CEMENT MASONS AND PLASTERERS LOCAL 518 HEALTH CARE FUND

Kansas City, Missouri

Combination

Summary Plan Description

and

Plan Document

JUNE 2016

CEMENT MASONS AND PLASTERERS
LOCAL 518 HEALTH CARE FUND

Dear Participants and Beneficiaries:

We are pleased to distribute this new restated Combination Summary Plan Description and Plan Document (Benefit Booklet) describing the Benefits provided under your Plan.

This Benefit Booklet contains the general Plan provisions, Eligibility Rules for participation in the Plan, the Benefits provided to those who are eligible, and the procedures that must be followed when filing a claim for Benefits.

There have been a number of changes to the Plan since the last Benefit Booklet was distributed. As a result, you should **READ THIS BENEFIT BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

From time to time, other changes and improvements to the Plan may be made. When this occurs, we will make every attempt to advise you of them. In order to assist us in keeping you up to date, **IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT HOME ADDRESS AT ALL TIMES.** This is the only way to be sure that you receive notice of any Plan changes.

This is your copy of the Benefit Booklet describing your Plan. Please take the time to read it in its entirety and refer to it when you have any questions about the Plan. You should keep this Benefit Booklet in a safe (but handy) place for future reference. If, at any time, you have questions about the Plan, please call or write the Fund Office at:

Cement Masons and Plasterers Local 518 Health Care Fund
6405 Metcalf, Suite 200
Overland Park, KS 66202

(913) 236-5490
(800) 542-4482

The Board of Trustees shall have the authority to interpret, construe and apply all terms of the Combination Summary Plan Description and Plan Document, the Amended Trust Agreement and/or any rules and regulations established by the Board of Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature of, amount and duration of Benefits.

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BOARD OF TRUSTEES
2016

MANAGEMENT TRUSTEES	**UNION TRUSTEES**
Ms. Erica Jenkins The Builders' Association 720 Oak Street Kansas City, MO 64106	Mr. David Kirkpatrick Cement Masons' Local 518 301 South Main Street Independence, MO 64050
Mr. Pete Browne Kissick Construction Company 8131 Indiana Avenue Kansas City, MO 64132	Ms. Alise Martiny KC Building Trades Council 400 South Main Street Independence, MO 64050
Mr. Rocky Queen Epic Concrete 3810 Freemont Avenue Kansas City, MO 64129	Ms. Stacy Diaz Cement Masons' Local 518 301 South Main Independence, MO 64050

PREFACE

WHEREAS, Section 7.10 of the Restated Cement Masons and Plasterers Local 518 Welfare Fund effective January 1, 2005, provides that the Plan may be amended by the Board of Trustees; and

WHEREAS, it is the desire of the Trustees to amend this Plan in order to comply with federal law and subsequent amendments thereto and to continue to maintain this Plan as a qualified Plan and Trust.

NOW, THEREFORE, the Plan of the Cement Masons and Plasterers Local 518 Welfare Fund shall be amended and restated as follows:

PREAMBLE

Effective as of April 1962, the Board of Trustees of the Masonry Industry Employees Welfare Fund adopted the Plan of the Masonry Industry Employees Welfare Fund and executed a Trust Agreement to provide health and welfare, death and any other such Benefits for its' Participants. Effective November 29, 2000, the name of the Fund was changed to the Cement Masons and Plasterers Local 518 Welfare Fund and effective, November 18, 2009, the name of the Fund was changed to the Cement Masons and Plasterers Local 518 Health Care Fund.

The Plan was subsequently restated effective October 1, 1976, August 1, 1988, July 1, 1998 and January 1, 2005 and June 1, 2010 and is now restated effective June 1, 2016; unless stated, the Trustees have adopted the Amended and Restated Plan, as set forth herein.

The Plan and Trust are intended to meet the requirements with the applicable provisions of Section 302 of the Labor Management Relations Act of 1947 as amended, or as it shall hereafter be amended, as well as with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), including any amendments thereto which have been made or which shall hereafter be made and all applicable regulation and rules of the United States Department of Labor and the Internal Revenue Service or Department of Treasury.

