METROPOLITAN D.C. PAVING INDUSTRY EMPLOYEES HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

Effective October 1, 2022

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INTRODUCTION
METROPOLITAN D.C. PAVING INDUSTRY
EMPLOYEES HEALTH AND WELFARE FUND
7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046
410-872-9541

Dear Friend and Participant:

WE ARE PLEASED to present this updated Plan of Benefits and Summary Plan Description of the Metropolitan D.C. Paving Industry Employees Health and Welfare Fund ("Fund"). It includes all Plan amendments to the date of printing.

The Plan provides coverage for hospitalization, surgical and medical care, prescription drugs, dental, vision, weekly accident and sickness income, and death benefits. This booklet is intended to explain the benefits available to you and your eligible dependents and the rules governing those benefits, including the procedures for filing a claim or an appeal.

We recommend that you read these pages carefully to become familiar with its contents and keep the booklet readily available as a handy guide for future reference.

The Paving Fund is administered by a Board of Trustees. Half of the Trustees are designated by the Employers, and half are designated by participating Local Unions. The Board of Trustees, in turn, employs the services of a professional administrative firm to carry out its instructions and to handle the day-to-day operation of the Fund. The administrative agent is BeneSys (formerly Carday Associates, Inc.)

The Trustees are always interested in providing increased benefits to you and your dependents when it is economically sound to do so. In order to protect the interests of all Fund participants and beneficiaries, the Trustees reserve the right to terminate, suspend, amend or modify the Plan in whole or in part at any time. In the event the Plan is terminated, Plan assets will be allocated, and benefit claims paid, in the manner determined by the Trustees.

The Fund participates in the CareFirst BCBS Preferred Provider Organization network. Use of hospitals and Providers in this network will ordinarily result in savings to the Fund and may save you money as well. Thus, whenever possible, you should use hospitals and doctors in the CareFirst BCBS network.

If you have any questions after reading this booklet, contact BeneSys, Administrative Agent for the Fund.

Sincerely,

THE BOARD OF TRUSTEES

GRANDFATHERED PLAN STATUS

The Board of Trustees believes that the Fund is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the Fund may not be required at this time to include certain consumer protections of the Affordable Care Act 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 Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act 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 BeneSys at 410-872-9541. You may also contact the Employee Benefits Security Administration, United States Department of Labor at www.dol.gov/ebsa/healthreform or by calling 866-444-3272. The DOL website has a table summarizing which protections of the Act do and do not apply to grandfathered health plans.

A SUMMARY OF YOUR BENEFITS
FOR ELIGIBLE EMPLOYEES ONLY

FOR ELIGIBLE EMPLOYEES ONLY

Death Benefits (Page 24)……...……...$10,000.00

Weekly Accident and Sickness Benefits (Page 23)…….$250.00
Maximum payable: 13 weeks

FOR ELIGIBLE EMPLOYEES & DEPENDENTS

Medical Benefits

Note: Dollar amounts listed below are the annual limits on the amounts paid as a Basic Benefit. The balance of the Allowed Amount is paid under Major Medical at 80% with your Coinsurance amount being 20%. After you have reached the Out-of-Pocket Maximum, the Fund pays 100% of the Allowed Amount . If a Covered Expense is incurred for care by an out-of-network Provider at an Emergency Department in connection with Emergency Services or for non-Emergency Services at an in-network facility, or for out-of-network air ambulance services, the Major Medical Benefit will pay the Out-of-Network Rate for the Covered Expenses. You are responsible for paying 20% of the Recognized Amount.

Medical Out-of-Pocket Maximum (Page 32) (per calendar year)

- Per individual……$5,000.00
- Per family……$10,000.00

Hospital Benefits (Page 26) (per condition, including Nervous/Mental and Substance Use Disorder) (pre-admission certification (Page 40) required for Hospital admissions other than for Emergency Services)

- Daily Room and Board (semi-private) up to……$130.00

  Maximum Benefit (31 days)……..$4,030.00
- Daily Room and Board (intensive care) up to……..$245.00

  Maximum Benefit (10 days)……..$2,450.00
- Additional Hospital Charges Maximum……$1,000.00

Surgical Benefits (Page 29)

- Maximum per condition……$1,000.00

Anesthesia Benefits (Pages 26, 32, and 34)

- Maximum per condition……$1,000.00

Diagnostic, X-Ray and Laboratory Benefits (Page 28)

- Maximum Per Calendar Year……..$250.00

Maternity Benefits (Page 27)

- Hospital Charges……..Same as any other illness
- Provider Charges……..See Surgical Expense Benefits

Provider Visit Benefits (Page 29) (per condition, including Nervous/ Mental and Substance Use Disorder)

- Basic Benefit Allowance per visit for first 20 visits……...$20.00

Annual Physical Benefits (Page 30)

- Basic Benefit Allowance Per Calendar Year……....$100.00

Major Medical Expense Benefits (Page 31)

- Maximum per Calendar Year……..UNLIMITED

Physical Therapy Benefits (Page 30) (Basic Benefit only; additional visits are not covered by Major Medical)

- Maximum Visits Per Calendar Year…….……15
- Visits paid at 100% of Allowed Amount

Preventive Services Benefits (Page 24) (In-network only)

- Maximum per Calendar Year……..UNLIMITED

Non-Medical Benefits (Page 34)

Dental Benefits (Page 34)

- Adults and non-essential pediatric benefits: Maximum per person per Calendar Year
  - through December 31, 2022……..……...……..……..$600.00
  - effective January 1, 2023……...……...…...$750.00
- For covered individuals under age 19: No maximum on covered, essential benefits

Vision Care Benefits (Page 35)

- Maximum per person per Calendar Year…….$400.00
- For covered individuals under age 19: No maximum on covered benefits.

Prescription Drug Card Benefits (Page 36)

- Maximum per Calendar Year, Per Family……...UNLIMITED

Hearing Aid Benefits (Page 36)

- Maximum per every three Calendar Years……...$500.00

DEFINITIONS

Capitalized words in this Plan document have a particular meaning. Some definitions are set forth below. Others appear elsewhere in the Plan.

Allowed Amount-refers to (1) the Preferred Provider Organization (PPO) rate established by CareFirst BCBS ("PPO rate") if the Provider participates in the CareFirst network, or (2) the usual, customary, and reasonable (UCR) rate if the Provider is out-of-network. The UCR rate is determined by the Trustees through various means, including, but not limited to, comparison with charges generally incurred by persons in like circumstances for similar services and supplies in cases of comparable nature and severity in the same geographic area concerned.

Basic Benefit-a benefit that is paid at 100% up to the limit set forth in the Summary of Benefits for the specific Covered Expenses identified there.

Coinsurance-the percentage of costs of a covered health care service you pay (20%, for example).

Continuing Care Patients-patients who, with respect to a Provider or facility, are (i) undergoing treatment for a complex or serious condition; (ii) undergoing a course of institutional or inpatient care; (iii) scheduled to undergo nonelective surgery, including post-operative care; (iv) pregnant and undergoing treatment for pregnancy; or (v) terminally ill and undergoing treatment for such illness.

Covered Employment-work for which an Employer is required to make contributions to the Fund under a Collective Bargaining Agreement or other signed stipulation.

Covered Expense-any charge that is allowable under this Plan for a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation, or cure of an illness or injury to a structure or function of the mind or body.

Emergency Department-refers to the emergency department of a hospital; another hospital department that provides Emergency Services; or a health care facility that provides Emergency Services and that is geographically separate, distinct, and licensed separately from a hospital.

Emergency Medical Condition-a medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the fetus) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. Whether a medical condition is an Emergency Medical Condition will not be determined based on diagnostic codes used by the Provider or facility.

Emergency Services-refers to an Emergency Medical Condition, (i) an appropriate medical screening performed in an Emergency Department, including ancillary services routinely available to evaluate such an Emergency Medical

Condition; (ii) such further medical examination and treatment as required under section 1867 of the Social Security Act (as if applicable to all Emergency Departments) to stabilize the patient; and, unless waived by the patient, other Covered Expenses furnished by an out-of-network Provider or out-of-network Emergency Department after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in (i) or (ii) of this definition are furnished.

Hospital-refers to any general hospital which is licensed under any applicable state statute or, in the absence of any state licensing statute, conforms with any other requirements imposed on hospitals within that jurisdiction, which is not primarily a clinic or a nursing, rest or convalescent home or similar establishment.

Major Medical Benefit-a benefit that typically covers 80% of the excess of the Allowed Amount over the portion that was paid by the Basic Benefit.

Medically Necessary-services or supplies furnished or prescribed by a Provider or other licensed provider to identify or treat a diagnosed or reasonably suspected illness or injury, the furnishing of which is: (1) consistent with the diagnosis and treatment of the patient's condition; (2) in accordance with standards of good medical practice; (3) required for reasons other than the convenience of the patient, Provider, or other licensed provider; and (4) the most appropriate level of service or supply that can be provided safely for the patient. When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Provider or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

Out-of-Network Rate-refers to the extent required under federal law with respect to care at an Emergency Department in connection with Emergency Services, services rendered by an out-of-network Provider at an in-network facility, and out-of-network air ambulance services, either (i) the amount agreed to as full payment by the Fund and the Provider or (ii) the amount determined by the independent dispute resolution process provided for under federal law (sections 9816(c) or 9817(b) of the Internal Revenue Code), in each case reduced by the amount owed by the participant as cost-sharing, if any.

Provider-a physician or surgeon (M.D. - Medical Doctor - or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services. To the extent that services are covered by this Plan, and while the person is practicing within the scope of his or her license, the term "Provider" includes a dentist, podiatrist, chiropractor, psychologist, licensed clinical social worker, physical therapist, or other licensed health care provider.

Qualifying Payment Amount-an amount determined in accordance with regulations issued by the Departments of Treasury, Health and Human Services, and Labor. Generally, the Qualifying Payment Amount equals the median contracted rate for an item or service as of January 31, 2019, and adjusted annually thereafter according to guidance from the Department of Treasury and Internal Revenue Service.

Recognized Amount-the lesser of the Qualifying Payment Amount and the amount actually billed by the Provider.

ELIGIBILITY RULES

Initial Eligibility (for new employees of existing contributing Employers)

When a new employee is hired by an Employer that already has an obligation to contribute to the Metropolitan D.C. Paving Industry Employees Health & Welfare Fund ("Fund"), the Employer is required to commence reporting the employee's hours to the Fund as of the first day of employment. After the employee works at least 380 hours within the first three (3) consecutive months of Continued Employment (as defined below), the Employer is required to commence making contributions to the Fund on behalf of the employee as of the first day of the fourth month of Continued Employment. The employee attains eligibility for benefits from the Fund as of the first day of the fifth month of Continued Employment.

If the new employee does not meet the minimum 380 hours requirement within the first three months of employment, then the Employer is required to commence contributions to the Fund on behalf of the new employee as of the first day of the month following when the employee has first worked at least 380 hours within three (3) consecutive months of Continued Employment. The employee attains eligibility for benefits from the Fund as of the first day of the month following the first month of contributions.

Continued Employment

Continued Employment is defined as working under the terms of a Collective Bargaining Agreement that requires contributions to the Fund for a minimum of 120 hours per month in consecutive months.

Retroactive Eligibility

You may become eligible for benefits under this section before you receive your benefit card from the Fund or even before the Fund Office knows of your eligibility given the time it takes for employer reports of hours to be submitted to and processed by the Fund Office. In that case, once the Fund has received the hours reports that establish your eligibility, coverage will be provided retroactive to the date described in this section. You may thereafter submit claims incurred during the period of your eligibility.

Initial Eligibility for "Experienced Employee"

When the Local Union and the Employer agree that a newly-hired employee who was not previously eligible for coverage from the Fund has sufficient work experience in the industry to be considered an "experienced employee," the Employer is required to commence reporting hours to the Fund as of the first day of employment. After the newly-hired employee works at least 240 hours within the first two (2) consecutive months of Continued Employment, the Employer is required to commence making contributions to the Fund on behalf of the employee as of the first day of the third month of Continued Employment. The employee attains eligibility for benefits from the Fund as of the first day of the fourth month of Continued Employment.

Initial Eligibility for Existing Employees of Employers That Are New to the Fund ("newly organized groups")

When a new Employer signs its first collective bargaining agreement requiring contributions to the Fund after March 1, 2017, the Employer will be required to commence reporting hours for and making contributions on behalf of its existing employees as of the date of signing the collective bargaining agreement ("signing date"). The Employer's existing employees shall attain eligibility for benefits from the Fund as of that date. For all future hires (hired after the signing date), employee eligibility will be governed by the initial eligibility rules set forth above for Employers that already have an obligation to contribute to the Fund.

Maintaining Eligibility

Once an employee attains eligibility under any of the above initial eligibility rules, the employee continues to be eligible as long as the employee works in Continued Employment. In the event that the employee does not work at least 120 hours in a month, then the employee must have accumulated a minimum of 720 hours in the six months prior to that month in order to retain eligibility.

Losing Eligibility

If the employee does not have sufficient hours to maintain eligibility under the above provision, the employee's eligibility will terminate at the end of the second month following the last month in which the employee worked a minimum of 120 hours. If the employee loses eligibility under this provision, the employee will have the opportunity to self-pay under the terms of this Plan. See Self Payment Program below.

Regaining Eligibility

In order for a previously-eligible employee to regain eligibility, the employee is required to work a minimum of 240 hours in two (2) consecutive months. The Employer is required to commence reporting hours and making contributions to the Fund on behalf of the employee as of the first day of renewed employment. The employee attains eligibility for benefits from the Health & Welfare Fund as of the first day of the second month of Continued Employment.

