STONE AND MARBLE MASONS OF METROPOLITAN WASHINGTON, D. C. HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

February 2019

STONE AND MARBLE MASONS OF METROPOLITAN WASHINGTON, D. C.
HEALTH AND WELFARE TRUST FUND
c/o Carday Associates
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(Phone) 410-872-9500

This booklet has been prepared so that you may become familiar with the Benefits available to you and your family at this time. It includes all changes through February 2019. For a description of the schedule of benefits in effect before February 2019, please see the previous Summary Plan Description, and Summaries of Material Modification.

We urge you to study the contents of this booklet carefully in order to understand the benefits to which you and your family are entitled.

The Trust Fund is jointly administered by The Board of Trustees; half of us are designated by the Employers and half by the Union. We, in turn, employ the services of a Contract Administrator to carry out the day-by-day functions pursuant to our instructions. The Contract Administrator is Carday Associates, Inc.

The Board meets as often as necessary, but normally at least once each quarter, in order to fulfill our responsibility to keep the Fund financially sound. The Fund is audited once each year by a Certified Public Accountant selected by us. Reports are filed annually with the Internal Revenue Service and the U.S. Department of Labor.

Each Employer who contributes to the Fund makes a monthly report on forms provided by the Fund Office. Copies of this report are sent to the Union by the Administrator. Once a year you will receive a copy of your Confirmation of Hours showing the number of hours reported for you during the prior year by those Employers who contributed to the Fund on your behalf, provided your current address is on file in the Fund Office.

Though we sincerely hope you and your family will continue to enjoy good health, it is comforting to know that the excellent benefits described in this booklet are available in time of need.

Very truly yours,

THE BOARD OF TRUSTEES

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SCHEDULE OF BENEFITS

Following are two Schedules of Benefits in effect as of February 2019, one applies to Stone and Marble Masons and it is named "Benefit for Stone Masons." A second schedule follows for Rubble Men and Caulkers, who contribute at a lower rate to the Plan, named "Benefit for Rubble Men and Caulkers." The Schedule of Benefits applicable prior to February 2019 may be different and you should refer to the previous Summary Plan Description and Summary of Material Modifications for prior benefits. The Board of Trustees reserves the right to modify the Schedules of Benefits at any time.

Benefits for Stone Masons

Description	Benefit Employees with more than 2 year of eligibility		Benefit Employees with less than 2 years of eligibility	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Benefits				
Annual Deductible				
Individual	$100	$100	$100	$100
Family	$300	$300	$300	$300
Annual Benefit Maximums				
Essential Health Benefits	Unlimited		Unlimited	
Non-Essential Health Benefits	Not Applicable		$100,000	
Lifetime Benefits				
Essential Health Benefits				
Paid per Basic & Major Medical	Up to $1,000,000		Up to $1,000,000	
Paid at 50%	Above $1,000,000		Above $1,000,000	
Non-Essential Health Benefits Maximum	$1,000,000		$1,000,000	
Annual Basic Benefit	100%	90%	100%	90%
	Limited to $20,000		Limited to $20,000	
Major Medical Benefit *Benefit begins after Basic Benefit Maximum has been reached*	80%	70%	80% up to $150,000 and then 50%	70% 50% above $150,000
Office Visits *(not applicable for Retirees)*	$10 copay	$10 copay	$10 copay	$10 copay
Chiropractic Treatment	$50 per visit	$50 per visit	$50 per visit	$50 per visit
Acupuncture Treatment *Limited to 24 visits per calendar year*	$50 per visit	$50 per visit	$50 per visit	$50 per visit
Hearing Aids *Benefit is for members and dependents and is limited to $4,000 every two years*	100%	100%	100%	100%

Dental Benefits	**Employee and Dependents**	**Dependents up to age 18**
Annual Maximums		
At 100%	$500	Benefit above $2,500 will be paid at
At 80%	$2,000	50%
Maximum paid per family	$4,000	Unlimited

Vision Benefits	**Members and Dependents**
Annual Per Person	$400
Laser Vision Surgery (lifetime, per person)	$1,000

Prescription Benefits	**Retail**	**Mail Order or CVS Retail**
Copayment for Generic Drugs	$10	$20
Copayment for Preferred Brand Name Drugs	$25	$50
Copayment for Non-Preferred Drugs	$40	$80
Copayment for Specialty Drugs	$75	$75

Weekly Accident and Sickness	**Members Only**	
Basic (maximum 10 weeks)	$435/week	
Extended (maximum additional 10 weeks)	$435/week	

Benefits for Rubble Men and Caulkers (PCC)

Description	Benefit Employees with more than 2 year of eligibility		Benefit Employees with less than 2 years of eligibility	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Benefits				
Annual Deductible				
Individual	$100	$100	$100	$100
Family	$300	$300	$300	$300
Annual Benefit Maximums				
Non-Essential Health Benefits	Unlimited		Unlimited	
	Not Applicable		$100,000	
Lifetime Benefits				
Essential Health Benefits				
Paid per Basic & Major Medical	Up to $1,000,000		Up to $1,000,000	
Paid at 50%	Above $1,000,000		Above $1,000,000	
Non-Essential Health Benefits Maximum	$1,000,000		$1,000,000	
Annual Basic Benefit	100%	80%	100%	80%
	Limited to $20,000		Limited to $20,000	
Major Medical Benefit *Benefit begins after Basic Benefit Maximum has been reached*	80%	70%	80% 50% above $150,000	70% 50% above $150,000
Office Visits *(not applicable for Retirees)*	$20 copay	$20 copay	$20 copay	$20 copay
Chiropractic Treatment	$50 per visit	$50 per visit	$50 per visit	$50 per visit
Acupuncture Treatment *Limited to 24 visits per calendar year*	$50 per visit	$50 per visit	$50 per visit	$50 per visit
Hearing Aids *Benefit is for members and dependents and is limited to $4,000 every two years*	100%	100%	100%	100%

Prescription Benefits	**Retail**	**Mail Order or CVS Retail**
Copayment for Generic Drugs	$10	$20
Copayment for Preferred Brand Name Drugs	$35	$70
Copayment for Non-Preferred Drugs	$50	$100
Copayment for Specialty Drugs	$75	$75
Weekly Accident and Sickness	**Members Only**	
First 2 weeks	$100/week	
Next 11 weeks (max 13 weeks total)	$435/week	
Dental Benefits	**Employee and Dependents**	**Dependents up to age 18**
Annual Maximums		
At 100%	$500	$500
At 80%	$2,000	$2,000
Maximum paid per family	$4,000	Not Applicable (Benefits above $2,500 will be paid at 50%)
Vision Benefits	**Members and Dependents**	
Annual Per Person	$400	
Laser Vision Surgery (lifetime, per person)	$1,000	

DESCRIPTIONS, CONDITIONS AND LIMITATIONS ARE DESCRIBED FURTHER IN THIS SUMMARY DESCRIPTION.

ELIGIBILITY RULES

INITIAL ELIGIBILITY

If you are an Employee within the jurisdiction of the Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund and employed by a participating Employer who has signed a Collective Bargaining Agreement with the Union, you will become eligible for benefits under one of two Schedules of Benefits on the first day of the month following any period within the preceding six months in which you have been credited with at least 750 hours of employment for which contributions have been paid by one or more contributing Employers. If you are a Stone Mason, upon reaching 750 hours of employment for which contributions have been paid for work as a Stone Mason by one or more contributing Employers, you will be eligible for the Benefits for Stone Masons. If you are a Rubble Man or Caulker, upon reaching 750 hours of employment for which contributions have been paid by one or more contributing Employers, you

will be eligible for the Benefits for Rubble Men and Caulkers. You also would qualify for initial eligibility if you do not have 750 hours in the previous six months, but do have 950 hours in the previous 12 months. Your initial eligibility will continue for up to 3 months, provided you have at least 750 hours of employment for which contributions have been made, during the previous 6 month period. Thereafter the rules for continuing eligibility apply.

Each qualified dependent will become eligible on the date you become eligible or the date he or she becomes a dependent, whichever is later. Eligible adult children that enroll (or re-enroll) will receive coverage that begins on the first of the month following the date the plan receives the completed application.

CONTINUATION OF ELIGIBILITY

You and your qualified dependents will continue to be eligible for benefits from month-to-month provided you continue to be credited with no less than 950 hours of employment during the twelve consecutive months preceding the first of each month.

TERMINATION OF ELIGIBILITY

You and your qualified dependents will terminate eligibility on the first day of the month following a consecutive twelve month period during which you fail to receive credit for at least 950 hours of employment with one or more contributing Employers.

You also will lose eligibility if you cease working for an employer that is a participating employer under this Plan and begin working for an employer within the geographical jurisdiction of Local 1 Bricklayers and Allied Crafts that is not a participating employer under this Plan. If this occurs, your eligibility and the eligibility of all your dependents will cease upon the date you ceased working for the participating employer. You may not again become eligible until you thereafter accrue sufficient hours to meet the requirements for initial eligibility under the plan.

Periods of proven disability up to a maximum of twelve months shall not be counted as periods of unemployment. You will be credited with 8 hours for every week day that you are receiving Weekly Accident and Sickness Benefits from the Fund. When you have exhausted Accident and Sickness Benefits of this Fund but continue to be disabled or if you are receiving Worker's Compensation Benefits, you will, provided adequate proof is furnished, continue to be eligible up to a maximum of twelve months by being credited with 8 hours for every week day that you continue to be disabled.

The following circumstances may result in your **ineligibility for benefits** under the Plan:

- Failure to satisfy the Plan's eligibility requirements as a result of:
- insufficient employment under the jurisdiction of the Plan
- insufficient employment due to disability for periods of time prior to or following periods during which credit is available

- failure to pay timely any sums that may be required to continue eligibility during periods of disability or when employment is not available or failure to file required forms to establish entitlement to benefits during a period of disability.

- Non-covered employment such as employment by an Employer who is not required to make contributions on the employee's behalf

- requirements of the Plan.

- Failure to provide your Social Security number to the Plan.

The following circumstances may result in the denial of a claim:

- Your failure to affirmatively take the following steps when necessary:

- file promptly and in good faith the necessary forms and other information required in support of a claim, or

- file claims within time limits specified in the Plan.

- Providing a material false statement may result in a denial of a claim.

- The Plan will not pay for any expenses which are recoverable under the Medicare program (Parts A, B, C or D).

The following circumstances may result in your **suspension of benefits under the Plan**:

- Entrance into the military service will operate to suspend eligibility under the Plan.

CONTINUING ELIGIBILITY DURING PERIODS OF DISABILITY

If the Trustees determine that you are disabled, you will be eligible for 12 months of disability benefits, provided that you obtain a Claim Form attesting to your disability and provide it to the Fund Administrator.

REINSTATEMENT OF ELIGIBILITY

If your benefits hereunder have been terminated you will again become eligible for benefits on the first day of the month following any period within the preceding twelve months in which you have been credited with at least 950 hours of employment, for which contributions have been made by one or more contributing Employers.

RETIRED EMPLOYEE

If you retire under either the Federal Social Security Laws or the Stone and Marble Masons of Metropolitan Washington, D.C. Pension Trust Fund and you are eligible under this Welfare Fund at time of retirement and you have been eligible under this Welfare Fund for at least five (5) of the ten (10) years immediately preceding your retirement and you submit sufficient evidence that you meet the above criterion you may continue to participate in the Welfare Fund except for the Weekly Accident and Sickness Benefit and any charge covered by Medicare. In order to maintain continuity coverage, you must pay the required monthly premium. The Welfare Fund will not pay any expenses for benefits available under Medicare whether or not you elected Medicare coverage. See Medicare Supplemental Benefits.

All pensioners who otherwise meet the eligibility rules for retired pensioners to receive health benefits and who retire with benefits on or after age 55, will be required to make monthly payment for benefits, in advance, at the rate established by the Board of Trustees, which may be modified from time to time.

When payment is required, the first payment under this provision shall be made within 90 days of the pensioner having received notice that his health benefits as an active employee are terminated. Payment must be made retroactive to the date of the termination of benefits; thereafter payment for each month is required in advance, If this payment is not initiated, or if initiated, is stopped, benefits will not continue and cannot be reinstated at a later date.

THE TRUSTEES RESERVE THE RIGHT TO MODIFY OR ELIMINATE RETIREE BENEFITS SHOULD FUTURE CIRCUMSTANCES WARRANT SUCH ACTION.

RETIREE AND WIDOW(ER) MONTHLY PREMIUMS

The following monthly premiums have been established for coverage for Retirees who are eligible under the plan for continuing participation as well as surviving spouses who are eligible for coverage. The Trustees reserve the right to change the monthly premium in their sole discretion at any time. COBRA rates are changed annually. Please contact the Fund Office to determine the current rates.

Stone Masons
The monthly Retiree Premium rates for Stone Masons are as follows:

COBRA Rates:

Single	$528.93/month
Family	$1,163.64/month

Retiree Rates:

Age 58-61, 30+ Years of Service, no Dependents	$415.00/month
Age 58-61, 30+ Years of Service, with Dependents	$550.00/month
Age 62-64, no Dependents	$415.00/month

Age 62-64 with Dependents	$550.00/month
Age 65+ (or Medicare-eligible disabled retiree), no Dependents	$131.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Dependents 65+	$196.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Dependents <65	$415.00/month

Surviving Spouse Rates:

Not Medicare Eligible	$415.00/month
Medicare Eligible	$131.00/month

Rates for Disabled Retiree Rates, prior to Medicare Eligibility (same as COBRA):

Single	$528.93/month
Family	$1,163.64/month

Rubble Men & Caulkers Plan

The monthly Retiree Premium rates for Rubble Men and Caulkers are as follows:

COBRA Rates:

Single	$400.00/month
Family	$879.00/month

Retiree Rates:

Age 58-61, 30+ Years of Service, no Dependents	$330.00/month
Age 58-61, 30+ Years of Service, with Dependents	$440.00/month
Age 62-64, no Dependents	$330.00/month
Age 62-64 with Dependents	$440.00/month
Age 65+ (or Medicare-eligible disabled retiree), no Dependents	$105.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Dependents 65+	$157.00/month
Age 65+ (or Medicare-eligible disabled retiree), with Dependents <65	$330.00/month

Surviving Spouse Rates:

Not Medicare Eligible	$330.00/month
Medicare Eligible	$105.00/month

Rates for Disabled Retiree Rates, prior to Medicare Eligibility (same as COBRA):

Single	$400.00/month
Family	$879.00/month

TERMINATION OF COVERAGE FOR DEPENDENTS UPON DEATH OF EMPLOYEE AND RETIRED EMPLOYEE

In the event of your death while eligible as an active employee, the eligibility of your dependents shall terminate on the date you would have normally terminated if you had ceased working instead of dying on that date. Eligibility for dependents of Retired Employees shall terminate as of the last day of the month in which the death of the Retired Employee occurs. Dependents may have the right to COBRA continuation coverage or to Surviving Spouse coverage, described elsewhere in this Summary Plan Description.

