing of the requested information.
- (2) Pre-Service Claim. The claimant must be notified of the decision, whether adverse or not, within 15 days after a claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Plan. If such an extension is necessary, the claimant must be notified, prior to the commencement of the extension, of the circumstances requiring the extension and the date by which the Plan expects to render a decision, which will not be more than 30 days from the date the claim was filed. If the extension is due to the claimant's failure to submit the information necessary to decide the claim, and the extension notice specifically describes the required information, the claimant must be given at least 45 days from the receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to the claimant to the earlier of: (i) the date on which the Plan receives the claimant's response; or (ii) the due date established by the Plan for the furnishing of the requested information.
- (3) Concurrent Care Decisions. Any reduction or termination by the Plan of an ongoing course of treatment (other than by Plan amendment or termination) before the end of the approved period or number of

treatments, constitutes a claim denial, and the claimant must be notified of the denial sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

- (4) Loss of Time Claim. The claimant must be notified in writing of a denial within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. If an extension is required, the claimant must be notified in writing, prior to the commencement of the extension and the date by which the Plan expects to render a decision, which will not be more than 180 days from the date the claim filed.

E. CLAIM DENIAL NOTICE

If a claim is denied in whole or in part, the claimant must be notified of the denial in writing. Such written notice of denial must contain the following:

- (1) The specific reason(s) for the denial;
- (2) Reference to the specific Plan provision(s) on which the denial is based;
- (3) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- (3) A description of the Plan's review procedures and the time limits applicable to such procedures; and,
- (4) A statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the denial of your claim on appeal.

If you filed a Group Health Claim, the notice may also contain:

- (1) If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant, free of charge and upon request.
- (2) If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to the claimant, free of charge and upon request.

F. FILING AN APPEAL

Any claimant whose claim is denied, in whole or in part, may file a written appeal with the Board of Trustees within 180 days (60 days for a Loss of Time Claim) after the claimant receives the written notice of denial. An appeal is considered “filed” when it is received by the Trust Fund Office, regardless of whether it contains all the information necessary to render a decision.

The appeal must state in clear and concise terms the reasons for disputing the denial and must be accompanied by any supporting documentary material. As part of the appeals procedure, the claimant must be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. Furthermore, the claimant must be given the opportunity to submit written comments, documents, records, and other information relating to the claim, which must be considered by the Board, regardless of whether such information was submitted or considered in the initial claims review.

Upon good cause shown, the Board of Trustees shall permit the appeal to be amended or supplemented and shall grant a hearing on the appeal before the Board of Trustees to receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence

For Group Health Claims only: The Board must not afford deference to the initial review. If a denial was based in whole or in part on a medical judgment, the Board must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional must not be the individual who was consulted in connection with the initial claim denial, nor the subordinate of any such individual. Furthermore, the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of the claim must be identified, even if the advice was not relied upon in denying the claim.

G. TIME PERIOD FOR REVIEWING APPEALS

- (1) Post-Service and Loss of Time Claims. The Board which meets quarterly, must make a decision no later than the date of the first meeting which occurs at least 30 days after an appeal is filed, unless special circumstances require an extension of time for review. If such an extension is required, the claimant must be notified in writing, prior to the commencement of the extension, of the special circumstances requiring the extension and the date as of which the decision will be rendered, which will be no later than the third meeting of the Board after the appeal is filed. If, however, the

extension is due to the claimants failure to submit the information necessary to decide the appeal, and the extension notice specifically describes the required information, and the claimant must be given at least 45 days from receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which extension notice is sent to the claimant to the earlier of: (i) the date on which the Fund receives the claimant's response; or (ii) the due date established by the Plan for the furnishing of the requested information, which must be specified by the Plan, and be at least 45 days from the date of the notification. The claimant must be notified within 5 days after the Board makes its decision.

- (2) Pre-Service Claims. The claimant must be notified of the decision, whether adverse or not, within 30 days after the appeal is filed.

H. APPEAL DENIAL NOTICE

If a claim is denied on appeal, in whole or in part, the claimant must be notified of the denial in writing. Such written notice of denial must contain the following:

- (1) The specific reason(s) for the denial of the claim on appeal;
- (2) Reference to the specific Plan provision(s) on which the denial on appeal is based;
- (3) A statement that the claimant is entitled, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and,
- (4) A statement of the claimant's right to bring an action under ERISA Section 502(a).