Special Provisions If You're Disabled

If, while you are eligible for benefits, you become unable to work because of any injury or illness, your eligibility will continue while you remain disabled, just as if you were still working for a contributing employer, up to a maximum of 12 months or four quarters after the last quarter you worked in Covered Employment so long as you continue to furnish medical evidence of your continued disability (including Workers' Compensation) to the satisfaction of the Trustees.

Eligibility Under FMLA

The Family and Medical Leave Act ("FMLA") of 1993, as amended, requires employers of 50 or more employees to give an employee, upon request, up to 12 weeks of unpaid, job-protected leave each year for the following: the Employee's own serious health condition; care for a child, spouse or parent with a serious health condition; the birth or placement of a child with the employee in the case of adoption or foster care; or a "qualifying exigency," as defined in applicable regulations, arising out of the fact that a covered family member is on covered active duty in the Armed Forces. In addition, the FMLA as amended provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 workweeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Your eligibility for such leave is to be determined between you and your employer. Employers covered by the FMLA are required to maintain medical coverage for Employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the Employee had continued to work. This means that an Employer is required to continue making contributions to the Fund on behalf of Employees while they are on FMLA leave. Employees should contact the Fund Office if they are planning to take FMLA leave, so that the Fund is aware of the Employer's responsibility to report and contribute during the FMLA leave. Employees with questions about the FMLA should contact their Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, Employment Standards Administration.

Eligibility for Non-Bargaining Unit Employees

A Non-Bargaining Unit Employee is an employee of a contributing employer to the Fund ("Employer") who does not work under the terms of the Collective Bargaining Agreement requiring contributions to the Fund. An Employer may sign a Participation Agreement with the Fund providing for contributions to be paid to the Fund on behalf of Non-Bargaining Unit Employees upon terms agreed to by the Trustees in their sole discretion. When a new employee is hired by an Employer that has signed a Participation Agreement with the Fund, and the employee is covered by the Participation Agreement, the Employer is required to commence reporting and paying contributions on that

employee's behalf as of the first day of employment. The employee attains eligibility for benefits from the Fund as of the first day of the month following the month in which the Employer began to remit contributions on behalf of the employee.

A Non-Bargaining Unit Employee that is covered by a Participation Agreement with the Fund and has thus attained eligibility for benefits from the Fund will retain eligibility for benefits from the Fund until the earlier of the following: (1) the last day of the month in which the employee ceases to be employed by the Employer as a full-time non-collectively bargained employee; or (2) the last day of the month in which the Employer's Participation Agreement is terminated. Non-Bargaining Unit Employees may not participate in the Fund's self-pay program.

Covering Your Dependents

Your eligible dependents will include your spouse and certain children as defined below:

The term "children" shall include the following: (1) the Participant's natural children; (2) the Participant's legally adopted children; (3) children lawfully placed in the Participant's home in anticipation of adoption; (4) the Participant's legal stepchildren; (5) eligible foster children lawfully placed in the Participant's home by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction; (6) grandchildren, nieces and nephews of the Participant who are living with the Participant in a parent-child relationship and dependent on the Participant for more than one-half of their financial support.

Dependent status shall continue for a child until the end of the month in which the child's 26th birthday occurs.

Dependent status shall also continue for a Participant's child beyond his or her 26th birthday if the child is disabled due to physical or mental incapacity which prevents self-support, provided that the disability began while the child was eligible for benefits as a dependent and the child either (a) is permanently and totally disabled, lives with the Participant for more than one-half of the year and does not provide more than one-half of his/her own support (including federal disability benefits) or (b) depends on the Participant form more than one-half of his/her financial support.

Coverage will also be provided as required by a Qualified Medical Child Support Order ("QMCSO") as defined by ERISA Section 609. A QMCSO is any court judgment, decree or approval of a settlement agreement which provides for coverage of a Participant's child under a group health fund or is 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. If your child who is the subject of the QMCSO is not your "dependent" as defined in Internal Revenue Code section 152, you may be subject to income tax on the

fair market value of the coverage provided to that child by the Plan under the terms of the QMCSO.

If you die while eligible for benefits, your eligible dependents will continue to be covered by the Fund for the period of eligibility that you had earned based on your work in Covered Employment. In addition, your eligible dependents will receive an additional six months of eligibility if you satisfy the following three requirements: (1) at the time of your death, you were eligible for benefits in the Fund based on your work in Covered Employment; (2) at the time of your death, you were vested in the pension plan that you participated in through your Local Union; and (3) at the time of your death, you were a member in good standing of your Local Union. Your eligible dependents will be entitled to elect Continuation Coverage after the expiration of their eligibility in the Fund under this provision.

Other than as set forth above, coverage for your Dependents (other than Self-Pay or COBRA coverage as described below) will end on the earlier of: (1) the last day of the calendar month in which you cease to be eligible for coverage or (2) the last day of the calendar month in which the Dependent is no longer considered a Dependent under the plan's definition as set forth above, e.g., as a result of divorce (in the case of a spouse) or an adult child attaining age 26.

Effective April 1, 2013, you may also elect to terminate coverage for your spouse or child before the date such coverage would otherwise end, but only if the following conditions are met: (1) the Dependent has other health coverage; (2) the Dependent (in the case of an individual over age 18) consents to having his or her coverage under this Plan terminated. Coverage will end on the last day of the calendar month in which the Fund Office receives your election to terminate Dependent coverage submitted in a form acceptable to the Board of Trustees. A Dependent whose coverage is so terminated may again obtain coverage under the Plan, if otherwise eligible, on the first day of the calendar month following the calendar month in which the Fund Office receives written notice of his or her re-enrollment, which may be at any time if the Dependent loses other coverage. If the Dependent still has other coverage, he or she may only submit a re-enrollment during the month of September.

NOTIFICATION OF CHANGES

All dependents must be listed on the approved enrollment card and the Fund may require further affidavits to be completed and approved, if the Trustees, in their sole discretion, find such further proof necessary to establish eligibility. If a dependent becomes eligible subsequent to your enrollment (e.g., due to a life event such as marriage, birth, adoption, etc.), you must notify the Fund within thirty (30) days of the life event (within sixty (60) if the life event is the birth of your child) for the new dependent's eligibility to take effect as of the date of the life event. If you do not give such timely notice, the dependent's coverage will instead take effect the first of the month following the Fund's receipt of satisfactory evidence of eligibility

Therefore, after your eligibility becomes effective, it is necessary to notify the Fund Office of changes in your family such as:

A. Any change in your marital status;

B. Names and birth dates of newborn or adopted children;

C. Date that any dependent child reaches his or her 26th birthday;

D. Any change of address;

E. Change in beneficiary.

This information is necessary to avoid any delay in the handling of your claims. The Administrative Agent may request certain documents to confirm eligibility and ensure swift processing of your claims. Notification of changes is also necessary so that the Fund knows to pay claims for individuals who are eligible (such as new children) and not to pay claims for individuals who are no longer eligible (such as your former spouse after a divorce).

Eligibility Related to Service in Armed Forces

The Fund will comply with all of the requirements of the Uniformed Services Employment and Re-employment Rights Act ("USERRA") for Participants in military service who are covered by its provisions. If you enter the Uniformed Services as defined in USERRA for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty or fitness-for-duty examination, coverage for you and your eligible dependents will terminate in accordance with the Fund's eligibility rules for Participants not working in Covered Employment. If you or your dependents want to elect to continue coverage in the Fund either by means of its Self-Payment Program or COBRA Continuation Coverage, you can do so, provided that these elections are made within the applicable time period.

If you are honorably discharged from the Uniformed Services, you and your dependents will be reinstated for coverage with the Fund on your first day of work in Covered Employment, provided the following requirements are met:

A. The cumulative length of the absence and all previous absences in the Uniformed Services must not be longer than five years;

B. You or your representative give advance notice to your employer of your impending service, unless military necessity prevents it;

C. You submitted an application for reemployment in Covered Employment within the time limits set forth in USERRA from the date of your discharge;

D. If your absence is for more than 30 days, you must furnish any available documents requested by your employer to establish your entitlement to the protections of USERRA.

If needed, you can get more information about USERRA and your eligibility for benefits from the Fund Office.

Reciprocity

There may be occasions when you find yourself working in the geographical jurisdiction of another local union that does not participate in this Fund, or you are working under a participating Local Union's Collective Bargaining Agreement that requires contributions to a Fund other than the Metropolitan D.C. Paving Industry Employees Health and Welfare Fund. This Fund has made arrangements with other Local Union Funds whereby credits that you earn in their jurisdiction will be transferred to this Fund. The Fund has established reciprocal arrangements with the following Local Union Funds:

Washington, D.C. Cement Masons Welfare Fund (Local 891)

Laborers' District Council Health & Welfare Trust Fund No. 2 (Local 11)

You will be credited with these hours as soon as the medical fund in the area in which you worked (or are working) confirms the hours and that the contributions will be reciprocated.

CERTIFICATES OF CREDITABLE COVERAGE

If you lose coverage in the Fund, the Fund Office will issue you a Certificate of Creditable Coverage showing how long you were covered in the Fund. You will receive the certificate automatically when you lose coverage or become entitled to the Self-Payment Program or COBRA Continuation Coverage, and when such coverage ceases. Also, you may request that the Fund Office provide you with a Certificate within 24 months after losing coverage in the Fund.

SELF PAYMENT PROGRAM

A Self Payment Program is available for participants who lose eligibility due to insufficient hours and who meet the following requirements:

A. You must be eligible for coverage under the Plan at the time you become unemployed due to a lack of available work in Covered Employment.

B. An election to self-pay contributions must be made within one month following the last month in which you worked in Covered Employment, by filing an application with the Fund Office.

C. Contributions will be required at the rate established by the Board of Trustees commencing with the first day of the calendar month following the month in which you lost eligibility due to insufficient hours. Payment must be made by the first of each month to receive coverage for that month. Please contact the Fund Office for the current self-payment rate.

D. You must remain available for immediate employment in the jurisdiction of your home Local.

E. Contributions must be made monthly to the Fund Office.

F. Your initial payment may not be made retroactively in excess of thirty days.

G. A reporting and payment form is available for the purpose of self-payment of contributions to continue eligibility. This form must be completed for each month that self-payment is made, and the Business Agent of your Local must sign this form certifying that work in Covered Employment was not available for the month in which you are electing to self-pay. This form with payment attached must be received in the Fund Office by the 1st of the month for which payment is made.

H. You may continue to self-pay for up to a maximum period of 6 months.

The Self-Payment Program differs from the opportunity available to continue participation under COBRA (described in the following section). You can use the Self-Payment Program only if your loss of eligibility is due to a lack of available work in your home Local. Unlike COBRA, which this Plan makes available under one premium rate for single participants and another for families, there is only a single self-pay rate. Also, if you choose to self-pay, you receive credit for hours worked as if you worked 120 hours during the month for which you self-paid for coverage. Thus, when you stop self-payment and resume work in Covered Employment, you are treated as having worked 120 hours during those months for purposes of regaining eligibility. This arrangement differs from COBRA where you pay a premium rather than receiving credit for hours worked. Therefore, when an individual who is maintaining eligibility in the Plan through COBRA resumes work in Covered Employment, he must satisfy the hours requirement to regain eligibility in the Plan.

Participants who lose eligibility due to a lack of available work are free to choose either COBRA or the Self-Payment Program. The Self-Payment Program is only available to bargaining unit employees whose employers contribute to the Fund on their behalf under the terms of the collective bargaining agreement; it is not available to non-bargaining unit employees (e.g., owners or office staff) whose employers contribute to the Fund under the terms of a Participation Agreement. If you have any questions about the Self-Payment Program, please contact the Fund Office.

CONTINUATION COVERAGE (COBRA)

Employees and their families covered by the Fund may purchase a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Fund would otherwise end. Such instances are known as "qualifying events."

You will have to pay the cost for your continuation coverage. The amount of this cost is determined annually by the Fund Trustees and is subject to change.

Qualifying Events

If you are an *employee* covered by the Fund, you have a right to purchase this continuation coverage if you lose your group health coverage because of the occurrence of either of the following events:

A. A reduction in your hours of employment; or

B. Termination of your employment, for reasons other than gross misconduct on your part.

If you are the *spouse* of an employee covered by the Fund, you have the right to purchase continuation coverage for yourself if you lose group health coverage under the Fund for any of the following reasons:

A. The death of your spouse;

B. A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;

C. Divorce or legal separation from your spouse; or

D. Your spouse becomes entitled to benefits under Medicare.

If you are a *dependent child* of an employee covered by the Fund, you have the right to purchase continuation coverage if regular coverage under the Fund is lost because of the occurrence of any of the following qualifying events:

A. The death of the participant parent;

B. The termination of the participant parent's employment (for reasons other than gross misconduct) or reduction in the participant parent's hours of employment;

C. Parents' divorce or legal separation;

D. A parent becomes entitled to benefits under Medicare; or

E. The dependent ceases to be a "dependent child" under the rules set forth herein.

Period of Coverage

An employee covered by the Fund who elects to purchase continuation coverage shall be eligible to receive this coverage for a period of 18 months, starting from the date when his coverage under the Fund otherwise ends. However, if the employee receives a determination from the Social Security Administration that he is disabled prior to the end of the 18-month period, and that determination is forwarded to the Fund Office within 60 days, then the 18 months of continuation coverage will be extended to 29 months of coverage unless the employee recovers from the disability before then or the employee's period of coverage ends earlier under another Fund rule.

If either a Covered Employee or a Qualified Beneficiary of a Covered Employee becomes disabled within the first 60 days of when that individual has

begun to be covered under COBRA, the Covered Employee and the Qualified Beneficiaries will be eligible for 29 months of COBRA coverage. The term "Qualified Beneficiary" will include children born to or placed for adoption with a Covered Employee during the period of COBRA coverage.