The Trustees shall have discretion and authority to revise, interpret, construe and apply the provisions of the Plan, including, but not limited to, provisions relating to the eligibility for, entitlement to and/or the nature, amount and duration of Benefits and matters pertaining to its administration, and their decisions thereon shall be final. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

ABOUT YOUR PLAN

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advanced planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by Sickness, injury or death.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established the Plan, which provides a specific, dependable Plan of Benefits. Since its beginning, the Plan has been improved in a continuing effort to provide the best Benefits possible consistent with sound financial management.

The Plan, known as the Cement Masons and Plasterers Local 518 Health Care Fund, was established and is maintained as a result of a Collective Bargaining Agreement (sometimes referred to as labor contract) between the Association and the Union.

The Plan receives the majority of its income through Employer contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives some income from investments.

Decisions on Plan operations are made by a joint Board of Trustees that is comprised of an equal number of Employer representatives and Union representatives. Working together, the Trustees establish rules of eligibility, levels of Benefits, supervise the investment of the Plan's money and see that the Plan is in compliance with all applicable federal and state laws.

This is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your family become eligible for Benefits and what your responsibilities are under the Plan. Of course, if you have any questions about the Plan that are not answered by this Benefit Booklet, please feel free to contact the Fund Office. The staff will gladly answer your questions.

In carrying out their responsibilities, the Trustees are assisted by a team of professionals including:

A. The **Administrative Manager** who handles the day-to-day business activities of the Plan, such as collecting Employer contributions, keeping records of money received, crediting each Participant's account with the correct number of hours worked, paying claims and answering inquiries from Participants about their eligibility and Benefits.

B. The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Plan comply with federal and state law.

C. The **Fund Consultant** assists the Trustees in determining the level of Benefits that can be provided from Plan resources and periodically advises the Trustees as to Benefit changes and improvements that further tailor the Plan to the current needs of Employees. By monitoring the claims experience, hours worked by Employees and contributions made to the Fund, the Consultant is able to advise the Trustees in their effort to continue management of the Plan and at the same time provide the highest possible level of Benefits to the Employees. The Consultant also assists the Trustees in maintaining the Fund's tax-exempt status in accordance with Internal Revenue Service regulations.

D. As required by law, an **Independent Auditor** examines the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees submit annual financial statements and other reports to the U.S. Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

BE A SMART HEALTH CARE CONSUMER!

Below are some ways you can reduce the amount of your personal out-of-pocket expenses as well as the Plan.

Use Generic / Brand Formulary Drugs
Generic and brand formulary drugs are less expensive than other brand name medications and can save you and the Plan money.

Follow the Directions on the Label
Take your medications as your Physician has prescribed them, especially antibiotics. Don't take other people's medications. If you are taking prescription medications, check with your Physician before taking over-the-counter remedies. They may interact with medications your Physician has prescribed for you or be inappropriate for your illness.

New Medications
You may find that you cannot tolerate a new medication, become allergic to it or it may not be effective. Ask your doctor for a sample or to prescribe a trial dosage before getting a full month's prescription.

Review your Explanation of Benefits (EOB) Forms
Make sure that the services your Plan has paid for were actually provided. If you do not recognize the name of the provider, or did not go to the Physician on the date of service shown on the form, call the Fund Office. The Fund Office staff will assist you in resolving any issues.

Use the Hospital Emergency Room for Real Emergencies
Your Physician can give you the best care for illness and injuries that are not life threatening. Use emergency care clinics – they may be less expensive than the Hospital emergency room and take less time to be treated.

Be Prepared when you go to your Physician's Office
Keep your scheduled appointments, especially if you are being treated for a chronic illness. Write down your symptoms and the changes in your health since your last visit and keep a log of the prescription and over-the-counter medications you are taking and how often you take them. This way, you won't forget to ask important questions and give your Physician pertinent health information during your appointment.

Fill out Insurance Information Completely and Accurately
Your claim can be processed more quickly when the complete insurance information is provided to your Physician or Hospital. Carry your ID card at all times.

LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund Office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, legal separation order, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU ARE INJURED ON THE JOB.**
- **YOU ARE INJURED IN AN ACCIDENT.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**
- **YOU CHANGE YOUR ENROLLMENT STATUS IN A MEDICARE PRESCRIPTION DRUG PLAN.**

IMPORTANT NOTICE

This Benefit Booklet is intended to describe the hospitalization, medical, death, accidental death and dismemberment, maternity, vision and other Benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the Benefits described in this Benefit Booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a Benefit from the Plan. The Plan contains appeal procedures that may be used if you feel the Benefits have been wrongfully denied. The Trustees decision can be challenged in court only after those procedures are exhausted. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. Any formal interpretations regarding this Plan must be communicated in writing signed on behalf of the full Board of Trustees either by the Trustees, or if authorized by the Trustees in writing, by the Administrative Manager.

Trustee Authority

The Board of Trustees, as Plan Administrator, has full authority to increase, reduce or eliminate Benefits and to change the Eligibility Rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and Benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and their Eligible Dependents. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Notices of Plan changes will be sent to each Participant's last known address. It is extremely important that you notify the Fund Office, in writing, of any address change!

Notice of Plan Changes

Notices of any changes will be sent to each Participant's last known address within the time required by applicable regulations. Therefore, it is extremely important to keep the Fund Office informed regarding any change of address. Plan changes, however, may take effect before notification is received. Therefore, before receiving non-emergency care, contact the Fund Office to confirm current health Benefits if you are unsure what they are.

Defined Terms

Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in Article IX – Definitions. It is important to understand the meanings of the defined terms when using this Benefit Booklet.

PREFERRED PROVIDER ORGANIZATION

The Fund's Preferred Provider Organization is Blue Cross Blue Shield of Kansas City (BlueKC). For up-to-date provider information, visit BlueKC's website at www.BlueKC.com, click on "Find BlueKS Doctors and Hospitals" and choose "Preferred-Care Blue PPO Network"

The Fund has negotiated special contracts with an organization of area Physicians and Hospitals ("Preferred Providers") known as a Preferred Provider Organization (PPO). These Preferred Providers will render services for fees that are in most cases below prevailing prices.

If the Covered Person uses a Preferred Provider for the Covered Person's health care needs, the Fund will pay 85% of most Covered Charges, after the annual Deductible Amount is satisfied.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a covered service is more than the provider's actual charge, then the Plan will pay Benefits so that the Participant's coinsurance amount is no more than 15% of the provider's actual charge.

The Covered Person is not required to use a Preferred Provider. The Covered Person has complete freedom of choice to use any Physician or Hospital. If an individual does not use a Preferred Provider, the Fund will pay 75% of most Covered Charges at the UCR Charge, after the annual Deductible Amount is satisfied.

For the most up-to-date provider information for Blue Cross Blue Shield of Kansas City (BlueKC), visit BlueKC's website at www.BlueKC.com or call toll-free at (800) 340-0109. To locate a provider outside of the Kansas City service area, call toll-free at (800) 810-BLUE (2583) or go directly to the Blue National Doctor and Hospital finder website at www.bcbs.com. Please have the three digit account specific alpha prefix (KWF) listed on the front of your identification card along with the zip code of the area you are looking for a participating provider.

Prior to receiving services be sure to confirm with the provider that they are still participating with the local BCBS Plan.

PRIOR AUTHORIZATION

The Plan has entered into an agreement with BlueKC to provide prior authorization for all CAT, PET and MRI scans that your Physician may recommend. Your Physician must contact BlueKC at (816) 395-3989 (locally) or toll-free at (800) 892-6116 prior to the scan to receive prior authorization. At the prompt, your Physician should press "0" to be directed to the proper department. If your Physician does not receive prior authorization and the scan is found to not be Medically Necessary, the scan will not be covered.

FILING AN ENROLLMENT CARD

IF YOU HAVE NOT FILED AN ENROLLMENT CARD, DO SO NOW! PAYMENT OF BENEFITS MAY BE DELAYED UNTIL A COMPLETED ENROLLMENT CARD IS FILED WITH THE FUND OFFICE.