For Group Health Claims only:

- (1) If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim and that a copy of such specific rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.
- (2) If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to the claimant, free of charge and upon request.

I. USE OF AN AUTHORIZED REPRESENTATIVE

An Eligible Individual, or the authorized representative of an Eligible Individual (collectively referred to herein as the "claimant"), may file a claim or appeal a denied claim. An Eligible Individual may be required

to furnish documentation showing that a person is, in fact, an authorized representative.

J. OTHER IMPORTANT INFORMATION ABOUT YOUR RIGHTS

Failure to Follow Procedures. If the Fund fails to follow these claims and appeals procedures, and it does not correct the error without prejudice to the Eligible Individual, such individual will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).

The claimant's failure to timely file a claim or an appeal within the appropriate time period shall constitute a waiver of the claimants right to file a claim or appeal a denied claim, as the case may be, provided that the Board of Trustees may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of action on his claim or appeal. No claimant or other person shall have any right or claim to benefits under this plan, or any right or claim to payments from the Fund, other than as specified herein. The denial of a claim as to which the right to review has been waived, or the decision of the Board of Trustees with respect to an appeal, shall be final and binding upon all parties, subject only to judicial review as provided under ERISA.

No action may be brought for benefits provided by the Plan, or to enforce any right under the Plan, until after a claimant has exhausted the administrative remedies available under the Plan, and thereafter, the only action that you may be brought is one to dispute the decision of the Board. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a participant or beneficiary of the Plan within the meaning of those terms as defined in ERISA.

For HMO claims and appeals procedures, see each specific certificate of coverage.

XXIV.DEFINITIONS

Any word in the male gender applies equally to the female gender unless a distinction is specified. The definitions in this section apply whether or not the defined words are capitalized when used in this booklet.

ACTIVE EMPLOYEE OR EMPLOYEE

The term “Active Employee” or “Employee” means any person who by reason of his active employment, meets the eligibility requirements hereunder as established by the Fund and as amended from time to time, and such other person as the Employer Council and the Union may agree to designate as employees within the meaning and purpose of an applicable Collective Bargaining Agreement.

The term “Active Employee” shall also mean an individual who is employed by an Employer, such as a supervisor or estimator, or who is less than a 100% shareholder in an Employer which is incorporated, such as a Corporate Officer, provided that any such individual was a Covered Employee in the Fund as stated in Section XXII and provided further that contributions to the Pension, Health and Welfare, and Apprentice Funds on any such individual shall be made on all hours worked or paid for subject to a minimum of 160 hours per month. Initial eligibility for such individuals is established on the basis as it is for other Active Employees.

The term “Active Employee” does not include Mason Finisher Apprentices.

AMBULATORY SURGICAL CENTER

Any public or private establishment with an organized medical staff of Physicians; with permanent facilities that are equipped and operated for the purpose of performing surgical procedures; with continuous Physician and registered professional nursing services whenever a patient is in the facility; and which does not provide services for patients to stay overnight.

ASSISTANT SURGEON

An Assistant Surgeon (M.D., D.O., D.P.M.) is eligible for benefits at 20% of the Reasonable and Customary allowance for the procedure, in those cases where an Assistant Surgeon is Medically Necessary. An Assistant Surgeon is considered Medically Necessary when a procedure is at a level of technical surgical complexity that the assistance of another Surgeon is required. An Assistant Surgeon is not considered Medically Necessary when the assistance required

is of a manual nature, and can be provided by non-Surgeon, paramedical personnel. Paramedical personnel include R.N.s, L.P.N.s, operating room technicians, and Physician assistants. Services of surgical assistants (paramedical personnel) are included in the operating room facility charges and are not eligible for separate benefits.

CALENDAR YEAR

The term “Calendar Year” means the year beginning January 1 and ending December 31.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985.

COLLECTIVE BARGAINING AGREEMENT

The term “Collective Bargaining Agreement” means any agreement between the Union and an Employer that provides for the making of uniform Employer contributions to this Fund, as well as any extensions, amendments, modifications or renewals of such agreement and any substitute, successor or predecessor agreement which provides for the making of Employer contributions to this Fund.

COMPLICATIONS OF PREGNANCY

- (1) Conditions, requiring Hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. False labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy are not considered “Complications”;
- (2) Non-elective caesarian section;
- (3) Ectopic pregnancy which is terminated; or
- (4) Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

“Complications of Pregnancy” as defined above are covered under the policy to the same extent as any other Sickness.