If the spouse or dependent child of an eligible employee covered by the Fund elects to receive continuation coverage, the spouse or dependent shall be eligible to receive this coverage for a period of 18 months, starting from the date when coverage under the Fund would otherwise end. However, the coverage can be continued for up to 36 months for the spouse or dependent child if coverage would otherwise end because of the employee's death, divorce from the spouse, or the child's loss of status as a dependent under the Fund.

Notice Requirements

An employer has 60 days to notify the Fund of the occurrence of certain qualifying events, such as the death of the employee, the employee's eligibility for Social Security benefits, or commencement by the employer of a Chapter XI bankruptcy proceeding.

Qualified Beneficiary and Covered Employee Notice Requirements

The Fund Administrator shall determine whether a qualifying event has occurred due to termination of employment or a reduction in hours of employment.

If you, your spouse, or your covered dependent experience a qualifying event other than your reduction in hours or termination from employment, you are required to notify the Fund Office, at the address listed on page one of this SPD, within 60 days of such event. The notice must include the names, addresses, telephone, and Social Security Numbers of all persons whose coverage will be affected by such event. The notice must also include an explanation of the nature of the qualifying event, the date on which it occurred and any supporting documents. Some examples of acceptable supporting documents are divorce decrees, separation agreements, Social Security Administration Disability Determinations, and death certificates.

The Fund has 30 days after you would otherwise lose coverage to notify you or your spouse of the right to elect continuation coverage.

Ways in Which Your Continuation Coverage May Be Cut Short

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

A. Your employer no longer contributes to the Fund for the purpose of providing group health coverage to its employees and their dependents;

B. You do not pay the premium for your continuation coverage on time;

C. You become covered under another group health fund, whether as an employee or otherwise. However, if the other group health fund under which

you become covered has any exclusion or limitation for coverage of preexisting conditions, then your coverage cannot be cut short for this reason; or

D. You become entitled to benefits under Medicare. However, if the employee's continuation coverage is cut short because he or she is entitled to Medicare, the dependents of the employee who are covered due to the election of continuation coverage will be entitled to extend their continuation coverage for a period of 36 months from the date the employee becomes entitled to Medicare coverage. (This provision is not applicable to individuals entitled to continuation coverage due to the employer's filing bankruptcy.)

PREFERRED PROVIDER ORGANIZATION

The Trustees have contracted with the CareFirst BCBS Preferred Provider Organization (PPO), a group of select Providers, specialists, hospitals and other treatment centers, to provide services for a contracted, discounted rate. CareFirst BCBS PPO network Providers can be used for medical problems, emergency medical problems, nervous/mental health conditions, or substance use disorder.

Participants are urged to use CareFirst BCBS PPO network Providers for all medical services and treatment covered by the Fund. Your use of network Providers will result in savings not only to the Fund but also to you if you are responsible for paying out-of-pocket expenses.

To find an up-to-date listing of providers that participate in the CareFirst network via CareFirst's website, use the following steps:

A. Go to www.carefirst.com

B. Click on the "Providers & Facilities" tab in the narrow black horizontal strip at the top of the page

C. Under the "Find A Doctor" drop-down column, click the link that reads "Find a Doctor or Facility"

D. Click on the blue "Search Now" link in the middle of the page. The link will direct you to a new page in your browser

E. Click on the "Care First – Network Leasing" link at the bottom of the webpage in the section titled "Other Sites"

F. In the top right of the page, select the City, State, or ZIP of the provider or health care facility that you are looking for. Alternatively, you can click "Use Current Location"

G. Click "Browse by Category" for a choice of types of medical services, or type the name of the provider or specialty in the search box with the magnifying glass. An alternative option is to click on one of the "Common Searches"

You may also check if a particular provider participates in the CareFirst network by calling CareFirst at 800-235-5160.

The list of network Providers is subject to change. You should check with your Provider each time you request health care services to ensure that the Provider and facility is still participating in the PPO so that you will be afforded the appropriate in-network discounts.

Please remember that the services of network Providers are paid for by the Fund at rates established by CareFirst BCBS ("PPO rate"). Participating Providers have agreed to accept this established fee as full payment for their services and have agreed not to "balance bill" participants. Therefore, once CareFirst BCBS has set the charges of network Providers, payment of this amount serves as full payment of the Provider's bill. Whether this amount is paid solely by the Fund or also requires a co-payment from you, the Provider is not entitled to "balance bill" you for an amount in excess of the rate set by CareFirst BCBS.

For example, suppose that you have services rendered by a Provider whose bill totals $50.00. CareFirst BCBS has set a PPO rate for this procedure of $40.00, which is the Allowed Amount. The bill is submitted to the Fund Office, which pays $36.00 in accordance with its Plan of Benefits ($20.00 Basic Benefit Allowance per visit plus 80% of balance of Allowed Amount). You are responsible for paying the remaining $4.00 (20% of balance of Allowed Amount). The Provider may not bill you for the $10.00 balance.

By contrast, if you use an out-of-network Provider, the Allowed Amount is the usual, customary and reasonable ("UCR") amount. The UCR amount is determined based on what Providers in this geographic area usually charge for the same or similar medical service. The Allowed Amount may be less than the amount billed by the Provider. The Fund will pay its share of the Allowed Amount (the Basic Benefit amount, if any, plus 80% of the excess under Major Medical). You will be responsible for the 20% Coinsurance as well as the balance billed by the Provider, if any. This may result in significantly higher out-of-pocket expenses than would be the case if you went to in-network Providers.

You should be aware that certain states prohibit balance billing. Recent federal law also prohibits balance billing for Emergency Services received at an out-of-network facility, care from an out-of-network Provider at an in-network facility, and air ambulance services. In such instances, you will be responsible for 20% of the Recognized Amount only. Your Coinsurance payment will also count toward your out-of-pocket maximum. In some circumstances, however, a Provider may balance bill you for these services if you provided written consent to be balance-billed.

Continuing Care Patients (see Definitions on page 5) may elect to receive continued coverage for a limited period at in-network rates if they are receiving care from a Provider or facility whose status changes from in-network to out-of-network due to their contract with CareFirst BCBS having been terminated or for some other reason. If a participant elects to receive continuing care, the Fund is required to cover the course of treatment administered by the Provider or facility on the same terms and conditions as would have applied and with respect to such items and services as would have been covered if the Provider or facility had

continued to be in-network. The Fund will provide continuing care for the lesser of (i) 90 days after a participant is notified of his or her right to continuing care; or (ii) the date when the participant is no longer a Continuing Care Patient with respect to the particular Provider or facility.

The Fund Office will send an Explanation of Benefits to you for each claim processed which will tell you the Allowed Amount, the amount paid by the Fund and the amount, if any, that you are responsible to pay.

COORDINATION OF BENEFITS

Where both spouses are working, members of a family may be covered under more than one group health plan. This may result in instances of duplication of coverage-where two plans are paying benefits for the same amount of hospital and medical expenses. For that reason, this Fund will coordinate the benefits payable under this Fund with any similar benefits payable under other plans that may also insure you and/or your eligible dependents.

Under this coordination of benefits, the total benefit received by any one person from all the plans combined may not exceed 100% of the total allowable expenses. Allowable expenses are any necessary and reasonable expenses for medical care or supplies covered by one or more of the plans insuring you or your dependents. Benefits are reduced only when necessary to prevent an individual from making a profit on his benefits.

You must report any duplicate coverage you or your dependents may have on the claim form you submit to the Fund Office.

Who Pays First

If duplicate coverage exists through two or more plans, one will be designated as Primary and will make payments up to the limits of its benefit allowances. The other plan or plans, designated as Secondary, will make additional payments up to the maximums available under these plans for any covered expenses not reimbursed by the Primary plan.

A. A plan covering a person as an employee will be Primary. A plan covering a person as a dependent will be Secondary.

B. If a dependent child is covered by both parents' health plans, and the parents are married to each other and live together, the benefits of the plan of the parent whose birthday occurs earlier in a calendar year will be Primary. The benefits of the plan of the parent whose birthday occurs later in a calendar year will be Secondary. (If both parents have the same birthday, the plan that has provided coverage longer is Primary.)

   If a plan containing the "birthday rule" is coordinating with a plan that contains the "gender rule" (father's coverage is Primary), and as a result the plans do not agree on the order of coverage, the gender rule will determine the order.

C. When the parents are divorced or separated the order is:

1. The plan of the parent with custody is Primary. The plan of the parent without custody is Secondary.

2. If the parent with custody has remarried, the order is:

   a. the plan of the parent with custody,

   b. the plan of the step-parent with whom the child resides,

   c. the plan of the parent without custody.

If, however, there is a court decree that meets the requirements of a Qualified Medical Child Support Order ("QMCSO"), which states that one of the parents is responsible for the child's health care expenses, the plan in which that parent is a participant is Primary.

Coordination with Medicare

In the event that an eligible employee or eligible dependent becomes covered under Medicare, this Fund will be Primary for as long as eligibility for coverage under this Fund continues. Medicare will be Secondary, paying only those covered costs that remain after the Fund has made its payments.

MEDICARE AND MEDICARE PART D

The Fund does not provide health coverage or prescription drug coverage to retirees. When you retire, you will lose eligibility for coverage from the Fund after you have worked an insufficient number of hours to retain eligibility. See Eligibility provisions above.

If you are approaching 65 and have not applied for Social Security Benefits, you should strongly consider filing a Medicare application during the three-month period prior to the month in which you become age 65 in order for Medicare coverage to begin at the start of the month in which you reach age 65. If you do not do so, you may be subject to late enrollment penalties, including increased premium payments and significant delays in coverage.

Because the potential penalties for failing to sign up for Medicare at the appropriate time are substantial, it is very important that you begin taking active steps to acquire Medicare for your retirement **at least** three months prior to reaching age 65. For more information on your Medicare options and the enrollment process, visit: https://www.medicare.gov/sign-up-change-plans/index.html. You may also call 800-MEDICARE (800-633-4227) for assistance. TTY users should call 877-486-2048.

You can enroll in a Medicare prescription drug plan ("Medicare Part D") when you first become eligible for Medicare and each year from October 15th through December 7th. You should note, however, that if you do not sign up for Medicare Part D when you first become eligible, you may have to pay a higher premium for your Medicare Part D coverage for as long as you are covered. In

order to avoid this situation, we recommend that you enroll in a Medicare Part D Plan as soon as you become eligible to do so.

Detailed information about Medicare plans that offer prescription drug coverage can be found in the "Medicare & You" handbook. If you have not received a copy, you can download it from www.medicare.gov/publications/pubs/pdf/10050.pdf. You can also get more information about Medicare prescription drug plans from: (a) visiting www.medicare.gov; (b) calling your State Health Insurance Assistance Program (see the inside back cover of the "Medicare and You" handbook for its telephone number); (c) calling 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

THIRD PARTY LIABILITY CLAIMS (REIMBURSEMENT/SUBROGATION)

This section addresses when a person who is eligible to receive benefits from this Fund is injured as a result of another party's wrongdoing or negligence. It may take months or even years for the injured person to obtain recovery in such a case, so the Fund pays for medical care otherwise covered under the Plan upon receipt of a signed statement from the Participant agreeing to repay the Fund for any and all expenses incurred by the Fund if and when the Participant or eligible dependent receives payments for their injuries from any source (such as from the wrongdoer or from an insurer).

An example of this would be if you or your spouse is injured in an automobile accident that was another person's fault. If the Fund pays $1,000.00 in benefits due to injuries resulting from the accident, and you or your spouse recovers money from the other driver, or from the other driver's insurance company, due to a legal suit or settlement, the Fund is entitled to receive up to $1,000.00 of such money as reimbursement for the benefits the Fund paid for you or your spouse.

The Fund has a right to first reimbursement out of any recovery from another party. Be accepting benefits from the Fund, you agree that any amounts recovered by the injured person (or by someone acting on the injured person's behalf) by judgment, settlement, compromise or otherwise will be applied first to reimburse the Fund even if the injured party is not made whole. The Fund has an equitable interest in any amounts that you recover, or will recover, for the entire amount paid by the Fund for your claim, and any amounts you recover must be segregated and held in trust on behalf of the Fund until the Fund's reimbursement rights are satisfied.

Claims arising from accidents will not be paid by the Fund until you have completed, signed and returned a reimbursement agreement in a form approved by the Trustees. **If you are represented by an attorney, it will be necessary for the attorney to also sign the form for benefits to be paid.** If you retain an attorney after you have submitted the reimbursement agreement to the Fund, the attorney will have to complete the form when retained.

You and your attorney must also provide proof, satisfactory to the Trustees, that no right, claim, interest, or cause of action against a third party has been, or will be, discharged or released without written consent of the Board of Trustees. Any settlement that you make against the other party must also be approved by the Trustees.

By accepting benefits from the Fund, you agree to notify the Fund promptly of efforts made to recover from a third party for such injuries, including when any third-party payments are made. You also agree that any amounts recovered, and regardless of whether the recovery is characterized as for medical expenses, are assets of the Fund and will be applied first to reimburse the Fund, in full and without any reduction for attorneys' fees or costs. You also agree to help the Fund in pursuing your claims against the other party, or to allow the Fund to pursue the claims on your behalf before any benefits are paid under this Plan. If the person who was injured is a minor, the parent or legal guardian must fulfill the above requirements on the child's behalf.

You should note that the Fund can seek recovery of any amounts you receive from another party even if you fail to inform the Fund of your claim or you fail to sign an agreement with the Fund. The Fund's subrogation right is established by the Plan and not by the agreement.

The Fund has a right to first reimbursement out of any recovery that the injured party receives from another party, whether or not you are made whole. This includes, but is not limited to, amounts that you may receive from a personal homeowners' insurance policy, an automobile insurance policy, or a group insurance arrangement of any kind. If the Fund pays benefits to you or your Dependents and you do not reimburse it after you recover from another party, or you fail to respond to the Fund's requests for information about the status of your claim, the Fund can withhold and offset any other benefits that may be payable to you or your Dependents, or may take legal action against you, in order to recover the amount paid, plus interest.