PAYMENT OF UNPAID BENEFITS UPON DEATH OF EMPLOYEE

In the event an eligible employee should die and there are Weekly Accident and Sickness Benefits, Hospital, Surgical or Medical benefits unpaid, such payment is to be made to the employee's Estate.

MILITARY SERVICE

When a participant is called to active duty with the Armed Services, the participant may continue health care eligibility status, or time worked towards eligibility status immediately upon reemployment. Upon honorable discharge, there will be no exclusion or waiting period imposed for the reinstatement of a participant's or a dependent's health coverage unless an exclusion or waiting period would have been imposed in the absence of military service, or else the exclusion or waiting period is based on an illness or disability determined by the U.S. Secretary of Veterans Affairs to have been connected to military service.

Participants going on active duty must provide the employer with advance notice in order to continue health benefits. Participants serving in the Armed Forces for more than 30 days, may elect to continue your health benefits for the lesser of 24 months or the period of military service (beginning on the, but you may be required to pay up to 102% of the full premium). If a participant serves in the Armed Forces for less than 31 days, the participant's health coverage is provided as if he had remained employed. A participant will only be excused for not giving advance notice to his employer under circumstances where the participant's ability to give notice "was impossible, unreasonable or precluded by military necessity." If the participant fails to give notice before going on active duty, the Plan Administrator may terminate the participant from the plan, but would then have to retroactively enroll the participant upon your reemployment from the last day of active coverage without any administrative charges.

Time spent in military duty determines the timeframe in which a participant has to apply for reemployment, report back to work, and to have his health benefit eligibility to be reinstated for him and his dependents after military service. For service of less than 31 days, you must return to work at the beginning of the next regularly scheduled work period on the first full day after release from service, taking into account safe travel home plus an eight-hour rest period. For service of more than 30 days but less than 181 days, you must submit an application for reemployment within 14 days of release from service. For service of more than 180 days, an application for reemployment must be submitted within 90 days of release from service.

In situations where you may leave for active duty in the military in excess of 30 days and you provide notice of the military service but do not elect to continue your coverage, the plan may terminate your health coverage retroactively to your date of departure. However, the Plan must

reinstate you retroactively to your last day of coverage upon your election for coverage and full payment of all required premiums within the time period set forth in the plan without administrative costs.

A copy of your honorable discharge must be submitted to the Fund Office.

SELF-PAYMENT OF CONTRIBUTIONS TO CONTINUE ELIGIBILITY

The Self-Payment of Contribution rules allow an employee of a Delinquent Employer to self-pay contributions for up to, but no more than, three (3) months while the Fund pursues collection. Self-payment will be based on actual hours worked for the Delinquent Employer multiplied by the Contribution Rate in effect at the time of the delinquency. When the Fund collects the delinquent contributions from the Employer, the employee will be reimbursed for the self-pay.

Further, if you become unemployed while eligible and employment is not available within the geographical jurisdiction of the Union or if your eligibility has already been continued up to a maximum of twelve months due to disability and you continue to be so disabled and furnish proof thereof, you may elect to pay your own contributions in order to retain your eligibility for benefits in accordance with the following requirements:

(1) You must be eligible at the time of becoming unemployed or must have your eligibility continued due to proven disability.

(2) A decision to self-pay contributions must be made no later than within one month following the last month in which you worked or the last month for which you received credit due to disability by filing an application with the Fund Office.

(3) You must pay your contributions on a 40-hour week at the current contribution rate, commencing with the first day of the calendar month in which you are not employed or have no hour credited. You must pay such contributions until the day prior to your reemployment.

(4) You must remain a resident in the jurisdiction of Local Union No. 1.

(5) You must remain available for immediate employment in the jurisdiction of Local Union No. 1 or furnish adequate proof of continuing disability.

(6) Contributions must be made monthly to the Fund Office.

(7) Payments may not be made retroactively in excess of thirty days.

(8) A reporting and payment form is available for the purpose of self-payments of contributions to continue eligibility. This form must be completed for each month that a self-payment is made and the Business Agent must sign this form certifying to the fact that employment was not available or that disability prevents you from working. This form with payment attached must be received in the Fund Office no later than the 15th of the month following the month for which payment is made.

(9) You may continue to self pay for up to a maximum of two (2) years.

CONTINUATION COVERAGE (COBRA)

Certain "Qualifying Events" may cause your Plan coverage to terminate. If these circumstances apply to you, you and your dependents may have an opportunity to continue your coverage for a limited time by purchasing "COBRA continuation coverage" at a monthly premium set by the Trustees. This right was established by a federal law known as COBRA.

QUALIFYING EVENTS

The following are qualifying events under the Plan:

Qualifying Event	Who May Purchase Continuation Coverage	For How Long
Employee loses eligibility due to termination (other than gross misconduct) or a reduction in hours of employment (including retirement)	**Employee, spouse and/or dependent children**	**18 months**
Termination or reduction in hours while you or your Dependent is disabled*	**Employee, spouse and/or dependent children**	**29 months (18 months plus an additional 11)**
Employee becomes entitled to Medicare and voluntarily drops coverage	**Spouse and/or dependent children**	**36 months**
Employee dies	**Spouse and/or dependent children**	**36 months**
Employee is divorced or is legally separated from spouse	**Spouse and/or dependent children**	**36 months**
Child is no longer considered a Dependent child by this Plan's definition	**Dependent child**	**36 months**
You are an eligible retiree under the Plan and your former Employer files for bankruptcy under Title 11 of the United States Code	**Retirees, Spouse/surviving spouse and dependents**	**Period ending on retiree's death, or for dependents, period ending 36 months from retiree's death**

*The disability must be determined by Social Security.

For eligible retirees under the Plan that are covered by an employer that commences a bankruptcy proceeding under Title XI of the United States Code, note that the bankruptcy proceeding must result in the loss of Plan coverage or the substantial elimination of coverage within one year before or after the date of commencement of the proceeding.

NOTIFICATION REQUIREMENTS FOR COBRA

If you experience a "Qualifying Event" such as divorce, separation or a child's age and are eligible for COBRA Continuation Coverage, you must:

(1) **Satisfy Notice Requirements:** Notify the Fund Office **in writing** of that event no later than **60 days after that event occurs.** The Fund Office will then send you forms and information about COBRA coverage. If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to elect COBRA continuation coverage.

(2) **Elect COBRA coverage:** You and/or your covered dependents have 60 days from the date you receive notice or the date your coverage ends, whichever occurs later, to complete the appropriate COBRA application forms.

(3) **Remit Payment.** You must remit payment for COBRA coverage **on time** in order to continue coverage. The Fund Office will notify you of the cost of the coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your eligible dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered dependents may continue only the same coverage that you and your dependents had before the COBRA-Qualifying Event, including:

- medical coverage (including hospitalization and surgery),
- prescription drug coverage,
- dental coverage,
- vision coverage, and
- hearing coverage.

You are *not* eligible to continue:

- weekly accident and sickness benefits,

COBRA FOR YOURSELF

COBRA coverage is available to you if coverage would otherwise end if:

- you become disabled;
- your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's health benefits program;
- your employment ends for any reason other than gross misconduct; or
- you are an Active Non-Bargaining Unit Employee and your employer no longer participates in the Plan because he or she no longer has employees covered under the collective bargaining agreement with the union.

COBRA FOR YOUR DEPENDENTS

COBRA coverage is available to your eligible dependents if dependent coverage would otherwise end if:

- your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program;
- you (the active employee) end employment for any reason other than gross misconduct;
- you (the active employee or retiree) die, are divorced, are living separately and apart from your spouse, are legally separated, or become entitled to Medicare;
- your dependent ceases to be eligible for coverage (see page 37); or
- if the employer terminates or substantially eliminated your coverage within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the United States Code.

You or your spouse or Dependent children must notify the Fund Office in writing within 60 days of a divorce or your child's loss of Dependent status under the Plan. Your Dependents should notify the Fund Office in writing within 60 days of your death. Your Employer must notify the Fund Office within 60 days of your death or your eligibility for Social Security benefits in writing in order to avoid confusion over the status of your health care.

The Fund Office will determine when your eligibility under the Plan would end due to the termination of your employment or the reduction in your hours for which contributions are received by the Fund. Following the receipt of a notice or after your loss of eligibility due to termination of your employment or reduction in hours of contributions is determined, the Fund Office will notify you and your Dependents of your and/or your Dependent's right to purchase COBRA coverage and the cost of this coverage. You will also be provided information concerning the cost to continue your coverage under the regular self-payment rules of the Plan.

ELECTING COBRA COVERAGE

Once you notify the Fund Office of a Qualifying Event, the Fund Office will send you and/or your covered dependents notice of the date your coverage ends, notify you and your Dependents of your and/or your Dependent's right to purchase COBRA coverage and the cost of this coverage, and give you the information and forms you'll need to elect COBRA Continuation Coverage.

If you and/or any of your covered dependents do not elect COBRA continuation coverage within 60 days after receiving that notice, you and/or they will not have any group health coverage from this plan after coverage ends. COBRA continuation coverage means just that – COBRA can only "continue" your coverage from the day your regular coverage ends. You cannot select the months you want for COBRA continuation coverage.

COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more dependents may elect COBRA even if the employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

COST OF COBRA COVERAGE

Individuals who continue coverage under COBRA pay 102% of the Plan's cost on an after-tax basis, except in cases of extended COBRA coverage due to disability. The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly.

Currently, the cost of COBRA coverage is as follows:

COBRA Rates for Stone Masons:

Single	$528.93/month
Family	$1,163.64/month

COBRA Rates for Rubble Men and Caulkers:

Single	$400.00/month
Family	$879.00/month

The Fund Office will notify you of the cost of the coverage at the time that you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

You have up to 45 days from the date you elect COBRA to pay all amounts due. If you elect COBRA coverage within the election period but after the date your coverage ends, you will have to pay the required COBRA premiums retroactively to cover the elapsed period. The full monthly amount must be paid before coverage starts. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. The Fund Office will accept third party payments of COBRA premiums.

If full payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate and cannot be reinstated.

YOUR REPORTING RESPONSIBILITY

The employee or a family member has the initial responsibility to inform the Board of Trustees of a divorce, legal separation, or a child losing dependent status under the Fund within 60 days of that event. Your contributing employer has the initial responsibility to notify the Board of Trustees of the employee's death, termination of employment, reduction in hours, Medicare eligibility, Social Security eligibility or the commencement of a bankruptcy proceeding under Title XI of the U.S. Code within 60 days of the event.

When the Board of Trustees is notified that one of these events has happened, the Board of Trustees will in turn notify you that you have the right to purchase continuation coverage. You must inform the Board of Trustees that you want to purchase continuation coverage within sixty days from the date you would lose coverage because of one of the events described above.

If you do not purchase continuation coverage, your regular coverage under the Fund will end.

If you do purchase continuation coverage, the Fund will provide coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

DURATION OF COBRA COVERAGE

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA-Qualifying Event. The COBRA Continuation Coverage period begins on the date of loss of coverage (rather than on the date of the Qualifying Event).

18 Months
COBRA health coverage can continue for up to 18 months if you would otherwise lose health coverage because of:

(1) your reduction in hours; or
(2) your change from active to inactive work status due to your:
    (a) resignation,
    (b) discharge (except for discharge for gross misconduct),
    (c) disability,
    (d) strike,
    (e) layoff,
    (f) leave of absence, except for leave under the family and medical leave act (FMLA), or
    (g) retirement.

29 Months
COBRA health coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA coverage. You or your dependent must notify the Fund Office of the determination no later than 60 days after it was received *and* before the end of the initial 18-month COBRA period in order to be eligible for this extended coverage.

This extended period of COBRA coverage will end at the **earlier** of:

(1) the last day of the month, 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
(2) the end of 29 months from the date of the COBRA Qualifying Event; or
(3) the date the disabled individual becomes entitled to Medicare.

Cost of COBRA Coverage in Cases of Disability
If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may charge employees and their families up to 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage.

36 Months
COBRA health coverage for your dependent(s) can continue for up to a total of 36 months from the date any one of the following COBRA Qualifying Events occurs:

(1) you die;
(2) you divorce or separate from your spouse;
(3) you become entitled to Medicare; or
(4) your dependent is no longer eligible for coverage under this Plan.

Acquiring a New Dependent(s) while Covered by COBRA
If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period at an additional cost.

For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new dependent for COBRA coverage, you must notify the Fund Office within 31 days. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time.

If you become covered under a different medical plan, you can continue COBRA eligibility if you've already elected COBRA when your new coverage begins. If you want to continue coverage with this Plan, you will have to continue paying the full monthly COBRA premium. Your coverage under this Plan will then continue, subject to coordination of benefits with your other plan.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage
If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the COBRA period. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent **within 31 days** after the termination of the other coverage. Adding a spouse or dependent child will increase the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. 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.