COVERED EMPLOYEE

The term “Covered Employee” means such Active Employee and Retired Employee.

CUSTODIAL CARE

Custodial Care which is designed to aid a person in the necessary activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary. Such care may involve:

- (1) Preparation of special diets.
- (2) Supervision over medication that can be self-administered.
- (3) Assisting the person in getting in or out of bed, walking, bathing, dressing, eating or using the toilet.

DENTIST

The term “Dentist” means a person licensed to practice dentistry in the state in which he renders treatment.

DOCTOR, PHYSICIAN, OR SURGEON

The term “Doctor,” “Physician” or “Surgeon” means a Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided while practicing within the scope of his license, Doctor will include a Dentist, podiatrist, chiropractor, optometrist, or psychologist. In no event will such term include the Eligible Individual or any person who is the spouse, domestic partner, parent, child, brother or sister of the Eligible Individual. The term will include a licensed clinical social worker who, upon referral by a Doctor of Medicine or Doctor of Osteopathy, is performing services covered under the terms of these Rules and Regulations.

DEPENDENT

The term “Dependent” means:

- (1) The Covered Employee’s lawful spouse; or registered same sex domestic partner in accordance with AB 2208 (opposite sex at age 62 or older). The Covered Employee must register the domestic partnership with the Secretary of State in accordance with Section 298 of the Family Code, and a copy of a valid Declaration of Domestic Partnership must be submitted to the Fund. Domestic partners will be deemed a Dependent for benefits in the HMO medical and prescription drug plans, prepaid dental plan, and

vision benefit plan only. Both the Covered Employee and his or her domestic partner must be enrolled in the same medical and dental plan.

- (2) The Covered Employee's children, from birth to age 26, including step-children, adopted children and foster children.

The Covered Employee's unmarried children older than 26 years of age who are prevented from earning a living because of mental and physical disability, provided such disabled children were disabled and eligible as a Dependent prior to age 19 and remain primarily dependent upon the Covered Employee for support. In no event shall a lawful spouse, domestic partner, child, mother, father, mother-in-law or father-in-law be eligible under the Plan both as an eligible Dependent and as a Covered Employee, nor shall a child be considered an eligible Dependent of more than one Covered Employee.

In no event shall a child of a domestic partner be considered an eligible Dependent.

DURABLE MEDICAL EQUIPMENT

Equipment which is:

- (1) Ordered by your Physician;
- (2) Primarily used for medical purposes;
- (3) Able to withstand repeated use;
- (4) Generally not of use in the absence of Injury or Sickness; and,
- (5) Appropriate for use in the home.

ELIGIBLE INDIVIDUAL

The term "Eligible Individual" means a Covered Employee and each of his/her Dependents, if any.

ERISA

Employee Retirement Income Security Act of 1974

EMPLOYER

The term “Employer” means any association, individual, partnership, joint venture or corporation which has agreed to be bound by the terms and provisions of the Trust Agreement and is obligated to make Employer contributions to the Trust Fund in accordance with a Collective Bargaining Agreement. “Employer” may also mean any Local Union, signatory hereto, and the Trust Funds which make contributions hereto and behalf of its employees, provided the inclusion of said Local Union or Trust Funds as an Employer is not a violation of any applicable law or state. An Employer shall not be deemed an Employer simply because he is part of a controlled group of corporations or of a trade or business under common control, some part of which is a contributing Employer.

ESSENTIAL HEALTH BENEFITS

Essential Health Benefits (EHB) are a set of benefits as set out in the Patient Protection and Affordable Care Act. The Trustees will determine what are considered EHB according to ACA guidance.

EXPERIMENTAL

The term “Experimental” means those treatments, procedures, methods, or services that: (1) lack endorsement by appropriate authorities, e.g. Food and Drug Administration (FDA), medical or dental societies, or specialties; (2) are uncertain in terms of efficacy, safety, or reliability as Reported in current medical literature; or (3) are undergoing or have yet to begin clinical trials.

EXTENDED CARE FACILITY

The term “Extended Care Facility” means an institution which (1) provides skilled nursing care under 24 hours a day supervision of a Doctor or Registered Nurse, (2) has available at all times the services of a Doctor who is a staff member of a Hospital, (3) provides 24 hours a day nursing service by a Registered Nurse, Licensed Vocational Nurse or skilled practical nurse and has a Registered Nurse on duty at least 8 hours per day, (4) maintains a daily medical record for each patient, and (5) is not a place of rest, Custodial Care, for the aged, for treatment of chemical dependency, nor is a hotel or similar institution.