If it becomes necessary for the Fund to institute legal action against you for failure to reimburse it, in full, or to honor the equitable interest in the amount recovered by you from a third party, you will be liable for all costs of collection, including attorneys' fees and pre-judgment interest at a rate of 10% or at a rate determined by the Trustees to be assessed on the collection of delinquent contributions from employers, whichever is higher.

The Fund's right to reimbursement also includes the right to reimbursement from any payment made to you from any source to which you assign any claim against, or otherwise agree to reimburse any recovery from, the person who caused your injury.

The Trustees have absolute discretion to settle subrogation claims on any basis they deem warranted and appropriate under the circumstances.

If you or your dependent has any questions or is asked to waive any rights or compromise any claims covering any conditions for which you have received or expect to receive payment from the Fund, contact the Fund's Administrative Agent as soon as possible.

WEEKLY ACCIDENT AND SICKNESS BENEFITS

Eligible Employees Only

The weekly benefit shown in the Summary of Benefits on pages 3-4 will be payable to you if, while you're eligible under the Fund, you become disabled and can't work because of an injury or sickness while you are under the care of a legally qualified Provider, and for which benefits are not payable under a Workers' Compensation Law. The weekly benefit will begin effective on the first day of disability due to an accident, or the eighth day of disability caused by sickness.

The maximum benefit is thirteen (13) weeks per calendar year. Successive periods of disability separated by less than two (2) weeks of full-time active work will be treated as one period of disability when applied against the maximum benefit of thirteen (13) weeks, except if due to an unrelated cause or illness.

The Fund will pay you Weekly Accident and Sickness Benefit every week while you are disabled and prevented from working due to a "non-occupational" accident or disease for which benefits are "not" payable under the Workers' Compensation Law but only (a) after commencement of a Hospital confinement, or (b) where accident or illness involves a fracture procedure, or (c) for periods certified to by a legally-qualified Provider following surgery, provided all of the requirements are met.

Thereafter, you don't have to be confined to your home to collect these benefits. However, you do have to be under the care of a legally qualified Provider who must examine you once each week. Additionally, you may, from time to time, be asked to submit proof of your continued disability and/or be examined by a doctor appointed by the Fund.

This benefit is subject to FICA (Social Security) taxes during the first six months of unemployment. Of course, if you're working at any kind of job for which you receive wages or profits, or you're receiving Workers' Compensation, unemployment compensation or other government related benefits, you won't be entitled to weekly benefits from this Fund. Benefits are not available for disability resulting from inherently dangerous activities such as jet skiing, bungee jumping, etc.

DEATH BENEFITS

Eligible Employees Only

If you die from any cause-on or off the job-while you are eligible for benefits under this Fund, your beneficiary will receive the Death Benefit amount shown in the Summary of Benefits on pages 3-4.

The Fund will pay death benefits to the beneficiary whom you have designated on a form provided by and recorded with the Fund Office.

A. You can name anyone you wish to be your beneficiary;

B. You can name more than one person, such as your children; or

C. You can have your Death Benefit paid to your estate.

You may change your beneficiary at any time by filling out the proper form and filing it with the Fund Office. Remember, your circumstances may change at some point after you first named your beneficiary--due to death of your spouse, divorce, remarriage, and so forth. If you want your Death Benefit paid to the right person, then please keep your beneficiary designation up to date. The Fund will rely only on the most recent beneficiary designation submitted by you on file with the Administrative Agent of the Fund.

If any designated beneficiary dies before you, that beneficiary's right to the death benefit will terminate. If there is no beneficiary designation on file, or if the designated beneficiary dies before you, your death benefit will be paid in the following order, if living:

A. Your Spouse

B. Your Children (equal shares)

C. Your Parents (equal shares)

D. Your Brothers and Sisters (equal shares)

E. Your Estate

PREVENTIVE SERVICES

Preventive services rendered by a network provider are paid in full by the Fund. Preventive services and supplies are covered to the extent required of non-grandfathered plans by applicable law (although the Fund is a grandfathered plan).

Covered Preventive Services

The specific preventive services that are covered are determined on the basis of the following federal guidelines:

A. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved;

B. Immunizations for children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("Advisory Committee") with respect to the individual involved. A recommendation is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention ("CDC"). A recommendation is considered to be for routine use if it appears on the CDC's Immunization Schedules;

C. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and

D. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). Preventive services for women include Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).

A comprehensive list of available preventive services may be found at the following website:

www.healthcare.gov/preventive-care-benefits/

The types of preventive services required to be covered by non-grandfathered plans under applicable law may change as the above-referenced guidelines are updated from time to time. Such changes will be deemed to have been incorporated into the Plan by reference and will take effect with respect to the benefits provided by the Fund on the first day of the Plan Year beginning on or after one year following the date the change or update occurs.

Billing Rules for Preventive Services

Certain office visits-such as well woman checkups for women under age 65-are themselves covered as preventive services. For other office visits, if a preventive service is billed or tracked separately from an office visit, the Fund will impose any applicable cost-sharing provisions with respect to the office visit but not the preventive service. If the preventive service is not billed or tracked separately from an office visit, and if the primary purpose of the office visit is the delivery of the preventive service, then the Fund will not impose the applicable cost sharing provisions on the office visit. If a preventive service is not billed or tracked separately from an office visit, and if the primary purpose of the office visit is not the delivery of the preventive service, then the Fund may impose the applicable cost-sharing provisions with respect to the office visit.

Additional Information Regarding Preventive Services

To the extent not already set forth in the above-referenced federal guidelines, the Fund may impose reasonable, recognized rules or other limits with respect to the number of visits or treatments it will cover in any given period of time for any one particular preventive service. To the extent any such limits or other rules are inconsistent with the preventive service requirements of applicable law for non-grandfathered plans, such applicable laws will control.

Preventive services must be billed correctly under the appropriate service codes. Preventive services may be subject to reasonable medical cost management techniques and standards (e.g., treatment, setting, frequency and medical management standards) as imposed by the Trustees from time to time. Preventive services may not be covered depending on the service at issue and the presence of various risk factors. The Fund will not cover preventive services incurred for non-medical reasons. A service that is provided to monitor or treat an existing condition and not as a preventive service will be covered to the extent otherwise covered under the Plan and will be subject to the applicable cost-sharing provisions.

BASIC BENEFITS

Basic Benefit amounts are set forth in the Summary of Benefits on pages 3-4. Generally, the Basic Benefit amount for covered services is paid in full first, and then some of the remaining cost is paid under Major Medical (usually 80% of the Allowed Amount, the meaning of which varies depending on whether the Provider is in-network or out-of-network). Some services (e.g., physical therapy) are indicated there as Basic Benefit only.

Hospital Expense Benefits

Your Hospital Expense Benefits (including for nervous/mental conditions or substance use disorders) begin with the first day of your (or your eligible dependent's) confinement in a Hospital and covers the following expenses:

Room and Board

The Fund will pay for the Daily Room and Board Benefits shown in the Summary of Benefits on pages 3-4, multiplied by the number of days of confinement for each separate and unrelated illness or accident. The Basic Benefit for room and board is limited to a total of 31 days for any one continuous period of confinement.

Additional Hospital Charges

The Fund will also pay for any miscellaneous hospital expenses you have while confined in a Hospital, such as the use of an operating room, x-rays, laboratory tests, medicines, including anesthesia, and for local professional ambulance service to and from the Hospital. The maximum amount payable for these Additional Hospital Charges is shown in the Summary of Benefits on pages 3-4.

NOTE: Except for where it is specifically provided for in the Fund (see "out-patient" Hospital Treatment) you must be admitted to a Hospital and incur Room and Board charges before these Additional Hospital Expenses become covered by the Fund.

Out-Patient Hospital Treatment

If hospital charges are incurred by you or one of your eligible dependents where:

A. Emergency treatment is provided within 72 hours of an accidental bodily injury, physical attack or unexpected onset of serious illness; or

B. Surgery is performed.

The Fund will pay for these expenses up to the maximum amounts shown in the Summary of Benefits on pages 3-4 and additional Hospital Charges and Surgical Expense Benefits even though you or your dependent is not confined as a bed patient. Out-Patient Hospital Treatment includes emergency treatment of nervous/mental health conditions and substance use disorder.

Maternity Benefits

Note: maternity benefits are payable only if delivery occurs while you are eligible under the Fund.

If pregnancy, resulting in childbirth, abortion, or miscarriage, requires Hospital admission, the Fund will pay for all Room and Board and Additional Hospital Charges on the same basis as any other illness, up to the maximum amounts shown in the Summary of Benefits on pages 3-4.

The Fund pays the fee charged by a Provider for delivery or other obstetrical procedures at the PPO rate (if in-network) or at the UCR rate (if out-of-network) up to $1,000.00 per condition. The excess of your maternity expenses not covered by the Basic Benefits described above will be treated as Covered Expenses under the Fund's Major Medical Benefit.

Newborns' and Mothers' Health Protection Act

Federal law generally bars group health plans and health insurance issuers from restricting benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, federal law bars plans and issuers from requiring that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours following a C section).

Diagnostic X-Ray and Laboratory Expense Benefits

If out-of-hospital x-ray or laboratory examinations are required for the diagnosis of a non-job-related accident or sickness other than COVID-19, the Fund will pay for these expenses up to the maximum amount shown in the Summary of Benefits on pages 3-4. Each eligible family member is entitled to the maximum benefit.

NOTE: The maximum amount applies to all conditions other than COVID-19 treated during a calendar year.

The excess of your diagnostic expenses not covered by the Basic Benefits described above will be treated as covered expenses under the Fund's Major Medical Benefit.

Vaccination, Testing and Treatment of COVID-19

The Fund covers the cost of expenses for vaccinations for COVID-19 at 100%. The Fund will also cover 100% of oral antiviral treatments of COVID-19 that have received approval from the FDA (including through emergency use authorization). Coverage of oral antiviral treatments of COVID-19 is limited to participants and beneficiaries who have reached the minimum age for which the FDA has approved the use of these antiviral treatments. Coverage of approved oral antiviral treatments will be limited to one course of therapy within a thirty-day period.

The Fund will also fully cover the cost of diagnostic testing for COVID-19 in most circumstances. When a COVID-19 test is ordered by a medical professional, the Fund will cover the cost of the test at 100% regardless of the setting of the testing (e.g., emergency room, urgent care center, Provider office or over-the-counter ("OTC") test). The Fund also pays laboratory costs incurred to test for COVID-19 at 100% regardless of whether the diagnostic testing is performed by an in-network or out-of-network Provider.

For tests ordered by a medical professional, the Fund will pay a network Provider the negotiated rate. The Fund will pay an out-of-network Provider the cash price for such services as listed by the Provider on a public internet website, or the rate negotiated by the Fund and the Provider if less than the publicly-listed price.

The Fund will also cover the cost of OTC tests designed to detect or diagnose COVID-19 without an order or individualized clinical assessment by a Provider. Coverage of OTC COVID-19 tests obtained without an order by a Provider is limited to 8 tests every thirty-day period per participant or beneficiary. The Fund has partnered with CVS/Caremark to provide OTC COVID-19 tests directly to participants and beneficiaries in store at participating pharmacies and through a mail order program without requiring any upfront payment. Under these circumstances, the Fund will reimburse participants and beneficiaries for OTC COVID-19 tests purchased from non-preferred pharmacies or other retailers at the actual price of each test or $12.00 (whichever is lower). For periods during which

the Fund does not provide for participants or beneficiaries to directly receive OTC COVID-19 tests in store and through a mail order program without requiring upfront payment, the Fund will reimburse 100% of the cost of OTC COVID-19 tests purchased from any retailer or pharmacy.

Requests for reimbursement of OTC COVID-19 tests must be submitted to CVS/Caremark in paper, online at Caremark.com or through the CVS Caremark mobile app. Requests for reimbursement must be supported by a receipt as proof of purchase. Participants or beneficiaries submitting a request for reimbursement will be required to attest that the OTC test was purchased for personal use and not for employment purposes, and that it has not been reimbursed by another source or purchased for resale.

Provider Visits

If you have a non-job-related accident or sickness that requires a Provider's attention, you may select any Provider licensed to provide the needed treatment for your condition. Under the Basic Benefit, the Fund pays $20.00 for each visit to the Provider up to a maximum of 20 visits in a Calendar Year for each separate and unrelated medical condition

However, only one visit per day is covered for each separate condition. Also, post-operative visits are not covered under the Basic Benefit for Provider visits for six weeks after surgery because the cost of these visits is covered under the Basic Benefit for surgical benefits (see below).

The excess of your Provider visit expenses not covered by the Basic Benefits described above will be treated as Covered Expenses under the Fund's Major Medical Benefit. Office visits for nervous/mental conditions or for substance use disorders will be paid under the Basic Benefit (and Major Medical) to the same extent as for medical Provider visits.

Surgical Benefits

When you or one of your eligible dependents has non-cosmetic surgery, the Fund will pay for the operation at the PPO rate (if in-network) or at the UCR rate (if out-of-network) up to $1,000.00 per condition.

The surgery must be:

A. Recommended, approved, and performed by a licensed Provider; and

B. The result of a non-job-related accident or sickness.

Hospital confinement is not necessary to receive these benefits.

When you have two or more operations due to the same or related conditions, the Fund will pay no more than $1,000.00 per condition per year as a Basic Benefit. Benefits for successive operations will be deducted from the same yearly benefit amount (if any remains) UNLESS they have been performed in a different calendar year.