When you first became employed under the terms of the Collective Bargaining Agreement you should have received an "ENROLLMENT CARD" from either the Union or the Fund Office.

This card requests certain basic information that is needed for your records in the Fund Office. This information is the **full legal name,** address**,** Social Security number and date of birth for you and your Eligible Dependents and the name of your Beneficiary in the case of your death.

All of this information is vital! Without it, the Fund Office will have difficulty in keeping you informed about Plan changes. Likewise, you run the risk of not having a permanent record of participation in the Plan.

If you are not sure whether you have an enrollment card on file at the Fund Office, contact the Fund Office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, TELEPHONE NUMBER, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, you will be sent notice of the change. This means that, in order to notify you, the Fund Office must have your current address information. **IF YOU MOVE,** make sure to notify the Fund Office of your new address. The failure to notify the Fund Office may jeopardize your eligibility or cause you to lose Benefits. **IF YOUR MARITAL STATUS** changes, don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of your marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of claims for Benefits.

If you wish to **CHANGE YOUR BENEFICIARY, DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office can only pay a Death Benefit to the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you wish to **ADD OR DELETE DEPENDENTS**, you must notify the Fund Office, **in writing.** You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, divorce decree, etc. Since the Plan provides Benefits to Eligible Dependents, the Fund Office must know who your dependents are at all times.

If the Plan makes any inadvertent, mistaken or excessive payments of Benefits, the Trustees or their representatives shall have the right to recover the payments.

ARTICLE I – SCHEDULE OF BENEFITS

Section 1.01 – Active and Retired Participant Program
(Active and Retired Participants Not Eligible for Medicare and their Eligible Dependents)

Once a Participant becomes eligible under the Plan, the Participant qualifies for a variety of Benefits. The following chart highlights the Benefit Plan. Other Plan maximums and limitations may apply to specific Benefits. Please refer to the appropriate Sections of this Benefit Booklet or contact the Fund Office for more information.

Active Employees Only

Death Benefit	$ 10,000
Accidental Death and Dismemberment Benefit	$ 10,000
Drug Testing Benefit	$ 35 per test Maximum one test per 12 month period

Retirees Only

Death Benefit	$ 10,000
Accidental Death and Dismemberment Benefit	$ 10,000

Active Employees, Retirees and Eligible Dependents

Major Medical Benefit
Prior authorization is required for all CAT, PET and MRI scans. See page 8 for more information.

Deductible Amount – PPO In-Network

Individual Deductible Amount (every Calendar Year)	$ 260
Family Maximum Deductible Amount (every Calendar Year)	$ 780

Deductible Amount – Non-PPO Out-of-Network

Individual Deductible Amount (every Calendar Year)	$ 390
Family Maximum Deductible Amount (every Calendar Year)	$ 1,170

Calendar Year Out-of-Pocket Limit

Family (excludes Deductible Amount)	$ 7,830

Calendar Year Out-of-Pocket Limit applies only to Covered Charges. PPO and Non-PPO charges are combined to reach the Out-of-Pocket Limit. Once the Calendar Year Out-of-Pocket Limit is reached in a calendar year, Covered Charges for the remainder of that calendar year at 100% of Covered Charges up to the applicable Benefit maximum.

Coinsurance (Fund Pays)

In-Network (after Deductible)	85% UCR
Out-of-Network (after Deductible)	75% UCR

Acupuncture Treatment Benefit

Coinsurance (Fund Pays)	
In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%
Maximum Benefit each Visit	$25
Maximum Visits each Day	1
Maximum Visits each Calendar Year	15

Acupuncture Treatment Benefit is limited to services performed by licensed professionals.