The premiums for continuation coverage are subject to modification by the Board of Trustees from time-to-time. Contact the Fund Office for information about continuation coverage premiums.

MULTIPLE QUALIFYING EVENTS WHILE COVERED BY COBRA

Your dependents may extend their coverage to 36 months from the date of the first Qualifying Event if, during an 18-month or 29-month period of COBRA Continuation Coverage, a second Qualifying Event occurs due to:

(1) your divorce or separation
(2) your entitlement to Medicare
(3) dependent ceases to be a dependent child under the Plan

Example: *Assume Jack loses his job (the first COBRA Qualifying Event), and enrolls himself and his covered eligible dependents in COBRA coverage. Three months after his COBRA coverage begins, his child turns 26 years old and is no longer eligible for Plan coverage. Although Jack's coverage is limited to 18 months, Jack's child can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.*

This extended period of COBRA Continuation 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 is available to any child(ren) born to, adopted by, or placed for adoption with you (the active employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

Medicare and Second Qualifying Events
If you become entitled to Medicare and you later have a termination of employment or reduction in hours, your eligible dependents would be entitled to COBRA Continuation Coverage for a period for 18 months (29 months if the 11-month Social Security Disability extension applies) from your termination of employment or reduction in hours or 36 months from the date you became entitled to Medicare, whichever is longer.

WAYS IN WHICH YOUR CONTINUATION COVERAGE MAY BE CUT SHORT

Your continuation coverage may be cut short for any of the following reasons:

(1) your employer no longer contributes to the Fund for purposes of providing group health coverage to its employees and their dependents;

(2) you do not pay the premiums for your continuation coverage on time;

(3) you become covered under another group health plan, whether as an employee or otherwise (except that you may still purchase coverage from this Plan, if your new plan does not cover pre-existing conditions);

(4) you become entitled to benefits under Medicare (this provision is not applicable to individuals entitled to continuation coverage due to the commencement of a bankruptcy proceeding by the employer);

(5) the date all health care coverage offered by the Stone and Marble Masons of Metropolitan Washington, D.C. Welfare Trust Fund terminates;

(6) the date on which the Fund is terminated; or

(7) if you fail to follow the Fund's policies and procedures and take actions that would result in termination of an active employee for cause. (For example, if you submit false claims to the Fund.).

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay all of the premiums for your continuation coverage.

CONFIRMATION OF COVERAGE TO HEALTH CARE PROVIDERS

Under certain circumstances, federal rules require the Fund to inform your health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances:

(1) If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage, the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during the election period; or

(2) If, after you have elected COBRA continuation coverage, a health care provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment; the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during that period.

The Fund cancels your and your dependents' coverage as of the first day of a period of coverage if it has not received payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is made. If you and/or your dependents have not paid the applicable COBRA payment, the Fund Office will inform the health care provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the first day of the period of coverage if timely payment is made.

NOTIFICATION OF CHANGES

Important
After you become eligible for benefits it is necessary to promptly notify the Fund Office of any change in the number of your dependents which will result in a change from one to another of the following classifications:

(1) Member without dependent

(2) Member with dependent

The Fund Office should also be notified of the following information as soon as available and in no event later than 30 days:

(1) Any change in marital status including legal separation (If you fail to do this you will be liable for claims paid on behalf of your ex-spouse.)

(2) Names and birth dates of additional children through birth, adoption or legal guardianship

(3) Date that any dependent child either:

(a) marries;
(b) reaches his/her 26th birthday

(4) Any change of mailing address

(5) Any change in other health coverage for you or your dependents

(6) Losing your eligibility

(7) If you take an FMLA leave of absence

(8) Entering military service

(9) Disability

(10) Retirement

(11) Death

To notify the Fund Office, complete and submit a new Enrollment Form.

IF YOU TAKE AN FMLA LEAVE OF ABSENCE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave from employment during any 12-month period due to:

(1) the birth, adoption, or placement with you for adoption of a child;
(2) to provide care for a spouse, child, or parent who is seriously ill; or
(3) your own serious illness.

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:

(1) have worked for a covered employer for at least 12 months;
(2) have worked at least 1,250 hours over the previous 12 months; and
(3) work at a location where at least 50 employees are employed by the employer within 75 miles.

The Fund will maintain your eligibility status until the end of your leave, provided the contributing employer properly grants the leave under the FMLA and the contributing employer makes the required notification and payment to the Fund. Call your employer to determine whether you are eligible for FMLA leave.

IF YOU ENTER ACTIVE MILITARY SERVICE

This Plan complies with the Uniformed Service Employment and Reemployment Rights Act (USERRA). Therefore, if you, as an eligible employee, go into active military service for up to 31 days, coverage continues for you and your eligible dependents during the period of that leave.

If you go into active military service for more than 31 days, you may be able to continue coverage for yourself and your dependents through COBRA for up to 18 months.

Any period of leave of absence under the provisions of USERRA will not be counted as a break in coverage. Questions regarding your entitlement to leave under USERRA and to Continuation Coverage should be referred to the Fund Office.

Reinstatement of Coverage after Completion of Military Service
In order to have coverage reinstated by the Plan after active military service, you must apply for reinstatement in accordance with USERRA. If your period of service in the uniformed services was less than 31 days, you must report to your employer for reemployment by the first day of the first full regularly scheduled work period and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence.

If your period of service in the uniformed services was for 31 days or more but less than 181 days, you must submit an application for reemployment not later than 14 days after the completion of your period of service.

If your period of service was for more than 180 days, than you must submit your application for reemployment with your employer no later than 90 days after the completion of your period of service.

If you have been hospitalized, or are convalescing from an illness or injury incurred or aggravated during your tour of duty in the uniformed services, you have until your recovery from that illness or injury to submit an application for reemployment. However, that period of recovery may not exceed two years.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

The law now provides that an Alternate Recipient, as defined below, under a "Qualified Medical Child Support Order," (QMCSO) also defined below, must continue to receive medical coverage in compliance with a court order.

A QMCSO is a judgment or court decree that requires a group health plan to provide coverage to the children of a plan participant. The term Alternate Recipient means any child of an employee who is recognized under a medical child support order as having a right to enrollment under a group health plan.

Procedures for Processing a QMCSO
Upon receipt of any document purporting to be a medical child support order, the Fund Manager shall provide written notice to the participant and all alternate recipients. This notice shall contain:

(1) a cover letter explaining the date the document was received;
(2) the effect the document might have on the rights of the participant and other payees under the plan of benefits if it is determined to be a Qualified Medical Child Support Order; and
(3) a copy of these plan procedures for processing medical child support orders.

The alternate recipient may designate a representative to receive copies of any notices sent to them pursuant to this procedure.

The Fund Manager will evaluate the document to determine if it is a QMCSO. In making the evaluation, the Fund Manager may consult with Fund Counsel and advisors. The Fund Manager shall make a determination as soon as possible but in no event later than 40 days after receipt of the Order.

The Order must clearly specify:
(1) the name and the last known mailing address of the participant and the name and mailing address of each alternate recipient covered by the Order;
(2) the alternate recipient is eligible for under the terms of the plan; and
(3) the period of time to which such order applies.

The Order must consist of a judgment, decree or order (including approval of a property settlement agreement) that provides for the provision of child support, related to health plan coverage, to a child or other dependent of a participant; and is made pursuant to a State medical child support law (including a community property law).

The Order cannot require the plan to provide any type or form of benefits, or any option, not otherwise provided under the plan; and require the plan to provide increased benefits.

The participant, all alternate recipients, and any counsel for these parties of which the Fund has notice shall be notified in writing of the Fund's decision concerning the qualified status of the medical child support order. The notice shall state that the Order is a Qualified Medical Child Support Order or shall state in what respect the Order is deficient. The letter shall also state the decision of the Fund Manager about the qualified status of the medical child support order is appealable to the Trustees and shall give information about the appeal procedures of the Fund.

If the Order is found to be deficient, the alternate recipient may have the Order amended to conform to the law.

For the purposes of this procedure, a final determination shall mean a determination by the Fund Manager. Any final determination may be appealed to the full Board of Trustees for resolution of whether an order is a Qualified Medical Child Support Order. Also, any appeal to the Board of Trustees shall comply with the Plan's Claims and Appeals Procedure.

PAYMENT OF CLAIMS

Each eligible Employee must complete and submit to the Fund Office an Enrollment Form which may be obtained from the Business Agent or the Fund Office. Claims cannot be processed until the Enrollment Form is filed with the Fund Office. Claim Forms are available at www.cardayassociates.com/documents.htm and must be filed with the Fund Office within 18 months of the date of service.

CLAIMS AND APPEALS PROCEDURE

The Plan maintains a claims and appeals procedure which includes three major components:

(1) Filing of benefit claims;

(2) Notification of benefit determinations; and,

(3) Appeal of adverse benefit determinations.

These procedures do not contain any provision that unduly inhibits or hampers the initiation or processing of claims for benefits, including, but not limited to:

1. requiring any payment of a fee or cost as a condition to making a claim or to appeal an adverse benefit determination;
2. the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible;

3. the denial of a claim for failure to obtain a prior approval under circumstances where application of the prior approval process could seriously jeopardize your life or health.

You may appoint an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Trustees may establish reasonable procedures for determining whether an individual has been authorized to act as an authorized representative on your behalf. In urgent care circumstances, a health care professional with knowledge of your medical condition may act as your authorized representative.

PLAN PROVISONS AND CONSISTENT TREATMENT REQUIREMENT

All administrative processes and safeguards of the Plan will be administered to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions treat similarly situated claimants consistently. Definitions of the terms used in this appeals procedure are set forth later in this section.

SPECIFIC PROCEDURAL RULES FOR HEALTH CLAIMS

Failure by Claimant to Follow Procedures

Pre-Service Claims In the case of a failure by you or your authorized representative to follow the Plan's procedures for filing a pre-service claim, then:

(1) you or your representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits within five (5) days following the failure; and,

(2) notification of the failure may be oral if no written request for notification is requested; or,

(3) if written notification is requested by you or your authorized representative, then the Plan will provide written notification of the failure.

Urgent Care Claims In the case of a failure by you or your authorized representative to follow the Plan's procedures for filing an urgent care claim, then:

(1) you or your representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits within five (5) days following the failure; and,

(2) notification of the failure may be oral if no written request for notification is requested;

(3) if written notification is requested by you or your authorized representative, then the Plan will provide written notification of the failure.

A failure is considered one that:

(1) is a communication by you or your authorized representative that is received by the Plan or one of its providers that handles benefit matters; and,

(2) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

No More Than Two Appeals of Adverse Benefit Determination Nothing in the procedures will be construed or administered in any way that requires you to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of ERISA.

Voluntary Level of Appeals To the extent that this Plan offers voluntary levels of appeal, in addition to those permitted by this Procedure regarding the two-appeal limit.

1. The Plan will not assert that you failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the Plan;

2. The Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

3. You may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the two-appeal limit of this procedure;

4. The Plan will provide to you, upon request, sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the your rights to any other benefits under the Plan and information about the applicable rules, your right to representation, the process for selecting the decision-maker, and the circumstances, if any, that may affect the impartiality of the decision-maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

5. No fees or costs will be imposed on you as part of the voluntary level of appeal.

CLAIMS FOR BENEFITS

A claim for benefits for the purpose of this Procedure is a request for a Plan benefit or benefits made by you in accordance with these procedures for filing benefit claims. This includes any pre-service and post-service claims.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION FOR INITIAL CLAIMS

Urgent Care Claims

1. General Rule – 72 Hours In the case of a claim involving urgent care, the Plan will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

2. Failure to Provide Sufficient Information to Accept or Deny Claim – 24 Hours In the case of a failure by you or your authorized representative to provide enough information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

3. You Have 48 Hours to Provide Information You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

4. Notification by Plan – 48 Hours The Plan will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of--
    a. The Plan's receipt of the specified information, or
    b. The end of the period afforded to you to provide the specified additional information.

Concurrent Care Decisions

General Rule

1. Reasonableness; Reduction or Termination If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination.

2. Time for Notice for Non-Urgent Care Treatment The Plan will notify you in accordance with these procedures of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

3. Urgent Care Concurrent Care Reduction or Termination – 24 Hours Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with the Notice provision of this Procedures.

4. Appeals of Concurrent Care Denials Appeals of denial of concurrent care claims are governed by the appeal rules of this Procedure depending on the nature of the claim as follows:
    a. Urgent Care Appeal Rules;
    b. Pre-service Appeal Rules; or,
    c. Post-service Appeal Rules.

Pre-service Claims Timing Rules – 15 Days to Notify – One 15 Day Extension If Plan Notifies Claimant Prior to Expiration of initial 15 Day Period

You have 45 days to submit information If a claim is neither Urgent nor Concurrent, then it is either a pre-service claim or a post-service claim. In the case of a pre-service claim, the Plan will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

(1) *One Fifteen Day Extension* This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
(2) *45 Days to Respond* If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) *Form of Notice* Notification of any adverse benefit determination will be made in accordance with the Notification provisions of this Procedure.

Post-service Timing Rules – 30 Days to Notify – 15 Day Extension If Plan Notifies Claimant Prior to End of Initial 30 Days – 45 Days for Claimant to Submit Information

(1) *30 Days* In the case of a post-service claim, the Plan will notify you of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.
(2) *15 Day Extension* This period may be extended one time by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
(3) *45 Days to Respond* If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.
(4) *Form of Notice* Notification of any adverse benefit determination will be made in accordance with the Notification provisions of this Procedure.

Disability Claims Accident and Sickness Claims Procedures are Separately Available through the Fund Office.

Calculating Time Periods

General Rule The period of time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Time Periods During Extensions In the event that a period of time is extended as permitted due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION OR ADVERSE NOTIFICATION ON APPEAL

Rules for Non-Urgent Care Notification of Benefit Determination
The Plan will provide you with written notification of any adverse benefit determination of a claim or appeal.