When you have two or more surgical operations performed at the same time, the Fund will:

A. Treat them as a single operation if the same incision is used and pay 100% of the Schedule amount for the major operation AND 50% for all secondary procedures;

B. Treat them as separate operations and pay the maximum allowed for each IF different operative areas and different causes are involved. In that case, the Fund will pay for each separate operation at the PPO rate (if in-network) or at the UCR rate (if out-of-network) up to $1,000.00 per condition.

The excess of your surgical expenses not covered by the Basic Benefits described above will be treated as Covered Expenses under the Fund's Major Medical Benefit.

Physical Examinations

If you or your dependents are given a complete physical examination that is not a preventive service covered at 100% in-network by the Fund (see page 24), you will be entitled to reimbursement of the Allowed Amount up to the Basic Benefit shown in the Schedule of Benefits in any one calendar year. The excess of the Allowed Amount not covered by the Basic Benefit will be covered under the Fund's Major Medical Benefit.

Physical Therapy

The Fund will provide a physical therapy benefit for you and your eligible dependents under your Basic Benefit only. This benefit will provide for fifteen (15) visits per calendar year, payable at 100% of the Allowed Amount per year. You will be required to present a letter of medical necessity from your Provider prior to payment of any claims.

Organ Transplants

Basic Benefits for claims involving organ transplants will be handled as follows:

A. If only the donor is an eligible employee, the Fund will provide no benefits.

B. If only the recipient is an eligible employee, the Fund will provide benefits for both the donor and the recipient subject to the maximums applicable to the recipient.

C. If both the donor and the recipient are eligible employees, the Fund will provide benefits for each under each one's respective record.

What's Not Covered Under Your Basic Benefits

In addition to the list of items that will not be covered medical expenses under either the Basic Benefits or the Major Medical Expense Benefits described later in this booklet, Basic Benefits are NOT payable for the following:

A. Prosthetics

B. Services of podiatrists, or

C. Services of chiropractors,

but these services will be covered under Major Medical Expense Benefits to the extent set forth below.

MAJOR MEDICAL EXPENSE BENEFITS

The Major Medical Benefit is designed to protect you against the cost of large medical expenses that may exceed the benefits you receive under other portions of the basic Plan of Benefits. Major Medical Benefits are in addition to your Basic Benefits under the Plan and include benefits for so-called catastrophic or disaster-types of illness or injury that may require hospitalization and/or surgery.

Description of Benefits

Basic Benefits are benefits paid by the Fund for Covered Expenses as described in the preceding section of this booklet. Those benefits are paid at 100% of the Allowed Amount up to the limits set forth in the Summary of Benefits on pages 3-4 in any one calendar year. If you have expenses beyond those limits, in most cases (except where the Summary of Benefits says "Basic Benefit only"), the Fund will pay 80% of the Allowed Amount of Covered Expenses that exceed your Basic Benefits under the Major Medical Expense Benefits ("Major Medical"). Additionally, there are some items that are not covered under Basic Benefits but are covered as Major Medical items. What is excluded under the Basic Benefits and what additional items may be covered as Major Medical expenses are set forth below. Major Medical Benefits for each of your eligible dependents is provided on the same basis as your own.

You are generally responsible for the 20% of the Allowed Amount that is not covered by Major Medical. With respect to care received from out-of-network Providers, you are generally responsible for the 20% of the Allowed Amount that is not covered by Major Medical and for any amounts that are balance billed by the Provider. However, if you received care from an out-of-network Provider at an in-network facility, Emergency Services from an out-of-network Provider, or out-of-network air ambulance services, the Plan pays the Out-of-Network Rate. You are responsible for paying 20% of the Recognized Amount, and you cannot be balance-billed. In some circumstances, however, a Provider may balance bill you if you provided written consent to be balance-billed. You will also only be responsible for paying 20% of the Recognized Amount if the Fund's provider

database mistakenly states that an out-of-network Provider is an in-network Provider.

Out-of-Pocket Maximum

The Fund limits your responsibility to pay for Covered Expenses to the annual Out-of-Pocket Maximum amount shown in the Summary of Benefits. The Out-of-Pocket maximum is a limit on the amount you are required to pay during each calendar year. Amounts you pay in Coinsurance for Covered Expenses, including your share of the Recognized Amount when applicable, count toward this maximum. Non-covered expenses, penalties, or balance billed amounts you are required to pay for out-of-network care do not count toward this maximum. After your out-of-pocket costs for Covered Expenses have exceeded the Out-of-Pocket Maximum, the Fund pays 100% of the Allowed Amount for Covered Expenses for the remainder of the calendar year. If you have other family members in this plan, the individual out-of-pocket maximum applies to each family member individually until the overall family out-of-pocket maximum has been met.

What is Covered Under Major Medical

As noted above, Major Medical covers expenses beyond those covered under the Basic Benefits and Preventive Services as well as the following specific types of charges if they are reasonable charges outlined for necessary medical care and services which are ordered by a legally qualified Provider:

A. Charges made by a duly constituted hospital; except that the daily room and board charges may not exceed the hospital's regular rate for semi-private or intensive care accommodations.

B. Charges for diagnosis, treatment, administration of anesthesia and surgery by a legally qualified Provider.

C. Charges made for in-patient and/or outpatient treatment of substance use disorders or nervous/mental disorders.

D. Charges for the following: local ambulance service, equipment, appliances, X-ray services, laboratory tests, anesthesia, the use of radium and radioactive isotopes, oxygen, iron lung, supplies, treatment, and manipulation provided by a chiropractor.

E. Growth hormone therapy due to a diagnosis of growth hormone deficiency in children, covered at 80% with the following restrictions/conditions:

    1. Verification of medical necessity must be provided through the Fund's medical consultant;

    2. Diagnosis must be made in the child prior to age 11;

    3. Continued coverage is contingent upon annual re-verification of medical necessity by the Fund's medical consultant;

    4. Coverage for this therapy will cease when the child attains age 18.

In the case of expenses incurred for care by an out-of-network provider at an in-network facility, in connection with out-of-network care at an Emergency Department for Emergency Services, or for air ambulance services by an out-of-network provider, expenses beyond those that may be covered as a Basic Benefit are paid at the Out-of-Network Rate as a Major Medical Benefit (including all Covered Expenses).

Women's Health and Cancer Rights Act of 1998

In the case of any participant or beneficiary receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided under the Plan in a manner determined in consultation with the attending Provider and the patient for:

A. Reconstruction of the breast on which the mastectomy was performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

C. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

As with other benefits under the Plan, applicable Coinsurance applies to the above coverage.

NON-COVERED MEDICAL EXPENSES

Payment will NOT be made for the following Medical Expenses under either the Basic Benefit or the Major Medical Expense Benefit:

A. Charges not prescribed as necessary by a legally qualified Provider;

B. Charges incurred for confinement in a hospital owned or operated by the Federal government;

C. Charges that you are not required to pay;

D. Charges incurred for services performed on or to the teeth, except as required because of accidental injury to natural teeth, including replacement of teeth, treatment of fractured jaw and related X-rays (may be covered under dental benefit-see below);

E. Cosmetic surgery, except as required because of accidental injury;

F. Eye refractions, eye glasses or their fittings (may be covered under vision care benefit – see below);

G. Hearing aids or their fittings (may be covered under hearing aid benefit-see below);

H. Transportation, except local ambulance service;

I. Injury as a result of war, declared or undeclared, including armed aggression;

J. Accidental bodily injury or disease arising out of and in the course of your employment;

K. Intentionally self-inflicted injury or injury arising out of and in the course of committing a crime;

L. Charges for education, training and bed and board while you or your dependent are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home;

M. 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 as determined by the American Medical Association or any items requiring governmental approval which approval was not granted or in existence at the time the services were rendered, are excluded and not covered by the Plan;

N. Prescription drugs (may be covered under prescription benefit-see below);

O. Charges for home nursing care or private duty nursing;

P. Charges of a podiatrist for office visits only;

Q. Charges of a chiropractor for office visits only.

DENTAL BENEFITS

The Fund will pay for dental examinations, cleanings, fillings, and other dental services up to the amount shown in the Summary of Benefits on pages 3-4, for you or your dependents.

For covered individuals under the age of 19, no annual dollar limit on essential pediatric dental benefits will apply. The following are essential pediatric dental benefits covered with no annual dollar limit under the Plan:

A. Dental care, treatment, surgery and appliances needed due to an accidental injury to healthy teeth (this excludes injuries from chewing or biting);

B. Anesthesia and facility charges when treatment needs general anesthesia supervised by a Provider in a hospital, surgical center or dental office (prior authorization is needed);

C. Bitewing X-rays as needed (not to exceed once every six months);

D. Complete mouth X-rays and panoramic X-ray as needed (not to exceed once every 24 months);

E. Amalgam, silicate, sedative and composite resin fillings (this includes the replacement of existing restorations);

F. Stainless steel crowns to posterior and anterior teeth;

G. Porcelain crowns to anterior teeth;

H. Simple extractions and extractions of impacted teeth;

I. Space maintainers on permanent teeth through age 15;

J. Pulpotomy, pulpectomy and root canals;

K. Fluoride treatments (limited to one every six months);

L. Prophylaxis (one every six months); and

M. Gingivectomy, gingivoplasty and gingival curettage.

The following items are non-essential pediatric dental benefits, and are covered only up to the annual limit set forth in the Summary of Benefits:*

A. Orthodontics;

B. Dentures;

C. Occlusional reconstruction; and

D. Inlays.

* Unless related to accidental injury or are recommended by the child's Provider or dentist to treat severe craniofacial anomalies or full-cusp Class III malocclusions.

VISION CARE BENEFITS

These are the vision care benefits you and your family are entitled to receive **annually** through the Fund:

A. A complete eye examination by a qualified registered optometrist or ophthalmologist; and

B. A pair of lenses and frame, if required.

You can elect to go to the doctor (optometrist, oculist, or ophthalmologist) of your choice, and you will be reimbursed for your expense up to the maximum benefit of $400.00 per person annually for you and each of your eligible dependents. For covered individuals under the age of 19, no annual dollar limit will apply on an annual eye examination and one pair of eyeglasses (if Medically Necessary) with covered lenses. Covered lenses include plastic lenses (including scratch-resistant coatings) and polycarbonate single-vision, bi-focal, tri-focal and lenticular lenses. Contact lenses are covered when vision cannot be corrected with eyeglasses.

To Get Your Vision Care Benefits You Must First

Contact the Fund Office for a Vision Care eligibility claim form. This form must be completed by the doctor and returned to the Fund Office before we can reimburse you.

HEARING AID BENEFITS

The Fund provides coverage for charges for hearing aids, limited to a maximum per person of $500.00 every three consecutive calendar years. If you have not used the maximum amount, the balance may be used for hearing aid repairs and/or batteries.

Through a partnership with Audicus, Participants who purchase hearing aids from Audicus will receive a discount on their purchase. Please see Audicus' website at www.audicus.com for more information about Audicus and how to make use of the offered discount.

PRESCRIPTION DRUG CARD PROGRAM

The Fund's prescription drug card program is provided through CVS/Caremark, and once you become eligible under the Fund, you will receive a prescription drug card and a list of participating pharmacies. Some important features and limits of the prescription drug card program are described below.

Covered Prescription Drug Expenses

Benefits are payable for any *Medically Necessary* FDA-approved generic drug prescribed by a licensed Provider. FDA-approved means that the Federal Drug Administration (FDA) has approved the drug as safe and effective treatment for certain illnesses or conditions.

Benefits are only available for drugs for which a prescription is required. Medication that you buy "over the counter" such as aspirin or antacids, are *not* covered under the prescription drug program.

Benefits are payable for medications prescribed for nervous/mental health conditions or substance use disorder to the same extent as medications prescribed for medical conditions.

Participating Pharmacy

You must obtain your prescriptions from a pharmacy that participates in the Prescription Drug Program through CVS/Caremark and pay the appropriate co-payment. The Fund will pay the balance of the cost subject to the limitations in this section. **If you obtain a prescription at a non-participating pharmacy, the Fund will not reimburse you for any portion of the cost of the prescription.**

Co-Payments

The co-payments vary depending on whether you obtain a **generic, brand-name, or non-formulary** prescription. A **generic** drug is one that is chemically similar to the brand name drug and becomes available once the patent for the brand name drug has expired. It is typically less expensive. A **brand-name** drug is a drug protected by a patent and other companies cannot manufacture the drug until the patent expires (unless they obtain permission from the patent holder).

When you get a prescription for a brand-name medication that does not have a generic equivalent, and that medication appears on the list of prescription drugs or formulary developed by CVS/Caremark, the Fund will be entitled to a rebate from those companies that manufacture those drugs. This rebate will be used to offset the costs to the Fund for the prescription drug program.

Your co-payment for brand name drugs that appear on the formulary list will be $15.00. If you obtain a brand name drug that is *not* on the formulary (**non-formulary**) your co-payment will be $30.00.

In summary, your co-payment for up to a 30-day supply purchased at a participating pharmacy, based on which prescription you or your Provider chooses is:

Generic:	**$5.00**
Brand:	**$15.00**
Non-Formulary:	**$30.00**

Excluded Drugs and Prior Authorizations

CVS/Caremark excludes certain prescription drugs from coverage. Generally, these are brand-name drugs for which less expensive alternatives are available. You can obtain a list of the excluded drugs from the Fund Office. The list of excluded drugs is subject to change. Coverage will only be provided by the Fund for these excluded drugs if a prior authorization is obtained from CVS/Caremark by the prescribing Provider who indicates that the particular drug is clinically necessary for the patient. The co-payment amount for excluded drugs for which a prior authorization is obtained will be $30.00.