FDA

The U.S. Food and Drug Administration.

FUND

The term “Fund” means the Brick Masons’ Health and Welfare Trust Fund; the “Fund” also means the Board of Trustees established by the Trust Agreement where applicable.

HOME HEALTH CARE AGENCY

- (1) A service or agency which holds a valid certificate of approval, or license, as a public home health care agency;
- (2) A Hospital holding a valid operating certificate authorizing it to provide home health care services; or
- (3) An establishment approved as a Home Health Care Agency under Medicare.

HOME HEALTH CARE PLAN

A program for care and treatment of a sick or injured Covered Person in his home by a Home Health Care Agency. The program must be established by the Covered Person's attending Physician. The attending Physician must approve the program in writing prior to the start of home health care services. The attending Physician must also certify that confinement in a Hospital or Skilled Nursing Facility would be required if home care is not provided.

HOSPICE

An agency which provides medical, health care services and Medical Social Services for the palliative and supportive care and treatment of terminally ill individuals. The agency must:

- (1) Provide 24 hour, 7 day a week service;
- (2) Provide a program of services under direct supervision of a Physician or licensed R.N.;
- (3) Maintain full and complete records of all services provided to all covered individuals; and,
- (4) Be established and operated in accordance with the applicable laws or regulations of the jurisdiction in which it is located.

HOSPITAL

- (1) The term “Hospital” means an establishment which:

- (a) Holds a license as a Hospital (if required in the state);
- (b) Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
- (c) Provides around the clock nursing service;
- (d) Has a staff of one or more Physicians available at all times;
- (e) Provides organized facilities for diagnosis and surgery;
- (f) Is not primarily a clinic, nursing, rest or convalescent home or a skilled nursing facility or a similar establishment; and
- (g) Is not, other than incidentally, a place for treatment of drug addiction.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the Hospital or at a facility with which it has a formal arrangement.

Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or skilled nursing facility will not be deemed confinement in a Hospital.

(2) A **HOSPITAL** also includes:

- (a) A Psychiatric Health Facility as defined in Section 1250.2 of the California Health and Safety Code, when service is rendered there for psychiatric or mental conditions; and,
- (b) A licensed Ambulatory Surgical Center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center in the same “working day.” The center will not qualify as a Hospital if:
 - (i) it is maintained as an office by a Physician for the practice of medicine;
 - (ii) its primary purpose is performing abortions; or
 - (iii) it is maintained as an office for the practice of dentistry.

<p>NOTE: Services provided in the facilities outlined in items (a) and (b) above may be covered under other provisions of the Plan other than Hospital benefits</p>

INJURY

Bodily injury caused by an accident. The accident must occur while coverage is in force. It must also result directly and independently of all other causes of a loss covered by the Plan.

INVESTIGATIONAL AND EXPERIMENTAL TREATMENT

For the purpose of administering the Plan, procedures that are scientifically proven ineffective will be considered investigational. This means that a procedure has been reviewed and not found to be safe and effective. It would also include outmoded procedures (an example of this would be the chymopapain injections for herniated spinal discs).

To be eligible for coverage, treatment must meet all of the following criteria:

- (1) It must have approval, if appropriate, from the proper regulatory authority (e.g. FDA). In the case of prescription drugs, the drug must be approved and it must be for one of the specific conditions that are included as approved in the FDA labeling. If it is being used for an off-label use, it is not considered eligible for coverage.

In the case of medical devices, they are often given a designation known as 510K. This was created because the FDA was overworked and did not want to take the time to evaluate every device. A 510K does not imply efficacy, and in fact in FDA letters to manufacturers, it clearly states that it is not an FDA approval. It does state that it is safe. It also states that it may be marketed and that it does not need full review because it is “substantially equivalent” to a device already on the market. In determining if a device with a 510K designation is eligible for coverage, it will be necessary to find out what it is “substantially equivalent” to. The eligible uses would be the same as those associated with the original device;

- (2) It must not be considered Investigational or Experimental by a recognized (American Board of Medical Specialties) appropriate specialty board;
- (3) Sufficient peer reviewed medical literature (controlled studies) must exist to document safety and efficacy. Anecdotal (what happened in one or more cases) evidence will not be considered;
- (4) It must improve the overall health outcomes of the case. This means that it must be better than existing treatments (i.e., less painful, more effective, safer, less invasive);
- (5) It must be currently in use in all parts of the country;
- (6) It must not be part of a clinical trial, Phase I, II or III; and,

- (7) The patient must not have signed an informed consent for Investigational or Experimental procedures.