The notification will set forth –

(1) The specific reason or reasons for the adverse determination;
(2) Reference to the specific Plan provisions on which the benefit determination is based;
(3) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to the definition of Relevance set forth in these Procedures
(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Urgent Care Claims
General Rule In the case of an adverse benefit determination involving urgent care, the information required by this Procedure may be provided to you orally, provided that a written or electronic notification in accordance with this section is furnished to you not later than 3 days after the oral notification.

Additional Content Requirement for Urgent Care Claims
In the case of an adverse benefit determination concerning a claim involving urgent care, the Plan will provide, in addition to the materials described above, a description of the expedited review process applicable to such claims.

CLAIMS FILING

PPO provider Claim Forms should be mailed to:

CareFirst
PO Box 981633
El Paso, TX 79998

Prescription Drug Claim Forms should be mailed to:

Caremark Claims Department
PO Box 52196
Phoenix, AZ 85072-2196

Non-PPO, Dental and Vision Claim Forms should be mailed to:

Stone and Marble Masons of Metropolitan
Washington, D. C. Health and Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Following is the procedure by which you will have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the Plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

Full and fair review
180 Days to Appeal You have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

No Deference The review on appeal will not afford deference to the initial adverse benefit determination and will be conducted by such individual, individuals or entity designated by the Trustees who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

Medical Consultation In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Plan, or other appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

Identification of Medical Consultants
The Plan will provide to you the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

Medical Consultant On Appeal Cannot Be, or Be Subordinate to, Medical Consultant for Initial Benefit Determination The health care professional engaged for purposes of a consultation on appeal under these Procedures will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

Urgent Care Appeals In the case of a claim involving urgent care, the review process shall be expedited:

(1) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and
(2) All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

Right to Supplement Claims You may submit written comments, documents, records, and other information relating to the claim for benefits;

Right to Access to Documents You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to the Definitions set forth in this Procedure.

Right to Consideration of All Documentation The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

SECOND LEVEL OF APPEAL: TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

Time to Notify Participant - Next Meeting if Appeal Received 30 Days Before Meeting The Trustees of the Plan will make a benefit determination no later than the date of the quarterly meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting.

Time to Notify Participant – Second Meeting Following Receipt of Appeal if Appeal Received Within 30 Days of First Meeting Following Receipt of Appeal If a claim is received by the Plan within the 30 day period prior to the next regularly scheduled quarterly meeting, then the benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review.

Special Circumstances – Third Meeting Following Receipt of Appeal If special circumstances (such as if it is determined by the Trustees that a hearing is necessary) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review.

Written Notice of Special Circumstances If an extension of time for review is required because of special circumstances, the Plan will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

Form of Notice and Time to Notify of Determination on Appeal – As Soon As Possible, But Not More than Five (5) Days The Plan will notify you in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Urgent care claims – 72 Hours In the case of a claim involving urgent care, the Plan will notify you, in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.

Pre-service claims In the case of a pre-service claim, the Plan will notify you, in accordance with the Manner and Content of Notification on Review Provision on Appeal of this Procedure, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances.

30 Days for One Appeal The Plan provides for one Mandatory Appeal. The Plan will provide notification not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

15 Days for Two Appeals If the Plan elects to provide an additional appeal of an adverse determination, then the Plan will provide notice to you not later than 15 days after receipt by the Plan of your request for review of the adverse determination, with respect to both appeals.

Post-service Appeals – Next Meeting if Appeal Received Prior to 30 Days Period Prior to Next Meeting The Trustees of the Plan shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting.

Furnishing documents In the case of an adverse benefit determination on review, the Plan will provide such access to, and copies of, documents, records, and other information described in the Manner and Content of Benefit Determination on Review set forth below.

DEFINITIONS FOR CLAIMS AND APPEALS PROCEDURE

- *"**Claim involving urgent care**"* is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

    1. Could seriously jeopardize your life or health or your ability to regain maximum function, or,

2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a "claim involving urgent care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the your medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

- *"**Pre-service claim**"* means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- *"**Post-service claim**"* means any claim for a benefit under a group health Plan that is not a "pre-service claim."

- "**Adverse benefit determination**" means any of the following:
  (1) a denial of a benefit;
  (2) reduction of a benefit;
  (3) termination of a benefit; or,
  (4) failure to provide or make payment (in whole or in part) for a benefit.

This includes any of the foregoing that is based on:
  (1) a determination of a participant's or beneficiary's eligibility to participate in a Plan;
  (2) application of any utilization review; or,
  (3) a determination that a particular covered item is experimental or investigational or not medically necessary or appropriate.

- *"**Notice**" or "**notification**"* means the delivery or furnishing of information to an individual in a manner that satisfies the standards of the Notice Section of this Procedure Described Below as appropriate with respect to material required to be furnished or made available to an individual.

- *"**Health care professional**"* means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

- *"**Relevant**."* A document, record, or other information shall be considered "relevant" to your claim if such document, record, or other information
  (1) Was relied upon in making the benefit determination;
  (2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or,
  (3) Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.

NOTICE

You have certain rights that are set forth later in this document under the heading "Your ERISA Rights".

Documents To Be Furnished Under These Procedures

Any material, including reports, statements and documents, required to be furnished by these procedures will be furnished using measures reasonably calculated to ensure actual receipt of the material by Plan participants and beneficiaries. Material which is required to be furnished to all participants covered under the Plan and beneficiaries receiving benefits under the Plan (other than beneficiaries under a welfare Plan) shall be sent by a method or methods of delivery likely to result in full distribution.

Pursuant to this Procedure, documents to be provided to an individual may be provided by:

(1) In-hand delivery to an employee at his or her worksite
(2) A special insert in a periodical distributed to employees such as a union newspaper or a company publication if the distribution list for the periodical is comprehensive and up-to-date and a prominent notice on the front page of the periodical advises readers that the issue contains an insert with important information about rights under the Plan and this procedure which should be read and retained for future reference. If some participants and beneficiaries are not on the mailing list, a periodical will be used in conjunction with other methods of distribution such that the methods taken together are reasonably calculated to ensure actual receipt.
(3) Material distributed through the mail by first, second, or third-class mail, provided that distribution by second or third-class mail will be used only if return and forwarding postage is guaranteed and address correction is requested. Any material sent by second or third-class mail which is returned with an address correction will be sent again by first-class mail or personally delivered to the participant at his or her worksite.

Summary Plan Descriptions and Summaries of Material Modification

For purposes of Summary Plan Descriptions and Summaries of Material Modification, materials furnished upon written request will be mailed to an address provided by the requesting participant or beneficiary or personally delivered to the participant or beneficiary.

Documents To Be Made Available for Examination

Where certain documents are required to be made available for examination by participants and beneficiaries in the principal office of the Plan and in such other places as may be necessary to make available all pertinent information to all participants and beneficiaries, disclosure will be made pursuant to the provisions of this paragraph. Such documents will be current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries. The Plan will make copies of the Plan description, latest annual report, and the bargaining agreement, trust agreement, contract, or

other instruments under which the Plan is established or operated available at all times at the Trust Fund Office.

Providing Documents at Employer Establishments or the Union Offices

The Plan is not required to maintain the Plan documents at all times at each employer establishment or union hall or office, but such documents will be made available at any such location within ten calendar days following the day on which a request for disclosure at that location is made. The Plan will make Plan documents available at the appropriate employer establishment or union meeting hall or office within the required ten day period when a request is made directly to the Plan or through a procedure separately establishing reasonable rules governing the making of requests for examination of Plan documents. If the Plan prescribes such a procedure and communicates it to Plan participants and beneficiaries, the Plan will not be required to comply with a request made in a manner which does not conform to the established procedure.

The procedure for making requests to examine Plan documents will permit requests to be made in a reasonably convenient manner both directly to the Plan and at each employer establishment, or union meeting hall or office where documents must be made available in accordance with this paragraph. If no such reasonable procedure is established, a good faith effort by a participant or beneficiary to request examination of Plan documents will be deemed a request to the Plan for purposes of this paragraph.

With respect to the Union and employers, documents will be made available for examination in the principal office of the employee organization and at each employer establishment in which at least 50 participants covered under the Plan are customarily working. In employment situations where employees do not usually work at, or report to, a single establishment, the Plan will take measures to ensure that Plan documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the Plan.

RECOVERY FOR THIRD PARTY LIABILITY (SUBROGATION)

Purpose of Third Party Liability Provisions

In some instances, you may be injured on the job or in a car accident or other accident. When injuries and/or death occurs in those situations, an employer's worker's compensation carrier, your own or someone else's car insurance company, may be responsible for paying your medical bills as well as your lost wages. Under those circumstances, the Fund is not responsible for paying your medical bills and accident and sickness expenses because some other person is at fault or some other company is responsible for paying your bills.

Waiting for an insurance company to pay for your injuries can be difficult, particularly in situations where your doctor or hospital requires pre-authorization of payment. Recovery may take a long time. This Fund is not responsible for paying your bills in these circumstances, but the Board of Trustees recognizes the problem and has developed a program to try and resolve this problem. The program is called Third Party Liability Recovery. This program provides you

limited coverage which would otherwise be unavailable and saves the Fund money by making sure that the responsible party pays for your injuries.

How Third Party Liability Recovery Works

The Third Party Liability provisions of the Plan entitle the Fund to collect any money it advances to pay your benefits directly from any third party or insurance carrier, including uninsured motorist policies, which owes or provides you money. In exchange for your written promise to pay the Fund back in full from any recovery you receive, the Fund will advance you benefits for medically necessary treatment which the Fund would otherwise not cover. In effect, the Fund "advances" benefits to you and acceptance of these benefits by the participant, dependent or provider constitutes their agreement to repay the Plan in the event a recovery is made from any other person or party.

To ensure that people repay the advance to the Fund, the Fund takes a lien on your right of recovery from any third party. The Fund shall be entitled to recover its lien directly from any third party, regardless of the reason for the recovery and regardless of whether your recovery from a third party is through a separate policy unrelated to medical expenses and weekly accident and sickness expenses. You shall be required to repay, and the Fund will be entitled to that payment, for a recovery from any third party or entity who pays you for any reason, even if the basis for the Third Party Recovery is characterized as being a recovery for damages other than medical expenses.

Please note that the Fund requires a written promise that you will repay the entire amount advanced by the Fund regardless of why, where or from whom you receive money. The Fund has no obligation to share in the legal costs and fees of obtaining a third-party recovery and disavows the common fund doctrine. Also, the Fund's right of recovery matures without regard to whether you are made whole economically for injuries you sustain. Thus, the Fund can regain, by legal action if necessary, benefits paid by it to the participant or that person's insurance company or plan from the participant or parties responsible for the injury.

What you need to do

Under the Plan's third party liability provisions, a participant must fulfill the following obligations in order to be entitled to receive the advance which is provided under this Section.

You must sign the Standard Reimbursement Agreement provided by the Fund. However, even if a participant or dependent has not signed the Standard Reimbursement Agreement, he/she will still be responsible to repay the Plan in the event of a recovery. A copy of the Standard Reimbursement Agreement is attached as an addendum to this Summary Plan Description.

(1) You must file a claim with the Fund Office on time.

(2) You must cooperate with Plan representatives as may be necessary or appropriate to recover from any third party, which includes any recovery you may obtain from uninsured motorist coverage and recovery from any person, firm, corporation or other entity as relating to your illness or injury, as damages, those payments made by the Plan.

(3) You must immediately reimburse the Plan for any expenses paid by the Fund with money recovered from a Third Party.

(4) You must not do anything to impair, prejudice or discharge the Plan's right to subrogation, or obtain recovery of the amounts advanced.

(5) You must assign to the Plan the right to bring an action against any third party responsible for the injuries sustained if you fail to bring such action. Recovered payment will be credited against any yearly or lifetime limits on a participant's benefits. The Plan can withhold future benefits to a Participant for failure to comply with these rules.

Failure to Comply with Third Party Liability Procedures

If you fail to comply with the terms of these Third Party Liability Recovery procedures or if you fail to comply with the Standard Reimbursement Agreement, the Plan may recover the full amount of the benefits advanced from you through institution of a legal action, and the Fund will be entitled to recover its legal expenses and fees for doing so. Furthermore, the Plan can withhold future benefits to a participant for failure to comply with these rules. If any participant or dependent has any questions or if you are asked to waive any rights covering any conditions for which you have received or expect to receive payment from the Plan, contact the Fund Office as soon as possible.

Express Limitations

This Plan conclusively disavows and overrides the judicially created "make whole" doctrine. This Plan's right to recovery matures without regard to whether the injured party is made whole economically for his or her injuries. The Plan's right of subrogation shall apply regardless of whether the member is made whole. This Plan also conclusively disavows and overrides the judicially created "common fund" doctrine. This Plan has no obligation to share in the legal costs and fees incurred by a member or dependent in securing a third-party recovery.

Expenses that are Not Covered

This Plan does not provide benefits if the medical expenses are covered by workers' compensation or occupational disease law. Since the resources of the Plan are limited, no benefits are payable with respect to any treatment, service or supply not specifically provided for in the Plan or for any expense, charge, or fee incurred in connection with any of the following:

(1) any injury or illness resulting from or arising out of any employment or occupation for compensation or profit; or

(2) any injury or illness for which benefits are payable under any workers' compensation law, occupational disease law or similar legislation.

HIPAA RELEASE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a law that serves to:

(1) protect your health coverage if you change or lose your job by guaranteeing renewability and availability of health coverage to certain employees;

(2) protect those who have preexisting medical conditions or who might suffer from discrimination in health coverage based on a factor that related to the individual's health; and

(3) require the establishment of national standards for transaction of electronic health records and to help keep your health information private.