Prior authorization is also required for all prescriptions for compound drugs that cost $300.00 or more. Compounds can contain substances that have not been rigorously tested for safety or effectiveness nor are all compounds approved by the FDA for use by the prescribed route of administration. Excluding certain ingredients and determining coverage through a prior authorization process helps to ensure that coverage is available for compound ingredients that are safe and likely to be effective for their intended use. Coverage for certain compounding chemicals (bulk compounding powders and bases) will be excluded from the prescription benefit.

Your Provider may request additional information or choose to initiate the prior authorization process for you by calling 800-294-5979.

Prescription Drug Expenses that are NOT COVERED

The Fund does not cover:

A. Non-legend ("over-the-counter") drugs even if prescribed by a Provider;

B. Drugs deemed excluded by CVS/Caremark for which no prior authorization is obtained from the prescribing Provider;

C. Vitamins, minerals, dietary supplements, dietary drugs, etc.;

D. Medications whose primary purpose is cosmetic in nature;

E. Nicorette, Habitrol or other smoking cessation prescription drugs;

F. Therapeutic devices or appliance, including prescription digital therapeutics (PDT) which may be software or a mobile application;

G. Imcivree;

H. Hypodermic needles or syringes (except those associated with insulin injections);

I. Fertility medications;

J. Diagnostics;

K. Rogaine, Minoxidil Solution, or any medication to promote hair growth;

L. Genetically engineered drugs;

M. Viagra (or its generic equivalent) or other prescription drugs for sexual dysfunction or inadequacy;

N. Growth Hormone Therapy (except for growth hormone deficiency in children-covered under Major Medical with restrictions, see above);

O. Spinraza (may be covered under Major Medical under appropriate circumstances with prior authorization)

Prescription Drug Identification Card

All covered employees will receive a Prescription Drug Identification Card which is only valid if you are eligible under the Fund. This card covers all eligible members of the family.

When you or one of your eligible dependents need to have a prescription filled, you must present your card to the participating pharmacist along with the prescription. Remember, the card may be used only on behalf of persons eligible under the Fund. Unauthorized or fraudulent use of your card to obtain prescription drugs will result in immediate cancellation of your prescription drug benefit and may cause the Fund to seek recovery of claims paid.

Maintenance Drugs and Mail Order Prescriptions

Maintenance drugs must be purchased at a CVS Pharmacy or through the mail order program. "Maintenance drugs" are drugs, which are prescribed for a long period of time and are necessary to sustain good health. Examples are drugs used to treat high blood pressure, diabetes, and arthritis. You will only be allowed to fill a prescription for a maintenance medication for less than a 90-day supply two times. After that, you will be required to get a 90-day supply either at a CVS Pharmacy or through the Mail Order Program.

Maintenance Drugs Purchased at CVS

Present your prescription for maintenance medications at a CVS Pharmacy and you will receive up to a 90-day supply for the mail order copayment.

Maintenance Drugs Purchased through the Mail Order Program

The first time you purchase a maintenance drug, you should get two prescriptions from your Provider. One prescription should be for a 14-day supply, which you may obtain at a participating pharmacy using your prescription drug card. The second prescription will be used to order a larger supply, up to a 90-day supply, through the mail order program.

Copayments for mail order drugs (up to a 90-day supply) are:

Generic:	**$10.00**
Brand:	**$30.00**
Non-formulary:	**$60.00**

How to Receive Mail Order Prescriptions

A. Get a prescription mail order form from the Fund Office, CVS/Caremark or online (at www.caremark.com , click on "Print Plan Forms").

B. Complete the form and mail it, along with the prescription, to the CVS/Caremark mail order facility at the address on the mail order form. Your prescription will then be sent to you through the mail.

C. Get refills by returning the refill card or calling the toll-free number at the mail order facility. You may receive as many refills as your Provider indicates are necessary on the original prescription.

Generic Step Therapy

This program saves costs by encouraging you and your Provider to choose a lower-cost, generic medicine as the first step in treating your health condition. Some health conditions have many treatment options that vary in cost. Just because a medicine costs more doesn't mean it works better. Generic Step Therapy helps make sure the medicines that are effective and priced right are used first.

With Generic Step Therapy, if you choose to stay on your current, higher-cost brand-name medicine, you may have to pay the full price if you have not first tried a generic option to treat your health condition. For some health conditions, you may have to try two generic options before the Fund will cover the brand-name medicine. If you have questions about Generic Step Therapy, call the toll-free number on the back of your prescription ID card.

Specialty Drugs

At times, certain medical conditions call for the use of specialty drugs, which are extremely costly to the Fund. A Specialty Drug is a drug that is biologically derived and that is on the list of specialty drugs maintained by CVS/Caremark.

To manage participants' use of Specialty Drugs, the Fund participates in CVS/Caremark's "Specialty Guideline Management Program." Under this program, all Specialty Drugs must be filled through CVS/Caremark's dedicated pharmacies.

A list of CVS/Caremark's specialty pharmacies can be found at www.caremark.com. The Fund also participates in the Preferred Plan Design feature, which will require you to use lower cost specialty drugs before trying more costly drugs (similar to the Generic Step Therapy program explained above).

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) Program is designed to help control increasing health care costs by avoiding unnecessary services or treatments that are more costly than other available effective treatments. If you do not follow these procedures, you will have to pay more out of your own pocket, in addition to any Coinsurance.

Prior to any scheduled Hospital admission, you or your Provider must call American Health Holdings for pre-admission certification. American Health Holdings will review the proposed treatment plan with your Provider to assure your care is appropriate. Check your health plan member ID card for the telephone number you are required to call for pre-certification.

Pre-admission certification is not required in connection with Emergency Services. In the event of an Emergency Medical Condition, go straight to the Emergency Department. You or a family member must notify American Health Holdings within 48 hours of the emergency care.

The Plan's Utilization Management Program consists of:

A. Pre-certification review of proposed health care services before the services are provided.

    1. Some Providers may obtain pre-certification for you. However, you are responsible for ensuring that hospital services have been pre-certified. Therefore, you should confirm pre-certification with your Provider prior to Hospital admission.

2. If you are expecting a baby, you should call about 30 days before your delivery date and then call again within 48 hours once you are admitted for delivery.

B. Case Management, whereby the patient, the patient's family, and the patient's Providers work with the UM Company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for patients who require complex, high-technology medical services. Case management may include prior approval for treatment, discharge planning and psychiatric procedure review, among other things.

The UM Program is currently administered by American Health Holding. The health care professionals in the UM Company focus on:

A. Necessity and appropriateness of Hospital stays, and

B. Necessity, appropriateness, and cost-effectiveness of proposed services for medical or surgical care, nervous/mental health conditions, or substance use disorder.

The UM Company determines whether a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms of this Plan.

IMPORTANT

Your Provider's recommendation for surgery, hospitalization, confinement in a specialized health care facility, or other medical services or supplies does not mean that the recommended services or supplies will be considered Medically Necessary for determining coverage for medical benefits under the Plan.

The UM Company does not diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification does not guarantee a benefit payment. Payment of benefits is subject to the terms and conditions of the Plan as described in this Plan document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

All treatment decisions rest with you and your Provider. You should follow whatever course of treatment you and your Provider believe to be the most appropriate, even if the UM Company does not certify the proposed medical treatment, hospitalization, or confinement in a specialized health care facility as Medically Necessary. The benefits payable by the Plan may, however, be affected by the determination of the UM Company.

Note: The Administrator, the Plan, and the UM Company are not engaged in the practice of medicine, and none is responsible for the quality of health care services actually provided, whether or not certified by the UM Company as Medically Necessary.

What Happens if you do not Follow Required Utilization Management Procedures

If you do not follow the required Utilization Management procedures outlined above, your claim for benefits will be referred to the UM Company for a retrospective review to determine if the services are Medically Necessary.

If the UM Company determines that the services are not Medically Necessary, no Plan benefits will be payable for those services.

If the UM Company determines that the services are Medically Necessary, Plan benefits will be payable for those services. However, you will have to pay up to an additional $100.00 toward the cost of services, in addition to Coinsurance that may apply.

PAYMENT OF CLAIMS

File Your Claim At Once!

A. Get your information from the Administrator. Complete employee information portion and sign the form.

B. Have the form filled out by the Provider or hospital.

C. At the time you receive treatment from the Provider or hospital, review your bill closely to ensure that you actually received the treatment and services for which you are being charged.

D. Sign only one claim form for each visit to your Provider. It is not necessary to sign more than one claim form for each visit.

E. Attach all receipts and bills to the claim form.

F. If you wish the Fund to make payment directly to the Provider, you must also sign the assignment on each form.

G. If payment is to be made directly to you, you must include paid receipts with the claim.

H. Mail the form to the Fund Office:

METROPOLITAN DC PAVING INDUSTRY
EMPLOYEES HEALTH AND WELFARE FUND
PO BOX 564
TROY, MI 48099

The Administrative Agent will have on hand a claim form to be used for accident and sickness, medical expense benefits, and diagnostic X-ray and laboratory services. The death benefit claim form should also be secured directly from the Fund Office.

CLAIMS FILED IN THE FUND OFFICE IN EXCESS OF ONE YEAR FOLLOWING THE DATE THE CLAIM OCCURRED OR SERVICE WAS RENDERED WILL NOT BE HONORED FOR PAYMENT.

We urge you to file claims promptly.

See the ERISA Claims and Appeals Procedure section of this booklet for more complete information.

PENALTY FOR FALSIFYING CLAIM OR FAILURE TO REFUND OVERPAYMENT

Any employee who, through error or misrepresentation, received improper payments from the Fund for himself or his dependents or former dependents, must make immediate repayment to the Fund upon request. Failure to comply within 30 days will result in the following penalties.

A. Interest will be added to the amount due at the rate of 6% per annum; and

B. If still not paid at the end of ninety (90) days, the employee's eligibility will be terminated; and

C. The employee's eligibility will not be reinstated until 12 months after the date of repayment after which he must work enough hours to satisfy the reinstatement rule.

D. All claims presented to the Fund for payment, in the interim of the 90 days prior to losing eligibility under item 2, will be applied to the amount of repayment due from the employee.

E. The Trustees reserve the right to waive any or all of these provisions in whole or in part.

BASIC PLAN INFORMATION

The following information is required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended (ERISA):

Summary Plan Description

A. The name of the plan is

Metropolitan D.C. Paving Industry Employees Health and Welfare Fund.

B. The name and address of the joint board of trustees comprised of representatives of the parties that established or maintain the plan is:

JOINT BOARD OF TRUSTEES
METROPOLITAN DC PAVING INDUSTRY
EMPLOYEES HEALTH AND WELFARE FUND
7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MD 21046

The Plan is maintained by employers obligated to make contributions to the Fund pursuant to collective bargaining agreements with certain employee organizations. Participants and beneficiaries may obtain from the Plan Administrator, upon written request, a complete list of the employers and employee organizations sponsoring the plan. Participants and beneficiaries may also receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund and, if the employer or employee organization is a Fund sponsor, the sponsor's address.

C. The employer identification number assigned to the Fund by the Internal Revenue Service is: 52-6098777. The Plan number assigned by the Joint Board of Trustees is: 501.

D. This Welfare Fund provides coverage for hospitalization, medical care, prescription drugs, dental and vision care, disability income and death benefits.

E. The day-to-day administration of the Fund is carried out by a contract administrator, BeneSys, Inc.

F. The name, address and telephone number of the Plan Administrator is:

BENESYS, INC.
7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MD 21046
(410) 872-9541

G. The name and address of the person designated as agent for the service of legal process is:

DINAH S LEVENTHAL, ESQ.
O'DONOGHUE & O'DONOGHUE, LLP
5301 WISCONSIN AVENUE, NW, SUITE 800
WASHINGTON, DC 20015

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

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

UNION TRUSTEES	**EMPLOYER TRUSTEES**
Julio Palomo Baltimore Washington District Council LiUNA 9104 Old Marlboro Pike Upper Marlboro, MD 20772	Ralph Kew Fort Myer Construction Co. 2237 33rd Street, NE Washington, DC 20018
Stephen Lanning Laborers' Local 11 5201 1st Place, NE Washington, DC 20011	Lewis Shrensky Fort Myer Construction Co. 2237 33rd Street, NE Washington, DC 20018
Jamie Buck Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Daniel Mullally Civil Construction LLC 2413 Schuster Drive Hyattsville, MD 20781
Mark Wildsmith Cement Masons Local 592 2843 Snyder Avenue Philadelphia, PA 19145	

I. The Fund 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 Fund Administrator. The Fund will make reasonable charge to provide copies of any such agreements, and the amount of that charge can be obtained from the Fund Administrator's office.

Also, the above-described materials are available for examination by participants and beneficiaries at all times at the principal office of the Fund Administrator and at each employer establishment at which at least 50 participants covered under the Plan are customarily working.

J. The Fund'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.

K. This Summary Plan Description sets forth the circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of benefits.

Those include, but are not necessarily limited to, the following:

1. Failure to satisfy eligibility requirements stipulated in the Plan by:
   i. insufficient employment under jurisdiction of the Plan;
   ii. insufficient employment due to disability for periods of time prior to or following periods during which credit is available;
2. Non-covered employment (employer not required to make contributions on employee's behalf);
3. Failure to file promptly and in good faith the necessary forms and other information required in support of a claim;
4. Failure to file claims within the time limit specified in the Plan;
5. A material false statement may result in denial of a claim;
6. Entrance into the Armed Forces will operate to terminate eligibility under the Plan except as may be required by the Uniformed Services Employment and Re-employment Rights Act ("USERRA");
7. No expense which is recoverable under the Medicare Program will be paid by the Fund;
8. Injuries sustained in the course of criminal activity are not covered under the Plan;
9. Employment for a delinquent employer that fails to pay contributions to the Fund for a three (3) month consecutive period or for a three (3) out of six (6) month period.