Alcohol and Drug Treatment Benefit

Coinsurance (Fund Pays)	
In-Network (after Deductible)	85% UCR
Out-of-Network (after Deductible)	75% UCR

Chiropractic Treatment Benefit

Coinsurance (Fund Pays)	
In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%
Maximum Visits each Day	1
Maximum Visits each Calendar Year	30

Dental Benefit

Coinsurance (Fund Pays)	
In- or Out-of-Network (no Deductible)	80%
Maximum Benefit per individual each Calendar Year	$ 1,500

Diagnostic X-Ray and Lab Benefit

Prior authorization is required for all CAT, PET and MRI scans. *See page 8 for more information.*

Coinsurance (Fund Pays)	
In- or Out-of-Network (after Deductible)	100%
Maximum Benefit each Calendar Year	$ 100

Expenses Incurred beyond the maximum benefit will be covered under Major Medical Benefit.

Emergency Room Service Benefit

Care Related to a Medical Emergency (as described in Section 3.10)	
Coinsurance (Fund Pays)	
In- or Out-of-Network (after Deductible)	90% UCR
Care Related to any Other Services	
Coinsurance (Fund Pays)	
In-Network (after Emergency Room Deductible)	85%
Out-of-Network (after Emergency Room Deductible)	75%
Emergency Room Additional Deductible	
(in addition to Major Medical Benefit Deductible)	$ 131

Emergency Room Service Benefit includes services billed by a Hospital or Physician.

Hospice Care Benefit

Coinsurance (Fund Pays)

In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%

Maternity Benefit

Coinsurance (Fund Pays)

In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%

Maternity Benefit is for female Employee or dependent spouse only.

Mental Health Benefit

Coinsurance (Fund Pays)

In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%

Organ or Tissue Transplant Benefit

Coinsurance (Fund Pays)

In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%

Out-Patient Surgery Benefit

Coinsurance (Fund Pays)

In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%

Prescription Drug Card Benefit

Calendar Year Prescription Drug Card Benefit Out-of-Pocket Limit	$ 6,526

Prescriptions for generic maintenance medication must be obtained through the mail order service after the initial fill and two refills.

Retail Employee Co-Payments (up to 30 day supply)

In-Network Only

Generic	lesser of $13 or cost of prescription
Brand – Formulary	greater of $18 or 25% of the cost of the prescription* with a maximum of $196
Brand – Non-Formulary	greater of $37 or 50% of the cost of the prescription* with a maximum of $326
Specialty	greater of $18 or 25% of the cost of the prescription* with a maximum of $196

* *plus the difference in the ingredient cost if the prescription is filled as a brand name drug when a generic is available.*

Mail Order Employee Co-Payments

In-Network Only (90 day supply only)

Generic	$ 21
Brand – Formulary	$ 34
Brand – Non-Formulary	$ 73

Routine Physical Examination and Preventative Services Benefit

Coinsurance (Fund Pays)	
In-Network (no Deductible)	100% up to $300; 85% thereafter
Out-of-Network (after Deductible)	75%

Second Surgical Opinion Benefit

Coinsurance (Fund Pays)	
In or Out-of-Network (no Deductible)	100%

Supplemental Accident Expense Benefit

Coinsurance (Fund Pays)	
In or Out-of-Network (no Deductible)	100%
Maximum Benefit each Calendar Year	$200

Expenses Incurred beyond the maximum benefit will be covered under Major Medical Benefit.

Urgent Care Benefit

Coinsurance (Fund Pays)	
In-Network (after Deductible)	85%
Out-of-Network (after Deductible)	75%
Urgent Care Telehealth Amwell Program (not subject to Deductible)	$10 Co-Payment

Vision Benefit (Age 19 and older)

Employee Co-Payments (In- or Out-of-Network)	
Exam Co-Payment	$ 15
Materials Co-Payment	$ 15
Elective Contact Lens Co-Payment	$ 60

Materials Co-Payment includes lenses and/or frames or Medically Necessary contact lenses.