MASON FINISHER APPRENTICE

An individual classified as a “Mason Finisher Apprentice,” as defined under the Collective Bargaining Agreement, and who is eligible for limited coverage under the Plan.

MEDICAL NECESSITY OR MEDICALLY NECESSARY

The terms “Medical Necessity” or “Medically Necessary” means a service or supply that is therapeutic for a diagnosed Injury or Sickness that (a) is appropriate and consistent with the diagnosis and in accordance with accepted standards of community practice, and (b) could not have been omitted without adversely affecting the patients’ condition or the quality of medical care. The fact that a Physician orders a service or supply does not, in itself, determine Medical Necessity. Medical Necessity shall be determined by the Trustees in their discretion, who may rely upon the advice of medical professionals of their choice.

MEDICAL SOCIAL SERVICES

Those services rendered in connection with the terminal Sickness of a covered individual by a Social Worker under the direction of a Physician. Such services will include but are not limited to:

- (1) Assessment of the social, psychological and family problems related to or arising from the Sickness and treatment; and,
- (2) Appropriate action and utilization of community resources to assist in resolving such problems.

MEDICARE

The term “Medicare” as used herein, means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

The conditions listed in the Mental Health and Substance Use Disorders section of the current edition of the World Health Organization’s International Classification of Diseases, as published by the Commission of Professional and Hospital Activities.

MENTAL DISABILITY

A condition of arrested or incomplete development of mind, present from birth or early infancy, which is especially characterized by subnormality of intelligence.

NECESSARY TREATMENT

Medical and dental treatment which is:

- (1) Consistent with generally accepted medical practice for the Sickness, Injury, or condition of the Participant;
- (2) Ordered by the attending or other licensed Physician (or, in the case of dental services, ordered by the Dentist); and,
- (3) In accordance with approved and generally accepted medical, surgical, or dental practice prevailing in the geographic locality where and at the time the service or supply is rendered. Determination of “generally accepted practice” is the prerogative of Board of Trustees of the Fund through consultation with appropriate authoritative medical, surgical, or dental practitioners.

Any confinement, operation, treatment or service not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. The fact that a covered provider has recommended, prescribed or ordered a covered service, does not, of itself, mean that the Plan considers it eligible for coverage. Treatment of any type that is for the complications or sequelae of any non-covered procedure will not be considered necessary under the Plan. No treatment provided only as a convenience to the covered person, covered person’s family or provider is considered Necessary Treatment. No treatment or service, or expense in connection therewith, which is Experimental or Investigational in nature as defined herein is considered Necessary Treatment.

Peer Review Organizations or other professional medical opinion sources may be used to determine if health care services are:

- (1) Medically Necessary;
- (2) Consistent with professionally recognized standards of care with respect to quality, frequency and duration; and,
- (3) Provided in the most economical and medically appropriate site for treatment.

If services do not conform to the qualifications or are not consistent with professionally recognized standards of care with respect to quality, frequency, or duration, expenses related to those services will not be deemed Necessary Treatment.

NON-PPO SCHEDULE

The term “Non-PPO Schedule” means a fixed schedule of allowances the Plan will pay for Medically Necessary Covered Expenses received from a Non-PPO Provider. This schedule is based on the 90th percentile of MDR for Non-PPO claims incurred prior to October 1, 2010 and the 90th percentile of Context for Non-PPO claims incurred on or after October 1, 2010, as updated from time to time.

NURSE MIDWIFE

A licensed Registered Nurse who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

OCCUPATIONAL THERAPY

The application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired due to physical or psychiatric Injury or Sickness, to achieve optimum recovery.

PATIENT PROTECTION AND AFFORDABLE CARE ACT of 2010

This law is also referred to as the Affordable Care Act (or PPACA or ACA).

PCP

Primary Care Physician.

PLAN

The term “Plan” means these Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

PPO

Preferred Provider Organization.

PHYSICAL THERAPY

Treatment provided by a registered physical therapist, certified occupational therapist, or licensed practitioner of the healing arts acting within

the scope of that person's license (acupuncturist, chiropractor) utilizing physical agents and methods to assist in rehabilitation and restoration of normal bodily function after Injury or Sickness.