The Trustees specifically reserve the right to change, eliminate, add to, or delete from the schedule of benefits provided to Participants and to their Dependents. The Trustees also reserve the right to terminate, suspend, amend, or modify the Plan, in whole or in part at any time, and to adopt new Fund rules and regulations or to modify the existing rules and regulations. ***Nothing in this book or elsewhere should be construed to mean the Fund's benefits are guaranteed.*** Pursuant to the Fund's Trust Agreement, the Plan may be terminated, suspended, amended, or modified by a majority vote of Trustees. Any of the aforesaid changes in the Plan shall be reflected in meeting minutes, Summary of Material Modifications or other written document retained in the Fund's files. The Trustees will notify Participants when they make significant changes in the rules, regulations, or schedule of benefits.

L. A description of the rights and obligations of participants and beneficiaries with regard to continuation coverage is provided in this booklet.

M. The source of contributions to the Fund is contributions made by individual employers under the provisions of the applicable collective bargaining agreement.

N. The Plan is funded through employer contributions to the Fund and through any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees or their dependents, and the paying of all expenses incurred with respect to the operation of the Fund. This is a self-insured Plan.

O. The Fund's annual fiscal year end date is September 30.

P. The Fund's claims and appeals procedures are set forth later in this booklet.

Q. The Fund's statement of ERISA rights is set forth later in this booklet.

R. The Fund's statement regarding maternity and newborn infant coverage is set forth in this booklet.

ERISA CLAIMS AND APPEALS PROCEDURES

General Information

All persons requesting benefits from the Fund shall be required to file a signed written claim for benefits on forms provided at the office of the Fund's Administrative Agent. Claims may be made by the participant or dependent directly or through a Provider subject to the Fund's limitations on assignments.

Requests for determination of whether a person is eligible for benefits will not be considered a claim. Similarly, casual inquiries about benefits or the circumstances under which benefits might be paid will not be considered a claim. Except where there are extenuating circumstances such as an emergency, a verbal inquiry (such as a telephone call) to the Fund Office to inquire if a particular service is covered by the Fund will not be treated as a valid claim for benefits. Further, no inquiry or request, whether verbal or written, will be considered a

valid claim for benefits if made or submitted to anyone (including a Trustee) other than the Fund office.

Claims should be filed with the office of the Administrative Agent, BeneSys, Inc., as soon as reasonably possible after the expense is incurred. **For a claim to be considered for payment, it must be received in the office of the Administrative Agent within one year after the expense was incurred.** Failure to submit a claim within this one-year period shall be grounds for denial of the claim. Properly completed claims must be accompanied by billings from the Provider and such other proof as may be required by the Administrative Agent.

The Fund's Administrative Agent shall examine all written claims for benefits filed with it. The Administrative Agent shall have the right to require submission of all necessary information in addition to that filed with the claim application needed to determine the claimant's eligibility for any benefit claimed. No benefit payment shall be made by the Fund until a signed written claim is received by the Administrative Agent, along with any other information requested by the Administrative Agent.

The address to which claims should be sent is as follows:

METROPOLITAN DC PAVING INDUSTRY
EMPLOYEES HEALTH AND WELFARE FUND
PO BOX 564
TROY, MI 48099

If a claimant makes a false statement material to his claim for benefits, the Board of Trustees shall have the right to recover any payments made in reliance on such false statement.

The Trustees shall be the sole judges of the standard of proof required in any case, and the Trustees shall have full discretion and authority to apply and interpret the terms of the Summary Plan Description, including, but not limited to, all determinations as to entitlement to benefits and the rights of participants and beneficiaries. In the application and interpretation of the Summary Plan Description, the decision of the Board of Trustees shall be final and binding on all parties, including employees, employers, unions, claimants, and beneficiaries.

A claimant shall comply with all requests for information or proof promptly and in good faith, and the failure to do so shall be sufficient grounds for denying or discontinuing benefits to such person.

In making a claim or appeal, the claimant may be represented by any authorized representative. If the representative is not an attorney or court-appointed guardian, the claimant must designate the representative in writing. Neither the claimant nor the claimant's representative shall have the right to appear personally before the Board of Trustees in making an appeal.

The Fund office will maintain records of determinations on appeals and Fund interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

The Fund will make all determinations in accordance with its governing documents, policies and rules and will apply the provisions of the Summary Plan Description consistently with respect to similarly situated claimants.

Definitions

The following definitions are important in understanding how your claim or appeal will be handled by the Fund and the time frame which must be met by the Fund:

Urgent Claims-are any Pre-Service Claims for medical care or treatment with respect to which the application of the regular time frames for making pre-service benefit determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function. This determination is to be made by a person, acting on the Fund's behalf, applying the judgment of a prudent layperson who possesses average knowledge of health and medicine. However, any such claim that a physician, with knowledge of the claimant's condition, determines is an urgent claim will be treated as an urgent care claim. In addition, Urgent Claims include claims that would, in the opinion of a physician with knowledge of the claimant's condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim. Urgent Claims also include claims for coverage of diagnostic services relating to COVID-19.

Pre-Service Claims-are claims for benefits for which the Fund conditions receipt of the benefit, in whole or in part, upon approval in advance of obtaining medical care (e.g. pre-authorization or utilization review).

Post-Service Claims-involve the payment or reimbursement of costs of health care that has already been provided.

Adverse Benefit Determination-means any of following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including such determinations based on eligibility to participate, from the application of any utilization review, or that the services were experimental, investigational or not Medically Necessary.

Concurrent Care Claim-is any claim to extend the course of treatment beyond the period of time or number of treatments that the Fund has already approved as an ongoing course of treatment. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

Concurrent Care Decisions-are those decisions to terminate or reduce previously granted benefits for an ongoing course of treatment being provided over a period of time or a number of treatments. These are treated as Adverse Benefit Determinations.

Relevant Information-means information, documents or records that: (1) were relied on in making the benefit determination; (2) were submitted, considered or generated during the course of making the benefit determination; (3) demonstrates

compliance with the Fund's administrative procedures; or (4) is a statement of Fund policy concerning the claim.

Deadlines

The Fund must comply with certain deadlines in handling claims and appeals. These deadlines will vary depending on what type of claim has been submitted.

A. Urgent Claims. Urgent Claims must be decided by the Fund Office and the claimant must be notified of the decision as soon as possible taking into account the medical exigencies, but no longer than 72 hours after receipt of the claim by the Fund Office. Appeals of Adverse Benefit Determinations of Urgent Claims must be decided by the Board of Trustees, and the claimant must be notified of the decision, within 72 hours after receipt of the appeal by the Fund office. No extensions of these time frames are permitted.

B. Pre-Service Claims. Pre-Service Claims must be decided by the Fund Office and the claimant must be notified within 15 days of receipt of the claim by the Fund Office. If the Fund Office determines that there are circumstances beyond its control, a 15-day extension is available if the claimant is notified of the extension and the circumstances before the initial 15-day period expires. Appeals of Adverse Benefit Determinations of Pre-Service Claims must be decided by the Board of Trustees, and the claimant must be notified of the decision, within a reasonable period of time, but not later than 30 days, after receipt of the appeal by the Fund Office, with no extensions.

C. Post-Service Claims. Post-Service Claims must be decided by the Fund Office and the claimant must be notified within 30 days of receipt of the claim by the Fund Office. If the Fund Office determines that there are circumstances beyond its control, a 15-day extension is available if the Fund Office notifies the claimant of the extension and the circumstances before the initial 30-day period expires. Appeals of Adverse Benefit Determination of Post-Service Claims must be decided by the Board of Trustees, and the claimant must be notified of the decision, in accordance with the time frames in (h) below.

D. Weekly Accident and Sickness Claims. Weekly Accident and Sickness Claims must be decided by the Fund Office and the claimant must be notified within a reasonable period of time but not later than 45 days from the date of receipt of the claim by the Fund Office. This period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund Office, if the claimant is notified of the extension and the circumstances prior to the expirations of the initial 45-day and the first 30-day extension period respectively. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information. Appeals of Adverse Benefit

Determinations of Weekly Accident and Sickness Claims must be decided by the Board of Trustees, and the claimant must be notified of the decision, in accordance with the time frames in (h) below.

E. Death Benefit Claims. Death Benefit Claims must be decided by the Fund Office and the claimant must be notified within 90 days from the date of the receipt of the claim. This period may be extended for up to 90 days for special circumstances, if the claimant is notified of the extension and the circumstances prior to the expiration of the initial 90-day period. Appeals of Adverse Benefit Determinations of Death Benefit Claims must be decided by the Board of Trustees, and the claimant must be notified of the decision, in accordance with the time frames in (h) below.

F. Concurrent Care Decisions. The Fund office shall notify the claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Determination before the benefit is reduced or terminated. Requests by claimants to extend the course of treatment beyond the period of time or number of treatments that is the subject of a claim involving urgent care shall be decided as soon as possible, and the Fund Office shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided such claim is made is made at least 24 hours in advance of the expiration of the prescribed period of time or number of treatments. Appeals of Concurrent Care Decisions must be decided by the Board of Trustees, and the claimant must be notified of the decision within the applicable time frames in (a), (b), or (h).

G. General Rule for Applying Time Frames. The time period within which a benefit determination must be made begins at the time the claim is filed without regard to whether all the information necessary to make a benefit determination accompanies the filing. If a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period of time for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information. Also, in processing a claim, the Fund can request that the claimant allow an additional extension beyond that described above. The claimant then has discretion on whether to allow such an extension, and also concerning how long that extension should be.

H. Timing on Decisions on Appeal. Appeals will be reviewed and decided by the Board of Trustees or its Appeals Committee. The Board of Trustees will have regularly scheduled meetings at least quarterly to review and decide appeals. Appeals of Urgent Claims will be reviewed and decided by the Appeals Committee within the 72-hour period described in (a) above. Appeals of Pre-Service Claims will be reviewed and decided by the Appeals Committee or Board of Trustees within the 30-day period described in (b)

above. All other appeals will be reviewed and decided by the Board of Trustees at its regularly scheduled quarterly meeting that immediately follows the Fund Office's receipt of the appeal, unless the appeal is received within the 30 days preceding such meeting. In such case, the appeal will be reviewed and decided not later than the date of the second meeting following the Fund Office's receipt of the appeal. If special circumstances require a further extension of time for processing, the appeal will be reviewed and decided not later than the third meeting following the Fund Offices receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension.

Insufficient Information from Claimant

If a claimant has not provided the Administrative Agent with all the information needed to process the claim, the Fund will contact the claimant to explain what must be done. The deadlines for this process, which depend on the type of claim, are described below:

A. Urgent Claims. If the claimant fails to follow the Fund's procedures for filing an Urgent Claim, the claimant must be notified of the proper procedures within 24 hours of the Fund Offices receipt of the claim. This notification may be oral unless the claimant requests written notice.

   If the claimant has not provided sufficient information to determine whether, or to what extent, benefits are payable, the claimant must be notified within 24 hours after receipt of the Urgent Claim of the specific information necessary to complete the claim. The claimant must be afforded a reasonable time, but not less than 48 hours, to provide the information. The Fund Office must notify the claimant of its determination as soon as possible, but no later than 48 hours after the receipt of the information or, if later, 48 hours after the end of the period afforded to the claimant to provide the specified information.

B. Pre-Service Claims. If the claimant fails to follow the Fund's procedures for filing a Pre-Service Claim, the claimant must be notified of the proper procedures within 5 days of the Fund office's receipt of the claim. This notification may be oral unless the claimant requests written notice.

   If the claimant has not provided sufficient information necessary to decide the Pre-Service claim, the Fund office may seek the 15-day extension described above, and the written notice of extension must specifically describe the required information. The claimant must be afforded at least 45 days from receipt of the notice within which to provide the specified information.

C. Post-Service Claims. If the claimant fails to follow the Fund's procedures for filing a Post-Service Claim, the claimant must be notified of the proper procedures within a reasonable period of time not to exceed 30 days.

If the claimant has not provided sufficient information necessary to decide the Post-Service Claim, the Fund Office may seek the 15-day extension described above, and the written notice of extension must specifically describe the required information. The claimant must be afforded at least 45 days from the receipt of the notice within which to provide the specified information.

D. Weekly Accident and Sickness Benefit Claims. If the claimant fails to follow the Fund's procedures for filing a Weekly Accident and Sickness Benefit Claim, the claimant must be notified of the proper procedures within reasonable period of time not to exceed 45 days.

E. Death Benefit Claims. If the claimant fails to follow the Fund's procedures for filing a Death Benefit Claim, the claimant must be notified of the proper procedures within reasonable period of time not to exceed 30 days.

Notice of Claim Determination

If the Fund Office reviews a claim and makes an Adverse Benefit Determination, the Administrative Agent will provide the claimant with written or electronic notification. In the case of an Adverse Benefit Determination involving urgent care, notification may be provided orally, provided that a written or electronic notification is provided within three days of the oral notification.

Notifications must include the following information written in a manner calculated to be understood by the claimant:

A. The specific reason or reasons for the Adverse Benefit Determination;

B. Reference to the specific provisions of the Summary Plan Description on which the determination is based;

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

D. A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following denial of an appeal;

E. A copy of the internal rule, guideline, protocol or similar criterion if one was relied on in making the Adverse Benefit Determination, or alternatively, a statement that such rule, guideline, protocol or similar criterion does not exist;

F. If the adverse determination is based on a medical necessity determination or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgement for the determination

applying the terms of the Fund to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request;

G. In the case of an Adverse Benefit Determination involving urgent care, a description of the expedited review process;

H. If applicable, in the case of an Adverse Benefit Determination involving Weekly Accident and Sickness Benefits, a discussion of the decision including an explanation of the Plan's basis for disagreeing with or not following: (1) views presented by the claimant's treating health care professionals and/or vocational professionals who evaluated the claimant; (2) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (3) a disability determination made by the Social Security Administration.