Eye Exam (once every 12 months)

Benefits payable after Exam Co-Payment

In-Network	100%
Out-of-Network	100% up to $45

Lenses (once every 12 months)

Benefits payable after Materials Co-Payment

In-Network	100%
Out-of-Network – Single Vision	100% up to $45
Out-of-Network – Lined Bifocal Vision	100% up to $65
Out-of-Network – Lined Trifocal Vision	100% up to $85
Out-of-Network – Lenticular Vision	100% up to $125

Lens Enhancements

Benefits payable after Materials Co-Payment

In-Network	100%
Includes the following covered Lens Enhancements: color, mirror or scratch coating; polycarbonate, polarized, tinted, UV protection lenses and rimless mounting	
Other Lens Enhancements available	$25 each
Includes In-Network anti-reflective, progressive and photochromatic lenses	
Out-of-Network	up to $5
Out-of-Network Lens Options available: tinted lenses	

Frames (once every 24 months)
Benefits payable after Materials Co-Payment
In-Network..... 100% up to $130 Retail Allowance
Out-of-Network..... 100% up to $47

Contact Lenses (once every 12 months)
Contact Lenses are Available Instead of Frames and Lenses
Medically Necessary
Benefits payable after Materials Co-Payment
In-Network..... 100%
Out-of-Network..... 100% up to $210
Benefit is payable for Exam and Materials (evaluation fee, fitting costs and materials)

Elective
Benefits for fitting and evaluation payable after Elective Contact Lens Co-Payment. 15% discount applies to an In-Network Physician's UCR Charge.
Materials
In-Network..... 100% up to $130
Out-of-Network..... 100% up to $105
Benefit is payable for Exam and Materials (evaluation fee, fitting costs and materials)

Low Vision
Supplementary Testing/Evaluation
In- or Out-of-Network ..... 100%up to $125
Includes evaluation, diagnosis and prescription of vision aids where indicated.
Supplemental Care/Materials
In- or Out-of-Network ..... 75% of Cost
Maximum Low Vision Benefit Every Two Years..... $1,000
Maximum Number of Low Vision Supplemental Tests Every Two Years..... 2

Vision Benefit (Dependents Under Age 19 Only)
Employee Co-Payments (In- or Out-of-Network)..... $ 0

Eye Exam (up to 2 exams every 12 months)
Comprehensive Well Vision Exam

In-Network..... 100%
Out-of-Network..... 100% up to $45

Lenses (1 pair every 12 months)
Additional lenses covered when a minimum of .50 diopter change is required.
Lenses (once every 12 months)
Benefits payable after Materials Co-Payment
In-Network..... 100%
Out-of-Network – Single Vision ..... 100% up to $45
Out-of-Network – Lined Bifocal or Progressive Vision ..... 100% up to $65
Out-of-Network – Lined Trifocal Vision..... 100% up to $85
Out-of-Network – Lenticular Vision..... 100% up to $125

Lens Enhancements
Polycarbonate, scratch-resistant coating and rimless mounting. Discounts available on other lens enhancements.

In-Network	100%
Out-of-Network	up to $5

Frames (1 pairs every 12 months)

In-Network – *wide selection of frames*	100% up to $130 Retail Allowance
In-Network – *Costco Optical*	100% up to $70 Retail Allowance
Out-of-Network	100% up to $47

Contact Lenses (once every 12 months) - Instead of Frames and Lenses)

Fitting and Evaluation (after Elective Contact Lens Employee Co-Payment)	100%
Elective Lenses	
In-Network	100% up to $130
Out-of-Network	100% up to $105

Medically Necessary Lenses
Benefits payable after Materials Co-Payment.
Benefit is payable for Exam and Materials (evaluation fee, fitting costs and materials.

In-Network	100%
Out-of-Network	100% up to $210

Additional Savings:

- 20% savings on glasses and sunglasses (including lens enhancements) from any VSP provider within 12 months of your WellVision Exam.
- Average 15% savings off the regular price or 5% off the promotional price for Laser Vision Correction, discounts only available from glasses and sunglasses (including lens enhancements) from any VSP provider within 12 months of your WellVision Exam.

ARTICLE II – ELIGIBILITY RULES

THE TRUSTEES OF THE PLAN HAVE THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE PLAN IN DETERMINING YOUR ELIGIBILITY FOR ENTITLEMENT TO BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DETERMINES THAT THE COVERED PERSON IS ENTITLED TO THEM.