PHYSICIAN

A licensed practitioner of the healing arts acting within the scope of his license.

The Physician may not be a Plan participant, a member of a covered Employee's immediate family (spouse, children, brothers, sisters, or parents of a Participant), the domestic partner of an Employee, or residing in an Employee's home. Physician includes a duly Certified Nurse Midwife.

REASONABLE AND CUSTOMARY CHARGE

The fee regularly charged and received for a given service by the health care provider which does not exceed the general level of charges being made by providers of similar training and experience when furnishing customary treatment for a similar Sickness, condition or Injury. The locality where the charge is incurred will also be considered. The term "locality" is the area designated as necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services or supplies for which the charge was made (sometimes referred to as usual and customary charge).

REGISTERED NURSE

The term "Registered Nurse" means a registered graduate nurse who does not ordinarily reside in the Eligible Individual's home and is not the spouse, domestic partner, child, brother, sister or parent of the Eligible Individual or of the Eligible Individual's spouse.

RESIDENTIAL TREATMENT FACILITY

Psychiatric treatment facility or chemical dependency treatment facility accredited under the Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, which:

1. Is mainly engaged in providing assistance in the treatment of mental health and substance use disorders/withdrawal from dependency on alcohol or drugs;
2. Is supervised by a staff of Physicians on the premises; and
3. Provides on the premises 24-hour nursing service by graduate registered nurses

RETIRED EMPLOYEE

Effective November 1, 2007, the term “Retired Employee” means any person who is not Medicare Eligible and who has qualified for benefits under any retirement plan sponsored by the Bricklayers and Allied Craftworkers Local #4.

REPORTED

An article which has been published or accepted for publication in a textbook or peer reviewed periodical.

REASONABLE CHARGES

The term “Reasonable Charges” means the customary charges, in the area in which they are incurred, but not exceeding such charges as would have been made in the absence of the benefits provided under this Summary Plan Description. A “customary charge” as used herein means the usual charge made by a Hospital, Extended Care Facility, Physician, Dentist, or other professional provider, or other person or firm having rendered or furnished the services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily Injuries or Sicknesses comparable in severity and nature to the bodily Injuries or Sickness treated or being treated. The term “area,” as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items. A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained. The Board of Trustees may, at its discretion, utilize the services of an independent source in determining Reasonable Charges as necessary.

SICKNESS

An illness or disease which causes loss covered by the Plan. The loss must commence while the Employee is insured under the Fund. For Fee-For-Service Medical Plan benefits, pregnancy is considered a Sickness with respect to female Covered Employees and the spouses of male Covered Employees only. Pregnancy for Dependent children is not covered except for Complications of Pregnancy.

TOTAL DISABILITY

The term “Total Disability” shall mean, with respect to an Active Employee, that as a result of bodily Injury or Sickness, the Active Employee is completely unable to engage in any gainful occupation for which he is reasonably qualified by reason of education, training or experience and that he is not engaged in any gainful occupation.

The term “Total Disability” shall mean, with respect to any other Eligible Individual, that as a result of bodily Injury or Sickness, the Eligible Individual is unable to engage in his or her regular and customary activities and is not, in fact, engaged in any employment occupation for wage or profit.

TRUST AGREEMENT

The term “Trust Agreement” means the Agreement and Declaration of Trust establishing the Brick Masons’ Health and Welfare Trust Fund dated May 26, 1960 and any modification, amendment, extension or renewal thereof.

TRUSTEES

The term “Trustees” shall mean any persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such persons from time to time in office. The term “Board of Trustees” and “Board” means the Board of Trustees established by the Trust Agreement.

UNION

The term “Union” means Bricklayers Local Union No. 4 of California International Union of Bricklayers and Allied Craftworkers and any other Local Unions which have a Collective Bargaining Agreement in effect with an Employer and agree to be bound by the terms and provisions of the Trust Agreement of the Brick Masons Health and Welfare Trust Fund.

**XXV. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT
INCOME SECURITY ACT OF 1974 (ERISA)**

- (1) Name of Plan.** This Plan is known as the Brick Masons' Health and Welfare Plan.
- (2) Plan Administrator and Sponsor.** The Board of Trustees is both the Plan Sponsor and Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974. The Board of Trustees has contracted with BeneSys, Inc. to administer the Plan. The Administrative Office will provide you, upon written request, information as to whether a particular Employer or union is a sponsor of the Plan and the address of the Employer or union.
- (3) Name and Address of the Board of Trustees.** The Board of Trustees consists of an equal number of management and labor representatives, selected by the Employers and unions, in accordance with the Trust Agreement which relates to this Plan.