I. In the case of an Adverse Benefit Determination involving Weekly Accident and Sickness Benefits, a statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information that is relevant to the claim.

Appeals

Any claimant has the right to appeal in writing any Adverse Benefit Determination by the Fund office within 180 days after receipt of the determination. The claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. In addition, with respect to appeals of Adverse Benefit Determinations of Weekly Accident and Sickness Benefits, the claimant will be provided, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the discretion of the Fund, the Trustees or the Appeals Committee, or any other person reviewing the appeal. Such information will be provided to the claimant as soon as possible and with sufficient time to give the claimant a reasonable opportunity to respond to such new or additional information. In addition, the claimant will be provided the same opportunity before an Adverse Benefit Determination on appeal may be rendered based on a new or additional rationale.

Failure to file a timely appeal will result in a complete waiver of a claimant's right to appeal, and the decision of the Administrative Agent will be final and binding.

The Board of Trustees will meet at least quarterly to review pending appeals. Appeals involving Urgent Claims or Pre-Service Claims will be reviewed and decided more quickly as set forth above. For appeals involving Urgent Claims, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing, and all information including the Fund's benefit

determination on review must be transmitted between the Fund and the claimant by telephone, facsimile, or other available expeditious method. The review by the Board of Trustees of all appeals will take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. Neither claimants nor their authorized representatives have the right to make personal appearances before the Board of Trustees.

In addition, the review of the claim by the Board of Trustees:

A. Will not afford deference to the initial Adverse Benefit Determination by the Fund office;

B. Will not be conducted by the individual who made the initial Adverse Benefit Determination or by a subordinate of that individual;

C. Will, when deciding a claim 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), include consultation with a health care professional who has appropriate training and expertise in the field of medicine upon which the initial Adverse Benefit Determination was based. Such professional will not be the individual who was consulted in connection with the initial Adverse Benefit Determination, nor the subordinate of that individual; and

D. Will identify the medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the Adverse Benefit Determination without regard to whether the advice was relied upon in making the determination.

Notice of Appeal Determination

Decisions of appeals will be given in writing. If the appeal is of a Post-Service Claim or a Weekly Accident and Sickness Claims, the decision must be mailed within five days after the Board of Trustees meeting at which the decision is made. If the appeal is of either an Urgent Care Claim or a Pre-Service Claim, the claimant must be notified within the deadlines described above. If the appeal is denied, in whole or in part, the written notification of the decision must set forth the following information, and must convey in a manner calculated to be understood by the claimant:

A. The specific reason or reasons for the adverse determination;

B. Reference to the specific Fund provisions on which the determination is based;

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

D. A statement of the claimant's right to bring an action under ERISA;

E. A copy of the internal rule, guideline, protocol or similar criterion if one was relied on in making the decision of appeal, or alternatively, a statement that such rule, guideline, protocol or similar criterion does not exist;

F. If the adverse determination is based on a medical necessity determination or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request;

G. If applicable, in the case of a denial of an appeal involving Weekly Accident and Sickness benefits, a discussion of the decision including an explanation of the Plan's basis for disagreeing with or not following: (1) views presented by the claimant's treating health care professionals and/or vocational professionals who evaluated the claimant; (2) views of medical or vocational experts whose advice the Plan obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (3) a disability determination made by the Social Security Administration.

Notice involving an initial Adverse Benefit Determination of Weekly Accident and Sickness Benefits or an appeal of Weekly Accident and Sickness Benefits will include a statement of the claimant's entitlement to obtain the relevant notices in a culturally and linguistically appropriate manner.

Independent External Review

The Fund has adopted a procedure under which you may appeal decisions of the Board of Trustees regarding the balance billing and cost-sharing protections you have under the No Surprises Act effective for services received on or after October 1, 2021.

Examples of claims that are eligible for external review include:

A. Whether treatment is for Emergency Services;

B. Whether a claim for items and services furnished by a non-participating Provider at an in-network facility is subject to the protections under the No Surprises Act;

C. Whether you were in a condition to receive a notice about the availability of the protections against balance billing and gave informed consent to waive these protections;

D. Whether a claim for items and services is coded correctly, consistent with the treatment you received, thus entitling you to the protections against balance billing; and

E. Whether cost-sharing was correctly calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.

For the above types of claims, the decision of the Board of Trustees is final and binding unless you timely file a request with the Fund Office for a review by an independent dispute resolution entity ("IDR entity") within four months after you receive from the Fund of a notice of denial of an appeal pertaining to no surprises billing.

In this case, the decision made by an IDR entity will be binding on you and the Plan.

Deadline for Filing a Request for External Review

You may file a written request for an external review with the Fund Office within four months after you receive from the Fund of a notice of denial of an appeal about a claim that involves consideration of whether the Plan is complying with the no balance/surprise billing and related cost-sharing protections under federal law. If there is no corresponding date four months after the date of receipt of such a notice, then your request must be filed by the first day of the fifth month following the receipt of the notice.

Preliminary Review

Within five business days following the date of receipt of the external review request, the Fund Office will complete a preliminary review of the request to determine whether:

A. You are covered under the Plan at the time the health care item or service was provided;

B. The adverse benefit determination pertains to a balance billing issue;

C. You have exhausted the Plan's internal appeal process; and

D. You have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Fund Office will send you a notice in writing. If your request is complete but not eligible for external review, the notice will include the reasons it is ineligible and contact information for the Employee Benefits Security Administration.

If the request is not complete, the notice will describe what is needed to make the request complete, and you will be allowed to fix your request within the four-month filing period or within the 48-hour period following the receipt of the notice, whichever is later.

Referral to Independent Dispute Resolution Entity

If the Fund Office determines that your request for external review is complete, it will assign a certified Independent Dispute Resolution entity ("IDR entity") that is accredited by an appropriate nationally recognized accrediting organization to conduct the external review. The Fund Office will refer the claim to one of the IDR entities with which the Plan has contracted.

The assigned IDR entity will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IDR entity within ten business days following the date of receipt of the notice additional information that the IDR entity will consider during the external review.

The IDR entity will review all of the information and documents timely received. In addition to the documents and information provided, the assigned IDR entity, to the extent the information or documents are available, and the IDR entity considers them appropriate, will consider all information required to be considered under the No Surprises Act and regulations issued thereunder.

Decision of the Independent Dispute Resolution Entity

The IDR entity will provide written notice to you of the external review decision within 45 days after the IDR receives the request for the external review. The IDR entity's decision is final and is not subject to further appeal.

Trustees Discretion and Authority to Render Final and Binding Decisions

The decision of the Board of Trustees on review/appeal shall be final and binding upon all parties including any person claiming a benefit on your behalf, and no further appeal is available. Under special circumstances, the Board of Trustees may determine that reconsideration of a claim or appeal is appropriate based on new information that was not initially available. The Board has full authority and discretion to determine if reconsideration is warranted. The Board has full discretion and authority to determine all matters relating to the benefits provided under this Summary Plan Description, including, but not limited to, all questions of coverage, eligibility and interpretation of the terms of Fund documents, policies and rules. The Board shall have full authority and discretion to determine if a benefit is covered or subject to reimbursement under the Plan. If the Board denies your appeal of a claim, and you decide to seek judicial review, the Board's decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

Fund Policies, Determinations, or Actions

If you disagree with a policy, determination, or action of the Fund, you may request that the Board of Trustees review the Fund policy, determination, or action with which you disagree by submitting a written appeal to the Trustees. You must state the reason for your appeal and submit any supporting documentation. Your written appeal must be submitted within 60 days after you learn of a Fund policy, determination or action with which you disagree and which is not a benefit denial. The Board of Trustees will have sole authority and discretion to interpret and apply Fund policy, determination, or action.

The Board of Trustees will review your appeal at its quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review for the Trustees or Committee, you will be notified in writing.

Denied Workers' Compensation Claims

In order for a claim that has been denied by Workers' Compensation to be eligible for payment by the Fund, the following procedures must be followed:

A. The Participant must notify the Fund within thirty (30) days of any injury for which a Workers' Compensation claim has been filed.

B. The Participant must exhaust all Workers' Compensation administrative remedies before the Fund will consider the claim.

C. The claim must be filed with the Fund Office within one year of the final denial by Workers' Compensation.

D. Once the Fund Office receives a claim after its final denial by Workers' Compensation, the Fund's claim and appeals procedures will apply.

STATEMENT OF ERISA RIGHTS

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

As a participant in the Metropolitan D.C. Paving Industry Employees Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and copies of documents filed by the plan with the U.S. Department of Labor.

Obtain, upon written request to the Fund Office, copies of documents governing the operation of the plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and updated summary plan description. The Fund Office may make a reasonable charge for the copies.

Receive a summary of the Fund's annual financial report. The Fund Office 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.

You are also entitled to 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 pre-existing 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 in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or another person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 Fund Office to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Office. 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 Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, 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.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Fund will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("Privacy Rules"). Under these standards, the Fund will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law. To the extent protected health information is used or disclosed, the Fund will use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

The Fund has adopted a written Privacy Policy setting forth the rules and procedures the Fund has established to protect your personal health information as required by applicable law. This Privacy Policy is set forth below in the following notice and is hereby incorporated as part of the Plan.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

(Effective April 14, 2003; revised effective September 23, 2013; updated February 23, 2017, August 16, 2022)

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, as amended. It describes how the Fund can use and disclose your Protected Health Information. Protected Health Information ("PHI") is information that is created, received, transmitted, or stored by the Fund 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

The Fund may use or disclose your PHI for treatment, payment, or health care operations without your written authorization:

A. "Payment" generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, 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.

B. "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.

C. "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.

Except where disclosure is required by law as described below, the Fund may not disclose your PHI to a health plan for purposes of payment, health care operations or treatment if you have requested that such disclosure be restricted and if the PHI pertains solely to a health care item or service for which the health care provider has been paid in full out of pocket.

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:

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

B. 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; (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; and (7) providing information related to proof of immunization to a school required to have such information after the Fund has documented that the individual or, if the individual is a minor, the individual's parent or guardian has agreed to the disclosure (unless State law requires disclosure of immunizations regardless of agreement).

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

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

K. 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.

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

M. 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.

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

O. 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.

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

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

R. 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.

The Fund may use or disclose your PHI to you, to your Personal Representative, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan:

A. 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 can be obtained from the Fund Office.)

B. 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.

C. 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.

Use of PHI pursuant to a written and signed Authorization Form:

A. Unless otherwise permitted by law or described in this Notice, the Fund will not use or disclose your PHI to someone other than you (such as your spouse) 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 recorded by the Fund. (Copies of each of these forms can be obtained from the Fund Office.)

B. The Fund may use or disclose Psychotherapy Notes only pursuant to an Authorization Form, unless the use or disclosure is otherwise required or permitted by law.

C. The Fund may use or disclose PHI for marketing purposes only pursuant to an Authorization Form. A use or disclosure is considered marketing if it is used for a communication that encourages the use of a product or service. However, the following uses and disclosures are not considered marketing: refill reminders or other usage reminders about a current treatment, as long as the Fund does not receive remuneration from a third party that is more than the cost of sending the reminder; for providing communications about alternative treatments, therapies, providers, health-related products or

services available to you or for coordinating care for you unless the Fund receives remuneration from a third party to make the communication.

D. The Fund may sell PHI only pursuant to an Authorization Form. A sale of PHI is a use or disclosure of the PHI in exchange for direct or indirect remuneration from the entity that receives the PHI from the Fund. However, the following transactions are not considered to be a sale of PHI, even if the Fund receives remuneration for them: a use or disclosure pursuant to research, public health, treatment, payment, or other purposes required by law, a use or disclosure made by or to a Business Associate for actions it performs as part of its agreement with the Fund to undertake certain functions, a use or disclosure to you when requested, a use or disclosure made as part of the sale, transfer, merger, or other consolidation of the Fund, and any other purpose permitted by law as long as the remuneration received is only a reasonable, cost-based fee to cover the expense to prepare and transmit the PHI, or a fee otherwise expressly permitted by other law.

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.

A. 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 unless it pertains solely to PHI related to a health care item or service for which the health care provider involved has been paid in full out of pocket.

B. 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.

C. 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.

D. You have a right to receive an electronic copy of PHI that is maintained electronically by the Fund upon request. The Fund will provide you the electronic copy either in the format that you request if it is easily producible to that format, or, if not readily producible in the format you request, then as a PDF or in another format agreed upon between you and the Fund.

E. 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.

F. 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.

G. You have a right to be notified in the event of a Breach of Unsecured PHI, as described below under "Duties of the Fund."

H. You have the right to receive a paper copy of this Notice upon request.

Duties of the Fund

The Fund has the following obligations:

A. 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.

B. If unsecured PHI is acquired, used or disclosed in a manner that is not permitted under the Privacy Rules that compromises the security or privacy of that PHI, (referred to as a "Breach"), the Fund is required to provide appropriate Notice as defined by law without unreasonable delay and in no case later than 60 days after the discovery of the Breach by the Fund or the receipt of information of the Breach by the Fund.

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

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

E. The Fund is prohibited from using PHI that is genetic information for any underwriting purposes.

Changes to Notice

A. 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.

B. 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 Board of Trustees, which is the Fund's Privacy Officer, at the following address:

BOARD OF TRUSTEES
METROPOLITAN DC PAVING INDUSTRY
EMPLOYEES HEALTH AND WELFARE FUND
7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MD 21046

You may also file a complaint with the U. S. Secretary of Health and Human Services in Washington, DC. 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 in writing at the address above or call the Fund's third-party administrator, BeneSys, Inc. at 410-872-9541.

For Further Information Contact:

Metropolitan D.C. Paving Industry Employees
Health and Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
410-872-9541

This booklet has been prepared for
your use as a convenient reference.

IT IS NOT A CONTRACT.