In the event the release of an individual's personal health information is necessary to adjudicate claims, a participant or dependent may be required to a sign a HIPAA authorization for release of health information release.

DEFINITIONS

● *Accidental injury* is defined as a bodily injury sustained solely through violent, external and accidental means. Treatment in the emergency room of a hospital or doctor's office is not considered an accident unless an injury has occurred. Treatment for an accident must be performed within a seventy-two hour period.

● *Custodial Care* means that care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to: help in walking and getting into and out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying medications, creams or ointments; routine administration of medical gases after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheotomy care; general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

● *Dependents* are defined as your spouse and children from date of birth up to 26 years of age.

The term "children" shall include your children by blood or adoption and foster children that are under the age of 26.

Effective February 1, 2011 through January 31, 2014, to be eligible for plan coverage, an adult child (age 19 to age 26) must not be eligible for health coverage through his/her employment or the employment of his/her spouse.

Dependents shall also include unmarried children who become disabled through the age of 19 as long as they remain continuously disabled, unmarried, financially dependent, and unemployed, and you remain eligible, provided you submit to the Fund Office a "Disabled Dependent Certification Form" with supporting medical evidence to the Fund Office. The form must be re-submitted annually without request by the Fund Office (even if the child is otherwise covered by virtue of being under age 26). After a disabled child turns age 26, annual proof of the child's status as eligible (continuously disabled, unmarried, financially dependent, and unemployed) for continuing coverage is required. To satisfy the requirement of being financially dependent, receipt of tax deductions for the dependent shall satisfy this proof.

Coverage will be provided as required by a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is any court judgment, decree or approval of a settlement agreement which provides for coverage of a participant's child under a group health plan or enforced as a state law that deals with medical child support. Once such an order is issued by the court, it must be sent to the Fund Office, which will determine whether it is qualified. When you submit such an order to the Fund Office, you will receive a copy of the Fund's procedures for determining whether the order is qualified.

The term "dependent" shall not include a previous spouse from whom you are divorced or from whom you are legally separated, a surviving spouse that has remarried (nor the newly acquired spouse or children), the spouse of a child dependent, the child of a child dependent, or step-children unless adopted or the subject of a Qualified Medical Child Support Order.

Proof of a spouse or child's status as a Dependent is required.

- *Essential Health Benefits* Consistent with federal law, items and services covered within the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

- *Hospital* is defined as:

  (1) an institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations; or

  (2) any other institution which is operated pursuant to law, under the supervision of a staff of Physicians and with 24 hour-a-day nursing service by registered graduate nurses, and which is primarily engaged in providing:

(a) general inpatient medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or

(b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities; or

(3) an institution that is an Intermediate Care Facility.

In no event shall the term Hospital include a convalescent nursing home, or an institution, or part of one, which: (i) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged, or (ii) furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living or (iii) is operated primarily as a school.

● *Illness* means a bodily or mental disorder of any kind. All such disorders due to injuries sustained by a person in one accident will be considered one illness. Any such disorder which is the same as, or is related to, another existing or previously existing disorder will be considered with that disorder as one illness.

● *Intermediate Care Facility* is an institution that provides care and treatment of mental, psychoneurotic, and personality disorders; alcoholism; or drug abuse through one or more specialized programs and meets all of these three tests:

(1) It is staffed by registered graduate nurses and other mental health professionals.

(2) It provides for the clinical supervision of such specialized programs by Physicians who are licensed in the state in which it is located.

(3) Each specialized program provided by it must:

(a) provide treatment for no less than three hours nor more than twelve hours per day; and

(b) furnish a written, individual treatment plan which states specific goals and objectives; and

(c) maintain, at a minimum, ongoing weekly progress notes which demonstrate periodic review and direct patient evaluation by the attending Physician; and

(d) meet either of these two tests:

(i) It is accredited by the Joint Commission on Accreditation of Healthcare Organizations to provide the type of specialized program described above; or

(ii) It is licensed, accredited or approved by the appropriate agency in the state in which it is located to provide the type of specialized program described above.

- *Legally qualified physician* is defined as a duly licensed doctor of medicine (M.D.) or a duly licensed doctor of Osteopathy (D.O); a duly licensed dentist for dental X-rays and treatment of such services; a duly licensed Podiatrist (Chiropodist) (DSC) for purposes of conditions of the feet; a duly licensed psychologist; licensed social worker; and a duly licensed chiropractor (D.C.).

- *Medical Emergency* is defined as the sudden and unexpected onset of a medical (non-surgical) condition accompanied by severe symptoms of same and requiring medical (not surgical) care which is secured immediately after the onset or as soon thereafter as the care can be made available, but in no case later than seventy-two hours after the onset. Medical Emergency includes heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions and such other acute conditions as may be determined to be medical emergencies; in any event, the diagnosis or the symptoms of the condition or the degree of severity must be such that immediate medical care would normally be required.

- *Non-Essential Health Benefits* Any item or services that is not considered an Essential Health Benefit under federal law.

- *Total and permanent disability* is that physical or mental condition which is medically determinable and arises as a result of bodily injury or disease which prevents the participant from engaging in any occupation or employment for wage or profit except such employment which is found by the Board of Trustees to be for the purpose of rehabilitation and not incompatible with the finding of total and permanent disability.

- *Spouse* shall mean, with respect to an individual covered by the Plan, the person to whom such individual is lawfully married in a binding marriage in accordance with the laws of a State of the United States or the District of Columbia; or, in the case of a marriage entered into outside of the United States, the person to whom such individual is lawfully married in a binding marriage in accordance with the laws of the such foreign jurisdiction that the Trustees determine to be consistent with the public policy of the United States.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Trustees have retained the services of CareFirst (Blue Cross/Blue Shield) to access its Preferred Provider network, a group of select physicians, specialists, hospitals and other treatment centers which have agreed to provide their services for a discount. CareFirst physicians and hospitals can be used for medical problems or emergency medical problems.

For actual savings to both you and the Plan, participants are advised to use CareFirst Provider for all medical services and treatments covered by the Fund.

The CareFirst physicians and hospital Directory lists all the participating physicians and hospitals. It is a guide to assist you in identifying providers and is organized by specialty and

geographical location. Please contact the Fund Office for a copy of the Directory. This information is also available at the CareFirst website, http://www.carefirst.com

The list of health care providers participating in the PPO panel is subject to change. The list in the directory is as accurate as our procedures allow at the time of issue. Since some listed providers may no longer participate in the panel, you must check with your provider each time you request health care services. This will ensure that your provider is still participating so that you will be afforded the appropriate discounts under your health care plan.

When you need to be admitted to the hospital for a scheduled admission call the Fund office before your admission. When you need to be admitted to the hospital for an emergency call the Fund office within 48 hours of your admission. The Fund Office number is (410) 872-9500.

CareFirst can be otherwise reached at:

CareFirst
PO Box 981633
El Paso, TX 79998(866) 505-8719– Member Services

UTILIZATION MANAGEMENT AND CASE MANAGEMENT

American Health Holding provides pre-certification services and case management in order to provide members with assistance navigating the health care system and reduce costs for the Plan and its participants. American Health Holding, Inc. ("AHH") is a cost containment company designed to ensure quality and appropriateness of care, while controlling costs by reducing unnecessary hospital admissions and certifying the length of treatments. AHH reviews admissions and treatments to determine medical necessity and to find treatments in alternative settings if appropriate. AHH also provides case management services to give plan participants a better understanding of specialized care needs, access to centers of excellence and specialty care facilities, education on alternatives to costly inpatient care, and direction toward in-network facilities. AHH works to educate members and help you make choices that contribute to a healthier lifestyle, thus reducing the incidence of complications and future medical costs in complex or high cost medical cases.

For example, suppose your physician recommends a procedure for you on an inpatient basis. AHH may find that the procedure is regularly performed on an outpatient basis. They would review your records to determine if less costly outpatient treatment is an option for you. This is savings for you and the plan, without limiting your medical treatment needs.

A. Pre-Certification Procedure

You must contact AHH at (800) 641-5566 to certify all inpatient hospital admissions (and within 48 hours of an emergency admission). This number is also shown on the back of your Fund ID card. This will help you to ensure that any medical treatment you undertake is medically necessary.

B. Medical Necessity

In order for claims to be paid under this Plan, all medical care must be medically necessary. The Plan has the right obtain a second opinion by another physician chosen by AHH to determine the medical necessity of the proposed care.

C. Certifying Care

1. Emergency Admissions

If you or your eligible dependent are admitted to the hospital due to an emergency, you (or a family member), the hospital, or your physician must contact AHH after your admission. The Fund will only cover treatment in an emergency or urgent care setting that is medically necessary and otherwise covered by the terms of the Plan.

2. Surgical/Non-emergency Inpatient Admissions (Scheduled Hospital Stays).

If you, your spouse or your children are scheduled for a hospital stay, you or your physician need to call AHH at (800) 641-5566 before your stay to get pre-authorization. If you are calling after hours, leave a message on the answering machine.

AHH will send you an approval letter for a certain number of days. Bring this letter with you when you are admitted to the hospital. If your medical condition warrants an extension of your hospital stay, AHH will authorize it.

You or your provider MUST contact AHH <u>prior</u> to any non-emergency admission! AHH verifies the medical necessity and authorizes the length of your hospital stay. However, **AHH does not certify that you are eligible for benefits or that a given procedure or hospital stay is covered under the Plan. A procedure excluded under the Plan will be excluded from coverage regardless of AHH's determination of medical necessity.** If you are not sure if a proposed procedure will be covered, please contact the Fund office.

D. Concurrent Care and Case Management

In situations involving more complex and costly medical treatment, AHH will also monitor your stay while in the hospital to assure appropriate length of hospitalization. AHH acts in its position as adviser to the Fund to monitor the type of care being provided and to recommend the number of days of your hospital stay the Fund should pay under your Schedule of Benefits. If your medical condition requires an extension of your hospital stay, AHH will authorize it.

WEEKLY ACCIDENT AND SICKNESS BENEFITS

GENERAL

The Weekly Accident and Sickness Benefit is payable to active employees:

(1) While you are wholly and continually disabled by a non-occupational injury or sickness that prevents you from working at your occupation, and

(2) While you are under the care of a legally qualified physician, and

(3) For which benefits are not payable under a Workers' Compensation Law.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of and seen by a legally qualified physician during the period of your disability. No disability will be considered as beginning more than three days prior to the first visit of a physician.

A legally qualified physician must certify on the claim form the dates you have been totally disabled and unable to work.

When you are totally disabled and prevented from working due to an occupational illness or injury, you must also periodically furnish the Fund with an Attending Physician Statement certifying to your disability in order to maintain eligibility for benefits for other illnesses or injuries.

FORMS

An Attending Physician Form may be obtained from the Fund Administrator and must be filled out in detail including diagnosis. If you are submitting a claim for Weekly Accident and Sickness Benefits you must complete the employee's section in detail; especially the date you last worked. Be sure to sign the claim form. The doctor must complete his side of the form giving the diagnosis of your illness and whether or not job related. No claim can be considered unless the doctor has filled out dates of disability on the form.

PERIOD OF COVERAGE

The Weekly Benefit to which you are entitled will begin on the first day if your disability resulted from an accident, or on the eighth day if your disability resulted from disease, except that if you are hospitalized due to this disease, then your benefit will begin on the first day of such hospitalization. Benefits are payable for a maximum of thirteen weeks for any one continuous period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

If you recover from a disability for which benefits have been paid and again become disabled after less than two weeks of active work on a full-time basis, both disabilities will be considered as one period of disability unless the subsequent disability is due to injury or sickness entirely

unrelated to the causes of the previous disability and commencing after you have completed one day of normal employment.

For Employees age 60 and over, benefits for all disabilities commencing during any twelve consecutive months are limited to a total of thirteen weeks.

The Accident and Sickness Benefit will be paid weekly and will include payments for fractional parts of a week. These benefits will be paid promptly if you furnish proof of your disability. Do not wait until you return to work before filing a claim.

This Benefit is subject to FICA (Social Security) taxes during the first six months of unemployment.

You may request that federal taxes be withheld from your benefit check provided that you submit a properly executed IRS form to the Fund Office and comply with IRS rules for such withholding. Contact the Fund Office if you have any questions or desire further information.

COMPREHENSIVE MAJOR MEDICAL COVERAGE

GENERAL

This coverage offers much broader protection than many health insurance plans. Furthermore, it is not necessary to be confined in a hospital or be totally disabled to collect benefits. The Plan pays a large share of a wide range of expenses - not only hospital bills, surgeon's fees, but also private nursing care, doctor's services at home, office or hospital, medicines, laboratory examinations, X-rays and many other items. See the Schedule of Benefits.

The Comprehensive Major Medical Benefits are available in the amount specified in the Schedule of Benefits to each eligible employee and eligible dependent.

The first medical expenses in each year must be paid by the employee up to the amount of the Deductible specified in the Schedule of Benefits. . After you have paid the Deductible, the next covered expenses for providers participating in the CareFirst PPO are paid in full by the Fund up to the maximum available Basic Benefits during the calendar year. (Fund payments for providers not participating in the CareFirst PPO are paid at 90% of allowed charges, up to the Annual Basic Benefit Maximum shown on the Schedule of Benefits) Thereafter, the expenses for CareFirst PPO providers, are paid at 80%, as specified in the Schedule of Benefits. Expenses incurred at a Non-PPO provider are paid at 70%

DEDUCTIBLE

The amount of the Deductible is specified in the Schedule of Benefits. This is the first amount of eligible expenses incurred which must be paid by you during the calendar year.

The Deductible applies separately to you and each eligible dependent; however, you and your dependents will not pay more than the total expense per family specified in the Schedule of

Benefits. The deductible does not apply to Vision Benefits, Dental Benefits, Prescription Benefits, Chiropractic Treatment, Acupuncture treatment, hospitalization, benefits for which another plan is primary or emergency treatment.

A new Deductible will apply each calendar year.