To contact the Board of Trustees, use the address and phone number below:

Brick Masons' Health and Welfare Plan
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

The Trustees have engaged the independent contractor named below to perform routine functions of the Trust:

BeneSys, Inc.
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

- (4) Names and Addresses of any Trustee or Trustees.** As of September 1, 2015, the Trustees of this Plan are:

Management Trustees	Labor Trustees
<p>Mr. Frank E. Smith Frank Smith Masonry 2830 Pomona Blvd. Pomona, CA 91768</p> <p>Mr. Jimmy Smith Kretschmar & Smith, Inc. 6293 Pedley Road Riverside, CA 92509</p> <p>Mr. Ken C. Tejeda R & R Masonry Inc. 5337 Cahuenga Blvd., Bldg. A, No. E North Hollywood, CA 91601</p> <p>Mr. Dana Kemp Masonry Concepts, Inc. 15408 Cornet Street Santa Fe Springs, CA 90670</p>	<p>Mr. Gary Anthony Bricklayers and Allied Craftworkers Local Union No. 4 California 11818 Clark St., Suite A Arcadia, CA 91006</p> <p>Mr. Daniel Garcia Bricklayers and Allied Craftworkers Local Union No. 4 California 11818 Clark St., Suite A Arcadia, CA 91006</p> <p>Mr. Doug Sles Bricklayers and Allied Craftworkers Local Union No. 4 California 11818 Clark St., Suite A Arcadia, CA 91006</p> <p>Mr. Dick Whitney, President Bricklayers and Allied Craftworkers Local Union No. 4 California 11818 Clark St., Suite A Arcadia, CA 91006</p> <p>Mr. Darryl Brandt Bricklayers and Allied Craftworkers Local Union No. 4 California 1412 Mills Avenue Redlands, CA 92373</p>

Alternate Management Trustee	Alternate Union Trustees
<p>Mr. John Chrysler Masonry Institute of America 1315 Storm Parkway Torrance, CA 90501</p>	<p>Mr. Robert Collins 12927 Lantern Lane Victorville, CA 92392</p>

- (5) **Identification Numbers.** The number assigned to the Trust by the Internal Revenue Service is 95-6041102. The Plan number is 501.
- (6) **Agent for Service of Legal Process.** The name and address of the agent designated for the service of legal process is:

BeneSys, Inc.
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

Legal process may also be served on any Plan Trustee or the Trust's legal counsel:

Reich, Adell & Cvitan
3550 Wilshire Boulevard, Suite 2000
Los Angeles, CA 90010

- (7) **Collective Bargaining Agreement.** Contributions to the Plan are made on behalf of each Employee in accordance with Collective Bargaining Agreements between the Bricklayers and Allied Craftsmen Local Union No. 4 of California and Employers in the industry.
- (8) **Source of Contributions.** The benefits described in this booklet are provided through Employer contributions, COBRA and Retiree self-payments. The amount of Employer contributions is determined by the provisions of the Collective Bargaining Agreements. The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of participants working under the Collective Bargaining Agreement.
- (9) **Type of Plan.** This Plan is maintained for the purpose of providing Life Insurance, Accidental Death and Dismemberment, Comprehensive Medical, Dental, Weekly Disability, Vision, and Hearing Aid Benefits.
- (10) **Trust Fund.** The Trust's assets and reserves are held in trust by the Board of Trustees of the Brick Masons' Health and Welfare Trust Fund.
- (11) **Identity of Providers of Benefits.** The Life Insurance and Accidental Death and Dismemberment benefits are insured by Prudential Insurance Company of America.

BeneSys, Inc. (BPA) provides third party administration to the Fund. Some benefits under this Plan are provided through a Health Maintenance Organization ("HMO") as indicated by an asterisk (*). Premiums are paid to the HMO for this coverage on behalf of Participants who have elected coverage under the HMO. Any claims dispute involving the HMO must be handled directly with the HMO. Although, as a last measure, the dispute may be presented to the Board of Trustees.

The Fee-For-Service Medical, Fee-For-Service Dental, Loss of Time, and Hearing Aid Benefits are self-funded and are provided by the Fund. BeneSys, Inc., administers the payment of claims for the self-funded programs.