Clarification of Deductible for Retirees and Spouses Eligible for Medicare
Retirees and Spouses who are both eligible for Medicare will have their annual deductible waived.

OFFICE VISIT CO-PAYMENT

Each Member and dependent is required to make a co-payment to a physician's office for an office visit in the amount set forth in the Schedule of Benefits. The balance of the charges for the office visit then become eligible for treatment under the Plan's Basic or Major Medical Benefits. The requirement for payment of an office co-payment does not apply to Retirees.

BASIC BENEFITS

The maximum of Basic Benefits is specified in the Schedule of Benefits. After you have paid the Deductible, the next covered expenses are paid in full by the Fund up to the maximum available Basic Benefits during the calendar year. The Plan will pay 100% of allowed charges up to the Annual Basic Benefit Maximum shown in the Schedule of Benefits if you use providers participating with the CareFirst PPO. The Plan will pay 90% % of allowed charges up to the Annual Basic Benefit Maximum shown in the Schedule of Benefits if you use providers who do not participate with the CareFirst PPO.

The Basic Benefit applies to each eligible person and a new Basic Benefit will be available each calendar year.

MAJOR MEDICAL BENEFIT

After the Deductible has been satisfied and expenses have been paid under the Basic Benefits, the Fund pays 80% (70% for non-PPO providers) of any remaining covered expenses. The percentage and the maximums are specified in the Schedule of Benefits. The Major Medical Benefit applies to each eligible person. The insured Major Medical Benefit is paid on a per illness per life-time basis.

During 2011, 2012 and 2013, the Major Medical Benefit is subject to the Annual Benefit Maximums set forth in the Schedule of Benefits. The Annual Benefit Maximums do not include vision, dental, prescription or accident and sickness benefits. Except for the $100,000 Annual Benefit Maximum that applies to Non-Essential Health Benefits (which is only applicable to participants and individuals in their first two years or portions of years of eligibility), the Annual Benefit Maximum do not exist after the 2013 plan year.

For individuals and participants in their first two years of eligibility, once the Plan has provided $100,000 in total Basic and Major Medical benefits for claims incurred by an individual during a

calendar year, it pays for additional Major Medical Benefit expenses incurred by that individual during that calendar year that are Essential Health Benefits at a rate of 50%.

Once the Plan has provided $1 million in total lifetime Basic and Major Medical benefits, it pays for additional such benefits that are considered Essential Health Benefits at a rate of 50%, and does not cover Non-Essential Health Benefits.

COVERED EXPENSES

A list of exclusions and limitations appears later in this Summary Plan Description.

HOSPITAL BENEFIT

Hospital Benefits will include the semi-private room rate and miscellaneous charges made by the hospital for the following services: operating room, drugs, X-rays, laboratory tests, meals, general nursing service, recovery room, intensive care room, cystoscopic room, oxygen and use of equipment for administering oxygen, anesthesia and administration thereof, radiology, splints, trusses, braces, crutches, artificial limbs or eyes, use of artificial heart and kidney machines, dressings, plaster casts, sterile tray service, intravenous solution and injections, blood and blood plasma, physical therapy when furnished by and billed for by the hospital, local ambulance service to a local hospital, outpatient service for emergencies (accidental injury and medical), first aid within seventy-two hours after an accident or medical emergency or use of operating room facilities, rental of wheel chair or hospital-type bed, iron lung or other mechanical equipment for treatment of respiratory paralysis.

SURGICAL BENEFITS

Surgical Benefits will include treatment of fractures and dislocated bones, operations necessary for treatment of a disease or ailment that involves cutting, suturing, electrocauterization, removal of stone or foreign body by endoscopic means, and injection of sclerosing solution.

The operation must be recommended and performed by a physician or surgeon legally licensed to practice medicine.

MATERNITY BENEFITS

Maternity Benefits are available only for charges incurred while the participant is eligible. Dependent children are not covered for maternity benefits.

Under federal law, group health plans and health insurance issuers offering group insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of a newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a Cesarean section, or require that a provider obtain authorization from the Plan or insurer for prescribing a length of stay not in excess of the above periods.

DENTAL TREATMENT FOR ACCIDENT

Medical Benefits for dental treatment are limited to expenses necessary for the repair of accidental injury to sound natural teeth, providing primary attention must be rendered within twenty-four (24) hours following the accident, the repair is initiated within 6 months after the accident causing the injury and the accident occurs while covered by the Plan. Benefits for such dental treatment are further limited to expenses incurred during the 24-month period immediately following the accident.

MEDICAL BENEFITS

Medical Expense Benefits will include: medical treatment in the home, hospital or physician's office by a legally qualified physician; check-ups, physicals, and well baby check-ups; routine and necessary vaccines, including the HPV (Human Papillomavirus) vaccine for women until age 26; drug and medicines requiring a prescription. Medical Expense Benefits will also include services of a registered private duty nurse (RN) or a licensed practical nurse (LPN) for necessary nursing care for the treatment of acute sicknesses and illnesses, provided such services are rendered by a nurse other than the one who ordinarily resides in the participant's home or who is related by blood or marriage to the participant.

For each patient, the Eligible Charge Limit is $20,000 in each Benefit Year under the Basic Benefit. Custodial care is not covered under the Plan.

ROUTINE PHYSICALS

The Plan covers routine physicals and their related diagnostic testing provided the services are performed by a legally qualified physician as described in this Plan. These benefits are payable under the Basic Benefit portion of the Plan at 100% after co-payment and your deductible are met.

X-RAY AND LABORATORY BENEFITS

Benefits will include X-rays and Laboratory Examinations conducted or ordered by a physician.

MASTECTOMY

Notwithstanding any limitations in this Plan to the contrary, consistent with federal law, the Plan covers the following benefits related to mastectomy:

(1) reconstruction of the breast on which the mastectomy was performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

MENTAL HEALTH BENEFITS

Mental health treatment is covered subject to the other rules and limits of the Plan.

ALCOHOL and SUBSTANCE ABUSE BENEFITS

Alcohol and substance abuse treatment is covered subject to the other rules and limits of the Plan.

DENTAL EXPENSE BENEFIT

GENERAL

This benefit is provided to help defray the cost of dental care for you and your eligible dependents.

You may visit the dentist of your choice and receive any service required but only the allowances set forth in the Schedule of Benefits will be paid by your Fund. In order to receive benefits, you must include all necessary information on the Medical Expense Form and clearly show that the claim is for dental work. Forms are available from the Fund Office and from the Local Union Office.

Benefits are self-insured and will be paid out of the assets of the Fund. Charges in excess of the allowances are your responsibility.

BENEFITS

The Fund will provide for the payment of dental expenses for the Stone Masons and Rubble Men and Caulkers, limited to the following maximums:

Employee and Dependents:

(1) 100% of first $500.00 per individual per calendar year

(2) 80% of next $2,000.00 per individual per calendar year

(3) $4,000.00 maximum per family per calendar year

These maximums do not apply to dental care provided to children under age 18. For children under age 18, dental benefits in excess of $2,500 are provided at a rate of 50%.

HEARING EXAMINATIONS AND HEARING AIDS

Annual hearing examinations by a licensed practitioner are covered by the Plan for both Stone Masons and Rubble Men and Caulkers. If a hearing exam indicates that hearing aids are necessary, hearing aids are covered up to a maximum benefit of $4,000 per person every other calendar year. This benefit includes the cost of the hearing exam, hearing aid, battery replacement, and the repair and maintenance of the hearing aid. This benefit is available to members and Dependents.

VISION CARE BENEFITS

The Plan reimburses the Members and Dependents for Vision Care expenses incurred under the following basis. **The Fund will reimburse the Eligible Member and Dependent for eye examinations and glasses in the amount of up to $400.00 once per year**. **In addition, Eligible Members and their dependents will have available to them a $1,000 lifetime benefit for laser vision surgery.** Tinted glasses qualify for Vision Care reimbursement for Eligible Members and Dependents.

Pediatric Vision Benefit

The pediatric vision benefit will be paid at 100%, subject to the limitations and restrictions reflected in this Summary Plan Description including, but not limited to, lenses, materials, and eye exams.

EXCLUSIONS

Benefits will not be payable for:

(1) Examinations, lenses, frames or contacts obtained more frequently than as stated above;
(2) Non-prescription glasses or sunglasses or the fitting thereof;
(3) Examination required by an employer in connection with the occupation of a covered person;
(4) Surgical or medical care of eye disease or injury, other than a vision examination;
(5) Visual training, orthoptics, aniseikonia or reading rate and comprehension studies;
(6) Replacement of lenses or frames lost, or stolen, if benefits have already been provided during the time limitations shown above;
(7) Expenses incurred prior to your date of eligibility or after termination of your eligibility;
(8) Services or supplies for which benefits are provided under any other provision of the benefit plan;
(9) Services covered under a Worker's Compensation Law or plan; and
Expenses for which benefits are not payable under the Plan

PRESCRIPTION BENEFITS

The Plan has an agreement with Caremark, a prescription drug program, to help pay for your covered prescription drugs. Under the agreement, if you purchase prescription drugs from pharmacies that participate in the program, you will save money.

In-Store
Prescription benefits are processed through Caremark instead of the Fund Office. When your doctor prescribes drugs and medicines, present your card and the prescription to a participating pharmacy, and you will get your medication with the following co-pays:

Class of Drug	**In-Store Co-Pay**
Generic Drugs	$10.00
Preferred Brand Name Drugs	$25.00
Non-Preferred Brand Name Drugs	$40.00
Specialty Drug	$75.00

You are generally limited to a 30-day supply of any prescription drug under this program.

Mail Order Program
Mail order service is also available with the prescription program. Maintenance drugs may be dispensed in supplies of up to 90 days through the mail order program or in store CVS purchases.

Purchasing your maintenance medication (medication like insulin or blood pressure medication that you take on an on-going basis) by mail order is the most cost-effective method. This is true because your co-payment for purchasing a *prescription drug through mail order for a 90-day supply* is less than the co-payments for obtaining the same medications through a retail pharmacy. Your co-payment for a 90 day supply of prescription medication obtained through mail order is equal to two co-payments of a 30 day retail prescription, saving you one retail co-payment each 90 days.

The following co-pays apply to the mail order service.

Class of Drug	**Mail Order or CVS Co-Pay**
Generic Drugs	$20.00
Preferred Brand Name Drugs	$50.00
Non-Preferred Brand Name Drugs	$80.00
Specialty Drug	$75.00

Maintenance Drugs
You are required to purchase maintenance drugs (i.e. all 90-day drug supplies) through the mail order program. Participants will have the option of filling maintenance drug prescriptions in a CVS pharmacy. There is a considerable savings to both you and the Fund when you use the mail order service; you pay only one mail-order co-pay for a 90-day supply, resulting in a savings to you from the normal in-store co-pay. Also, there is the added convenience of home delivery.

PRESCRIPTION DRUG PROGRAMS

The Fund participates in various prescription drug programs designed to maintain costs while continuing to provide meaningful benefits. These programs are described below:

Generic Drugs/ Dispense As Written Savings Program

The Plan provides for certain prescription benefits for participants and dependents through its pharmacy benefit manager, Caremark. Many brand name prescription drugs have a generic equivalent that has the same chemical components as the brand name drug and are just as effective. Generic drugs, however, less expensive alternatives to brand name drug. If a participant or dependent presents a prescription from the participant's or dependent's physician which has a generic equivalent, the participating pharmacy will substitute the generic equivalent for the brand name drug, unless the physician specifically requires that the brand name be dispensed instead of the generic drug. This is a program provided by Caremark known as "dispense as written savings program". Unless your physician specifically requires that the brand name drug be dispensed, the Plan will only pay for the generic price, and you are responsible for the remainder. Substitution of the generic drug will provide both the Plan and the participant a savings on the cost of the medication.

Generic Incentive Co-Pay Program

The Plan has implemented Caremark's Generic Incentive Co-Pay. Under this program, when you substitute a brand name drug with a generic drug, you are eligible to receive an initial one-time prescription fill of the generic substitute with a $0.00 co-pay. Substitution of the generic drug will provide both you and the Plan a savings on the cost of the medication.

Mandatory Generic Step Therapy Program.

If you are prescribed a brand name medication, but there is a generic medication of the same class that is available to treat your medical condition, the Plan will only pay for the generic medication, unless you try the generic medication and your physician certifies that the generic medication is not effective to treat your medical condition and provides a prescription that requires filling with the brand name medication. The Plan will pay for the generic medication first, to see if it works, and if your physician certifies that it does not, the Plan will pay the appropriate amount, subject to your co-pay, for the brand name medication. Usually available generic medications that are not the chemical equivalent to the brand name medication will be effective to treat your condition. Use of these generic medications will provide both you and the Plan savings on the medication.

Specialty Guideline Management Program

At times, certain medical conditions call for the use of Specialty Drugs, which are extremely costly to the Plan. To manage participant's use of Specialty Drugs, the Plan has implemented Caremark's "Specialty Guideline Management Program." Under this program, all Specialty Drugs shall be filled through Caremark's dedicated pharmacies. A list of Caremark's specialty pharmacies can be found at www.caremark.com. A Specialty Drug is a drug that is biologically derived and that is on the list of specialty drugs maintained by your prescription benefits manager, CVS Caremark. You will be able to obtain your Specialty Drug prescription, subject to the Specialty Guideline Management Program, at a co-pay of $75.00 per fill. Any participant utilizing this class of drugs on or before January 1, 2009 shall be grandfathered in at the lower

co-pay of $25.00 per refill; these participants, however, will be subject to the new co-pays for any new Specialty Drug prescriptions.