The insurance carriers and providers of service for this Plan are:

For the Hospital, Medical, and Surgical:

Brick Masons' Health & Welfare Trust Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

Kaiser Foundation Health Plan, Inc. (*)
Regional Offices, Southern California
393 East Walnut Street
Pasadena, CA 91188-8110

United Healthcare (*)
Corporate Headquarters
5701 Katella Avenue, Mail Stop 6441
Cypress, CA 90630

For Loss of Time Benefits:

Brick Masons' Health & Welfare Trust Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

For Dental:

Brick Masons' Health & Welfare Trust Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

United Concordia Dental Plans (*)
21700 Oxnard Street, Suite 500
Woodland Hills, CA 91367

For Prescription Drug under the Fee-For-Service Medical Plan:

Express Scripts, Inc
One Express Way
St. Louis, MO 63121
(800) 467-2006

For Vision:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

For Hearing Aid Benefits:

Brick Masons' Health & Welfare Trust Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090

For Life Insurance and Accidental Death and Dismemberment:

The Prudential Insurance Company of America
Group Life Insurance
80 Livingston Avenue
Roseland, NJ 07068
(800) 524-0542 (Claims)

- (12) **Fiscal Plan Year.** The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins May 1 of any year and ends April 30 of the following year.
- (13) **The Plan's Requirements With Respect to Eligibility for Participation and Benefits.** The eligibility requirements are specified in this booklet, in Section I. A Summary of Benefits appears in Section VII and a more detailed description of benefits is included in item C of the section.
- (14) **Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.** Loss of eligibility is described in Sections I, II, and III. For information regarding situations under which benefits may be reduced or denied, see the description of exclusions for each benefit which are set forth throughout this booklet.
- (15) **Procedures to Follow for Filing a Claim.** The procedure to be followed in filing a claim for benefits is described in Section XXI.
- (16) **Review Procedure.** The procedure to be followed in filing an appeal is described in Section XXI.F.
- (17) **Availability of Documents and Other Important Information.** As a participant in the Brick Masons' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income

Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan including insurance contracts, Collective Bargaining Agreements, a copy of the latest annual report (Form 5500 series) and an updated summary plan description and other Plan information. 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.

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Obtain, without charge, a copy of the Claims Procedures adopted by the Board of Trustees as a separate document accompanying this Summary Plan Description.

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 welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the 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 a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in

part, you may file suit in a state or federal court but only after first exhausting the claims and appeals procedures herein. 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 but only after first submitting the order to the Plan for review. 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 state or federal court. The court will decide who should pay 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 frivolous.

Any questions about the Plan should be addressed to the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

- (18) **Authority to Terminate or Reduce Benefits and Rights of Participants and Beneficiaries upon Termination or Reduction of Benefits.** The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. If there is a material modification or reduction in covered services or benefits provided by the Plan, a summary description of such modification or change will be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the event of termination of the Plan, any assets remaining after satisfaction of all liabilities shall be applied to provide, either directly or through the purchase of insurance, life, sick, accident or other benefits as required by Treasury Regulations issued under Internal Revenue Code §501(c)(9).

This Summary Plan Description is required by federal law. Of necessity, many of the substantive Plan provisions mentioned in the Summary Plan Description have been set forth in summary or abbreviated form. It is not to be considered the contract of insurance. All statements made in this booklet are subject to the complete terms of the coverages as set forth in the master service agreements issued by Kaiser Foundation, United Healthcare, United Concordia Dental Plan, Express Scripts, Vision Service Plan, and the group insurance policy issued by Prudential Insurance Company of America, and all amendments to their respective documents, as well as the Rules and Regulations of the Trust Fund. Please refer to the master policies, agreements, and Rules and Regulations for a complete and detailed description of the coverage.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration, should be referred to the Administrative Office of the Fund:

**Brick Masons' Health & Welfare Fund
1050 Lakes Drive, Suite 120
West Covina, CA 91790
(626) 646-1090**

No representations made to a participant, Physician, Dentist, Hospital or other medical provider concerning eligibility, entitlement to benefits or the amount of benefits payable are binding against the Trust Fund unless the representations are made in writing by the Board of Trustees or Administrator.

The only parties authorized to answer questions concerning the Trust Fund and Plan are the Board of Trustees and the Administrator. No participating Employer, Employer association or labor organization, nor any individual employed thereby, has authority in this regard.

Nothing in this statement is meant to interpret, extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. All benefits not expressly stated in this booklet as being covered are excluded.