Advanced Control Specialty Formulary
Certain specialty generics and specialty brand therapies, will be excluded by the Plan unless prior authorization is obtained from CVS/Caremark for use of the medications. In addition, the Advanced Control Specialty Formulary (ACSF) excludes certain preferred specialty drugs. The list of exclusions and/or preferred products may change quarterly. You can access the formulary for the first and second quarters at:
http://www.caremark.com/portal/asset/Advanced_Control_Specialty_Preferred_Drug_List.pdf

Transform Diabetes Care Program
The Fund has implemented the CVS/Caremark Transform Diabetes Care Program. The Program targets the diabetic population in an attempt to help members monitor and control their condition by providing assistance and equipping members with the digital tools and resources necessary to improve success outcomes including, live diabetes coaching, one-on-one pharmacist adherence counseling, MinuteClinic diabetes health evaluations, and delivery of diabetes medications and supplies through CVS/Caremark.
As part of the preauthorization process, your prescriber will have the opportunity to request coverage for an excluded product if certain clinical scenarios are met and the drug is determined to be medically necessary.

If CVS/Caremark provides prior authorization, then the drug will be covered under the normal rules of the Plan. If CVS/Caremark does not provide prior authorization, your prescription for the excluded drug will not be covered under the Plan rules at all. If you agree to use the alternate medication, rather than the excluded drug, the alternate medication will be covered under the normal rules of the Plan.

Core Pharmacy Advisor Program: Introducing Personal Pharmacy Care
The Fund participates in the CVS/ Caremark CORE Pharmacy Advisor Program.

The Trustees of the Stone and Marble Masons Health and Welfare Plan and CVS Caremark understand that serious health conditions – like diabetes, high blood pressure and heart disease – can affect each person differently. People who take long-term medication to manage chronic conditions need personal attention and support to manage their health and stay on track with their medication. As a result, plan participants can now utilize the Core Pharmacy Advisor program, which provides personal pharmacy care for adults (18 years of age or older) and adults and children with Asthma.

With Pharmacy Advisor Counseling, participants can look forward to a more personal approach to care. Staffed with registered pharmacists and technicians, Pharmacy Advisor Counseling can be a valuable resource to help you manage your medication and provide you with:

- Quick, confidential advice at your convenience
- Information about medications and how they work in your body
- Tips to help manage or avoid side effects from your medication
- Guidance to help you stay on track with your prescriptions

Just having someone to talk to about your medicine may make you feel better about taking it. Look for more information about this program through a letter or phone call.

Seasonal Flu/Vaccines Programs
The Trustees have authorized the participation of all participants and dependents in the CVS/ Caremark Flu/Vaccine Program. Subject to any limitations set forth in the plan, the following services will be available to Eligible Participants and Dependents:

- **Flu Shot**: Members and their dependents will be able to visit any network pharmacy for a flu shot. For convenience, individuals should call ahead for availability and to make an appointment. Always remember to bring your prescription card and a valid photo ID to your appointment.
- **Shingles Vaccine**: The Trustees have approved coverage for the Shingles Vaccine based on the CDC guidelines. CDC recommends the shingles vaccine for people **age 60 years and older**. Individuals meeting the CDC guidelines for the shingles vaccine will be able to visit any network pharmacy for the vaccination.

The following vaccines will be available to all eligible participants and dependents:

Seasonal Vaccines: August – April
Injectable Seasonal Influenza Vaccine (Trivalent)
Injectable Seasonal Influenza Vaccine (Quadrivalent)
Intranasal Seasonal Influenza Vaccine (FluMist)
Intradermal Influenza Vaccine Quadrivalent (Short Needle) and Flublok
Injectable Seasonal Influenza – Vaccine High Dose

Participants and their dependents will be able to visit any network pharmacy for a vaccination. For convenience, individuals should call ahead for availability and to make an appointment. Always remember to bring your prescription card and valid photo identification to your appointment.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS
The following items are limited or excluded under the Plan's prescription drug program:

- Smoking Cessation Prescriptions **-** Coverage for smoking cessation products available by prescription under a one (1) time course of treatment for up to two (2) treatments per lifetime.

- Pain Medications and Sleeping Agents – Consistent with pain management guidelines, prior authorization will be required before sleeping agents and pain medications in certain drug classes are disbursed

- Oral Allergy Serums – Will now be covered by the Plan.

- Testosterone Products – In compliance with Section 1557 of the Affordable Care Act (ACA), the criteria in several medication classes have been updated to allow coverage for patients undergoing transgender care. Section 1557 of the ACA prohibits exclusion from

participation, denial of benefits or discrimination on the basis of race, color, national origin, sex, age or disability, in health programs or activities any part of which receive federal financial assistance. The Department of Health and Human Services (HHS), through the Office of Civil Rights (OCR), recently issued final regulations broadly interpreting the scope of Section 1557 and expressly prohibiting exclusion or limitation of transgender care coverage. For additional information, we have included the July 2016 Clinical Knowledge Management New on Transgender Care by CVCHealth.

- Contraceptive Coverage – The Trustees have approved the expansion of the contraceptive options allowed by the Plan to include other forms of contraceptive products, including contraceptive devices. The covered products and the applicable rules and limitations are set forth in the following chart:

Drug Category Note: OTC products require a prescription	**Cover**	**Clinical programs**	**$0 co-pay**	**Exclude Deductible**	**Prior Authorization**	**Age Edits**	**Quantity Limit**	**Generic Drug Rule Allowed**	**Gender Edits**
Contraceptives – (Oral) – Rx Only, Generic and Single Source Brands, Brands until generics become available	Y	N	N	N	N	N/A	N/A	N/A	Female Only
Contraceptives – (Emergency) – Rx or OTC	Y	N	N	N	N	N/A	N/A	Y	Female Only
Contraceptives – (Injectables) – Rx Only, Brands until generics become available	Y	N	N	N	N	N/A	(1 inj. Per 75 days) OR (4 inj. per 300 days)	Y	Female Only
Contraceptives – (Implantable Devices &Vaginal Rings) – Rx Only	Y	N	N	N	N	N/A	1 IUD/ Device per 300 days; 13 rings per 300 days	Y	Female Only
Contraceptives – (Transdermal Patch) – Rx Only	Y	N	N	N	N	N/A	N/A	Y	Female Only
Contraceptives –(Barrier Methods: diaphragms & cervical caps – Rx Only	Y	N	N	N	N	N/A	1 per 300 days	Y	Female Only
Contraceptives –(OTC spermicides, female condoms) – **OTC**	Y	N	N	N	N	N/A	N/A	N/A	Female Only

The above-referenced limitations and exclusions apply in addition to those listed elsewhere in the Plan.

Medicare Part D
The Plan provides prescription benefits to Retirees. The Plan's actuary has determined that the benefits provided under the Plan exceed the Medicare Part D coverage for Medicare eligible participants. The plan therefore receives a subsidy from the Medicare program for providing these benefits. If you or a covered dependent enrolls in a separate Medicare Part D program, you will lose your prescription benefits with this Plan.

You may contact Caremark as follows:

Address for Mail Order Pharmacy:
Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Address to Submit Paper Claims:
Caremark Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

Caremark also provides the following contact information:

Customer Care (866) 282-8503
www.caremark.com

MEDICARE SUPPLEMENT BENEFITS

All persons 65 years of age or over as well as certain disabled persons after receiving 24 months of Social Security disability payments are entitled to free hospital care under the Medicare Program called "Part A" and, if they pay a monthly premium, are also entitled to surgical and medical care provided under the Medicare Program called "Part B" or "Part C".

Employees who are not yet 65 years of age are required to enroll in the Medicare Program as they become 65, including "Part B," or benefits will be administered as if Part B had been elected.

Enrollment periods for Medicare coverage are during the month of your birthday, or during the three months before and after the month of your birthday.

Contact your Social Security Administration Office for enrollment procedures.

Any active eligible Employee, and spouse of any active eligible Employee over the ages of 65, shall be covered for benefits the same as any other eligible employee not enrolled in Medicare and will not be reimbursed any Medicare premiums.

A qualified Retired Employee (see Eligibility Rules) and/or his spouse will continue to participate in the Welfare Fund for the same benefits provided active eligible employees, except:

(1) No Weekly Accident and Sickness Benefit

(2) No payment of expenses for benefits available under Medicare whether or not Medicare coverage was elected.

A qualified Retired Employee (and spouse) who retired prior to being eligible for Medicare will be provided all benefits from the Welfare Fund except the Weekly Accident and Health Benefit until such time as you become eligible for Medicare. At that time you will only be entitled to receive the benefits described for a Retired Employee as the Welfare Fund will not pay any expenses or benefits available under Medicare whether or not you select Medicare coverage.

SPECIAL MEDICARE ENROLLMENT PERIOD

If you are covered by an employer health plan related to current employment, you may be able to delay enrollment in Medicare's medical insurance (or premium hospital insurance) without premium penalty and without waiting for a general enrollment period to enroll. Delayed enrollment without penalty or wait is available only if you are covered by an employer health plan at the time you were first able to get Medicare.

In general, if you are 65 or over, you may enroll in Medicare medical insurance (Part B or Part C) during the 7-month period beginning with the month you are no longer covered under the employer plan based on your employment or the employment of your spouse even if the employer plan is not the primary payer. If you are disabled and covered by an employer health plan, you are also given a special enrollment period in certain circumstances. Certain disabled people who, when first able to get Medicare, are covered under a group health plan, may enroll in Medicare medical insurance during the 7-month period that begins when they are no longer covered under the plan, or when the plan is no longer classified as a group health plan, or when the plan coverage is terminated.

Disabled people who, since first becoming able to get Medicare, are covered under an employer group health plan of any size, based on their own or their spouse's current employment, may also enroll during the 7-month special enrollment period after the plan ends, or the employment terminates, whichever occurs first.

Social Security can give you more information on special enrollment periods or delayed enrollment in Medicare's medical insurance.

RETIREE PRESCRIPTION BENEFITS MEDICARE PART D

The prescription benefits available to retirees under this Plan have been determined to be actuarially equivalent to prescription benefits through Medicare Part D. This means that you do not need to purchase prescription benefits through another plan. If you do obtain prescription benefits through another plan, then this plan will lose a subsidy from Medicare for providing prescription benefits to you, and you will cease to be eligible for prescription benefits under this

plan. Please contact the Fund Office before making any decision to obtain prescription benefits as a retiree from a source other than this plan.

MEDICAID and MEDICAID REIMBURSEMENTS

The Plan complies with the requirements of ERISA §609(b) regarding participants and beneficiaries eligible for Medicaid. The Plan shall not reduce or deny benefits for any participant or dependent to reflect the fact that such an individual is eligible to receive medical assistance under a state Medicaid plan. Under state and federal law, should a participant or dependent covered under the Plan be entitled to payment of a claim under the Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the participant or dependent's right to payment under the Plan to the extent of the amount paid by Medicaid and reimbursement under the Plan will be made in that amount directly to the state.

EXCLUSIONS AND LIMITATIONS

The following charges are generally excluded:

(1) Occupational injury or disease charges incurred in connection with (a) injury arising out of, or in the course of, any employment for wage or profit or (b) disease covered with respect to such employment, by any Workers' Compensation Law, occupational disease or similar legislation.

(2) Government plan charges for: (a) a service or supply furnished by or on behalf of the United States Government or any other Government, or (b) a service or supply to the extent to which any benefit in connection with such a service, supply or charge is provided by any law or governmental program under which the individual is or could be covered.

(3) Charge for Unnecessary Services or Supplies: A charge for services or supplies, including tests and check-up exams, to the extent that they are not needed for (a) the diagnosis of a sickness or injury, or (b) the medical care of a diagnosed sickness or injury.

To be considered "needed", a service or supply must be determined by the Trustees to meet all of these tests:

(a) It is ordered by a Physician.

(b) It is recognized throughout the Physician's profession as safe and effective, is required for the diagnosis or treatment of the particular Sickness or Injury, and is employed appropriately in a manner and setting consistent with generally accepted United States medical standards.

(c) It is neither Educational nor Experimental or Investigational in nature.

(i) "Educational" means that the primary purpose of a service or supply is to provide the patient with any of the following: training in the

activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

(ii) "Experimental" and "Investigational" mean that the medical use of a service or supply is still under study and the service or supply is not yet recognized throughout the Physician's profession in the United States as safe and effective for diagnosis or treatment.

Services, treatment, drugs and supplies which are experimental or investigational in nature, including any services, treatment, drugs or supplies which are not recognized as acceptable medical practice or any items requiring Governmental approval, which approval was not granted or in existence at the time the services were rendered. Decisions concerning which procedures are experimental shall be made by the Trustees which shall be final and binding. In investigating whether a procedure is experimental the Trustees may consider relevant information which may be brought to their attention in connection with the determination including, but not limited to such information as the following: whether there exists substantial and well recognized medical literature establishing the procedure as acceptable medical treatment, the length of time in which the procedure has been utilized, whether the procedure has been accepted by the American Medical Association and/or any agency of the United States government as accepted medical practice, whether the procedure is commonly performed purely for its medical or curative value rather than for scientific or educational purposes and the like. In addition, the Trustees may conduct a poll of organizations knowledgeable in the health care industry to determine whether or not they consider a procedure to be experimental.

Services or supplies which are provided only because an unnecessary service or supply is being provided will also be considered not needed.

In the case of a Hospital stay, in addition to meeting the above tests, the length of the stay and Hospital services and supplies will be considered "needed" only to the extent that the Trustees determine them to be not allocable to the scholastic education or vocational training of the patient.

(4) Charges in Excess of Customary Medical Charge: This is the portion of any charge for any service or supply in excess of the customary medical charge. The customary medical charge made by the provider for a like service or supply in the absence of the benefits of this Plan, but not more than the general level of charges, for sickness or injury of comparable severity and nature, made by others within the area in which the service or supply is actually provided.

(5) Dental Services Charge: A charge for Physician's services and X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including but not limited to crowning, wiring or repositioning teeth. This exclusion does not apply to charges made for treatment or removal of a malignant tumor.

(6) Foot Condition Charges for Physician's services in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for any open cutting operation and would, except for this part 7, be covered. Charges will be covered if Physician determines medically necessary. Orthotics are covered if Physician determines medically necessary.

(7) Eye Care Charge (except for charges listed under Vision Care Benefits): A charge for or in connection with:

(a) Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

(8) Maternity charges are covered only for charges incurred while the participant is eligible. Dependent children are not covered.

(9) Charges for X-ray examination made without film.

(10) Impregnation or Fertilization Charge: A charge for either of the following that involves either a Covered individual or a surrogate as a donor or recipient:

(a) Actual or attempted impregnation.

(b) Actual or attempted fertilization.

(11) Custodial Care: Charges for services in connection with custodial care.

(12) Any charges for which a third party is liable.

(13) Erectile dysfunction medications will be covered with a limit of six (6) units per 30 days and eighteen (18) units per 90 days. Coverage of erectile dysfunction medications will be expanded to include MUSE, Caverject and EDEX products. Erectile dysfunction (ED) medications are not covered for dependents.

Coverage of Cialis 2.5mg and 5mg (daily dose) will be limited to thirty (30) units per thirty days and ninety (90) units per 90 days for the treatment of erectile dysfunction and Benign Prostatic Hyperplasia (BPH). Benefits for daily dose Cialis (2.5mg or 5mg) will be provided with prior authorization from the Pharmacy Benefits Manager. Your physician may contact CVS/Caremark Customer Care at 866-282-8503 for more information on the prior authorization process.

COORDINATION WITH OTHER PLANS

The purpose of coordinating with other health plans is to permit employees to receive benefits from one or more Group Plans but in no event more than 100% of covered incurred expenses.

Since most health plans have some form of "coordination of benefits" if this Plan did not include such a provision it would always be considered the "primary" Plan, and, therefore, would always

pay benefits first. If such were the case other Plans would experience great savings at the expense of this Plan. If this were to happen, employees of our Plan would then have to assume greater claims expense or reduction of benefits.

The order of benefit determination is as follows:

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

(2) The secondary Plan will not pay for any expense not allowed by the primary Plan because of the failure of the person to comply with the provisions of the primary Plan.

(3) If a dependent child is covered by both parents' Plans, the benefits of the Plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first. The benefits of the Plan which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined second.

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

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

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

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

(i) the Plan of the parent with custody,

(ii) the Plan of the step-parent

(iii) the Plan of the parent without custody.

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

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

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

(6) The secondary Plan pays up to the amount of allowable expense it would have paid if it had been primary.

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY.

This Notice is required by the Standards for the Privacy of Individually Identifiable Health Information ("Privacy Rules") issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996. It describes how the Stone and Marble Masons of Metropolitan Washington D.C. Welfare Fund (the "Fund" or "Plan") can use and disclose your Protected Health Information and its duties to you if this information is improperly accessed or disclosed. Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Plan which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. In general, the Fund may not use or disclose your PHI unless you consent to or authorize the use or disclosure, or if the Privacy Rules specifically allow the use or disclosure.

Use or Disclosure of PHI

1. <u>The Fund may use or disclose your PHI for treatment, payment or health care operations without your written authorization:</u>

- "Payment" generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing and collection, making claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

- "Health Care Operations" are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run its business and to support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fund's attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called "business associates." Federal law requires the Fund to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Fund's contract with them. Other

examples of business associates are the Fund's stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs and HMOs.

- "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. The Fund is not typically involved in treatment activities.

2. <u>The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:</u>

- The Fund will use or disclose your PHI to the extent it is required by law to do so.

- The Fund may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.

- The Fund may disclose your PHI to the appropriate government authority if the Fund reasonably believes that you are a victim of abuse, neglect or domestic violence.

- The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including: (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.

- The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

- The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.

- The Fund may disclose your PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

- The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure and/or the Fund determines in its professional judgment that such disclosure is in your best interest.

- The Fund may disclose your PHI to law enforcement officials to inform them of your death, if the Fund believes your death may have resulted from criminal conduct.

- The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Fund.

- The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out his or her duties upon your death or before and in reasonable anticipation of your death.

- The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.

- The Fund may use or disclose your PHI for research purposes, if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.

- The Fund may use or disclose your PHI to avoid a serious threat to the health or safety to you or others.

- The Fund may disclose your PHI if you are in the Armed Forces and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.

- The Fund may disclose your PHI to a correctional institution where you are being held.

- The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.

- The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

3. <u>The Fund may use or disclose your PHI to you, to your Personal Representative, to a third party (such as your spouse) pursuant to an Authorization Form, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan:</u>

- The Fund will provide you with access to your PHI. [*The Fund will first require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the Request Form, or as otherwise required by law. A*

copy of the Request for Protected Health Information Form is attached to this Notice for your information.]

- The Fund may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or lawyer has authority under applicable law to act on your behalf.

- Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an "Authorization Form." You can revoke an Authorization Form at any time by submitting a "Cancellation of Authorization Form" to the Fund. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Fund. [*Copies of each of these forms is attached to this Notice for your information.*]

- The Fund will disclose your PHI to the Fund's Board of Trustees only in accordance with the provisions of the Fund's Privacy Policy and the provisions of the Plan.

Breach Notification

If your protected health information is used, accessed, or disclosed in a manner not described in this Notice of Privacy Practices, we will investigate the "breach" and take available steps to mitigate the harm. In addition, if we determine that the breach poses a significant risk of financial, reputational, or other harm, we will send a "breach notification" notice to you and any other affected individual within 60 days of the breach. The breach notification notice will: (1) briefly describe the breach; (2) describe the types of protected health information that were disclosed; (3) describe the steps to take to protect yourself from potential harm caused by the breach; (4) describe what we are doing to investigate and mitigate the breach and to prevent future breaches; and (5) instruct you to contact us.

Individual Rights

You have certain important rights with respect to your PHI. You should contact the Fund's Privacy Officer, identified below, to exercise these rights.

- You have a right to request that the Fund restrict use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.

- You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations, if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.

- You have a right of access to inspect and copy your PHI that is maintained by the Fund in a "designated record set." A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in

connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.

- You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set, if you submit a written request to the Fund in which you provide reasons for the amendment.

- You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, nor any disclosures that were made for treatment, payment or health care operations.

Duties of the Fund

The Fund has the following obligations:

- The Fund is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Fund's entire Privacy Policy, you should contact the Fund's Privacy Officer, identified below.

- The Fund is required to abide by the terms of the Notice that is currently in effect.

- The Fund will provide a paper copy of this Notice to you upon request.

Changes to Notice

- The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund prior to issuing the revised Notice.

- Whenever there is a material change to the Fund's uses and disclosures of PHI, individual rights, the duties of the Fund, or other privacy practices stated in this Notice, the Fund will promptly revise and distribute the new Notice to participants and beneficiaries.

Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Fund's Privacy Officer at the following address:

Claims Manager
Stone & Marble Masons of Metropolitan Washington D.C. Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

You may also file a complaint with the Secretary of the Department of Health and Human Services and mail it to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Ave., SW
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Office for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

For More Information About Privacy

If you want more information about the Fund's policies and procedures regarding privacy of PHI, contact the Fund's Privacy Officer at the address above.

GRANDFATHERED STATUS

During the health reform debate, President Obama stated to Americans that "if you like your health plan, you can keep it." The Trustees of the Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund have chosen to do so, and believe that the Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA").

The Plan uses collectively bargained employer contributions to the Plan, and income from the investment of Plan assets, to provide the most generous health plan that is prudently possible given the assets of the Plan. To avoid the financial and other burdens on the Plan that would be associated with full implementation of the PPACA, the Trustees have decided to operate the Plan as a "grandfathered health plan" under the PPACA.

A health plan that was in existence on March 23, 2010, the enactment date of the PPACA, is referred to under the PPACA as a "grandfathered health plan." As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, coverage of dependents up to age 26.

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 plan administrator at: Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund, 7130 Columbia Gateway Drive, Suite A, Columbia,

MD 21046, (410) 872-9500. 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 protections do and do not apply to grandfathered health plans.

BASIC PLAN INFORMATION

The following information is required by Section 102 of the Employee Retirement Income Security Act of 1974.

Summary Plan Description

(1) The name of the Plan is: The Stone and Marble Masons of Metropolitan Washington, D.C. Health and Welfare Fund

(2) This Plan is maintained by the:

Joint Board of Trustees
Stone and Marble Masons of Metropolitan Washington, D. C. Health and Welfare Fund
c/o Carday Associates
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

(3) The Employer Identification Number assigned by the Internal Revenue Service is: 52-6038514.

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

(4) This Welfare Plan provides coverage for hospitalization, physician's care, disability income, medical care, vision care, prescription and dental care benefits.

(5) The day-to-day administration of the Plan is carried out by a Contract Administrator: Carday Associates, Inc.

(6) The Plan Administrator is:

Board of Trustees
Stone and Marble Masons of Metropolitan Washington, D. C. Health and Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (410) 872-9500
Fax: (410) 872-1275

(7) The name and address of the person designated as agent for the service of legal process is:

William P. Dale, Esq.
McChesney & Dale, P.C.
4710 Bethesda Avenue
Suite 205
Bethesda, MD 20814

Service of legal process may also be made upon a Plan Trustee or the Plan Administrator.

(8) The name, title and address of the principal place of business of each Trustee of the Plan is as follows:

UNION TRUSTEES	EMPLOYER TRUSTEES
Scott Garvin BAC Local 1 5879 Allentown Road Camp Springs, MD 20746	Joseph Pagliaro Pagliaro Brothers Stone Co., Inc. 6301 Foxley Road Upper Marlboro, MD 20772
Michael Patterson BAC Local 1 5879 Allentown Road Camp Springs, MD 20746	Brett Rugo Rugo Stone, LLC 7953 Angleton Court Lorton, VA 22079
Vital Cardoso BAC Local 1 5879 Allentown Road Camp Springs, MD 20746	Michael R. Bratti R. Bratti Associates 401 E Glebe Road Alexandria, VA 22305
Cesar Rodriguez (alternate) BAC Local 1 5879 Allentown Road Camp Springs, MD 20746	Manuel Seara (alternate) Lorton Contracting 7544 Fullerton Court Springfield, VA 22153

(9) The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

Any participant or beneficiary making request of the above shall pay the Plan's reasonable costs of furnishing these materials. Information about the charge that would be made to provide copies of the above described materials shall be provided upon request at the office of the Plan Administrator.

The above described materials are available for examination by participants and beneficiaries at all times at the principal office of the Plan Administrator, and within 10 calendar days after written request to the Plan Administrator at the principal office of the employees' organization, Stone and Marble Masons of Metropolitan Washington, D. C. Bricklayers and Allied Crafts, Local 1, 5879 Allentown Road, Camp Springs, MD 20746, and at each employer establishment at which at least 50 participants covered under the Plan are customarily working.

(10) The Plan's requirements respecting eligibility for participation and for benefits are set forth in this Summary Plan Description which explains in detail the rules for becoming eligible for benefits as well as continuing eligibility for benefits.

(11) The following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of benefits:

(a) Failure to satisfy the Plan's eligibility requirements as a result of:

(i) insufficient employment under the jurisdiction of the Plan

(ii) insufficient employment due to disability for periods of time prior to or following periods during which credit is available

(iii) failure to pay timely any sums that may be required to continue eligibility during periods of disability or when employment is not available

(iv) exhaustion of rights under Continuation Coverage

(b) Non-covered employment such as employment by an employer who is not required to make contributions on the employee's behalf

(c) Failure to file promptly and in good faith the necessary forms and other information required in support of a claim.

(d) Failure to file claims within time limit specified in the Plan.

(e) A material false statement may result in a denial of a claim.

(f) Entrance into the military service may operate to suspend eligibility under the Plan.

(g) Participation in the Welfare Fund terminates upon retirement unless the "Retired Employee" requirements are satisfied.

(h) The Weekly Accident and Sickness Benefit does not apply to a Retired Employee unless the employee, prior to age 60, becomes totally and permanently disabled while eligible.

(i) The Plan will not pay for any expenses which are recoverable under the Medicare program (Parts A, B, C or D).

(j) Claim is for a work-related accident or illness.

(k) Failure to follow the third party liability provisions of the Plan.

(12) Contributions to the Plan are made by individual employers under the provisions of a collective bargaining agreement. Under certain conditions stipulated in the Plan, employees may qualify to contribute on their own behalf, to continue their status of eligibility when there are periods of certified disability or employment is temporarily not available.

(13) The Plan is financed by contributions to the Trust and any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees and/or their dependents, and the paying of all expenses incurred with respect to the operation of the Plan.

(14) The Plan's annual year end date is: January 31.

(15) The Administrative Agent for this plan is:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(Phone) 410-872-9500

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

As a participant in Stone and Marble Masons of Metropolitan Washington, D. C. Health and Welfare Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HOW YOU CAN DO YOUR PART

The benefits for medical care described in this booklet have been designed to pay a large part of the customary charges for a broad range of necessary services, treatments and supplies, and will give you substantial protection against the cost of serious sickness and injuries.

Like any good tool, the Plan must be used properly if it is to endure. For the Plan to work successfully, it is important that its cost be kept reasonable and, of course, the cost is governed by the claims submitted by you and your fellow workers.

When arranging hospital, medical and related services, discuss the charges that are to be made with your doctor, the hospital, and others who are to furnish treatment. Generally your doctor or hospital will be pleased to discuss the charges with you. In fact, most medical societies encourage patients to talk over charges with their doctors in advance.

Satisfy yourself that the charges will not be more than you would pay if you were not covered by this Plan, nor more than is generally charged in your area for similar services.

If you are in doubt as to the level of the charge consult the Fund Office. Remember, the amount of any charges which are in excess of the customary charges are excluded under the Plan. Also make sure only necessary services are ordered. In this way you will be doing your part in keeping the Plan available for everyone, and at the same time will be holding your own out-of-pocket expenses to a minimum.