The following topics are discussed under this Article on Eligibility Rules:

Section 2.01 – Eligibility for Benefits

All Employees working for a contributing Employer or Employers within the various jurisdictions of the Plan shall be eligible to receive Benefits after meeting the following eligibility requirements.

Section 2.02 – Initial Eligibility

An Employee who has worked at least 450 hours in a six month period or less shall become initially eligible on the first day of the third month following the month in which the 450 hours has been accumulated.

Section 2.03 – Continuation of Eligibility

Once an Employee has satisfied the initial eligibility requirements as described in Section 2.02, he shall remain eligible for the duration of that Benefit Period. Thereafter, he shall remain eligible as long as he had at least 450 hours in a six month work period or 1,000 hours in a 12 month work period for which contributions have been received as described in the following table:

Primary Eligibility Rule: Work at least 450 hours in the following Work Periods	Secondary Eligibility Rule: Work at least 1,000 hours in the following Work Periods	Benefit Period
August 1 – January 31	February 1 – January 31	April 1 – September 30
February 1 – July 31	August 1 – July 31	October 1 – March 31

Section 2.04 – Termination of Eligibility
A Participant's, Retiree's or Eligible Dependent's eligibility for Benefits under the Plan will terminate on the earliest of the following:

A. The first day of the Benefit Period following the work period in which the Employee's contribution hours fall below the minimum requirement for continuing eligibility (see Section 2.03 – Continuation of Eligibility); or

B. The first day the Participant or Retiree works for an Employer whose contractual obligation to contribute to the Fund was terminated (termination does not occur if the Employer is negotiating for a new contract and making contributions to the Fund); or

C. The day the Participant or Retiree works in cement masons or plasterers employment in the geographic jurisdiction of the Fund for an Employer that does not have a contractual obligation to contribute to the Fund; or

D. The last day of the month following the month in which the Local Union or collective bargaining unit representing the Employee terminates its participation in the Fund (for this purpose, a Local Union or other bargaining unit shall be considered terminated as of the last day its Collective Bargaining Agreement requires Employer contributions to the Fund); or

E. The first day of any month in which the Participant, Retiree or Eligible Dependent does not make the full and appropriate self-payment contribution; or

F. The last day of the month during which the Participant or Retiree fails to meet the Eligibility Rules or an Eligible Dependent fails to meet the definition of Eligible Dependent in Section 9.11.

A temporary extension of the Plan Benefits to any Covered Person that loses coverage under the Plan is offered as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See Section 2.11 for details.

Section 2.05 – Reinstatement of Eligibility
A Participant or Retiree whose eligibility terminates can become eligible again by meeting the initial eligibility requirements stated in Section 2.02.

Section 2.06 – Active Disabled Employees Hours Credit
If any Covered Employee becomes Totally Disabled from a Sickness or accidental bodily injury which prevents him from engaging in **ANY** occupation or employment for compensation (wage) or profit, the Covered Employee will receive credit for 30 hours worked per week for a maximum of 14 weeks provided that:

A. a claim form is submitted that certifies the dates of disability and which is signed and dated by a Physician; and

B. a new form is submitted for each period and signed by the Physician certifying the dates of continued disability; and

C. disabled Employees on Worker's Compensation must submit Proof of Compensation and be unable to engage in any occupation or employment for wage or profit.

Section 2.07 – Working Spouse Rules

A. Spouse Coverage
The Spouse of a Covered Employee will not be an Eligible Dependent unless the Covered Employee and Spouse provide information about the employment status of the Spouse and whether the Spouse is eligible to enroll in an employer-sponsored healthcare plan whenever requested by the Plan.

During any period when a Covered Employee's Spouse is employed and eligible to enroll in a "qualified" employer-sponsored health care plan, the Spouse must enroll in the employee-only coverage offered through the Spouse's employer. However, if the Spouse's employer does not contribute 70% or more per month towards the cost of health care coverage on behalf of the spouse, enrollment will not be required. When the Spouse satisfies this requirement, coverage under the employer-sponsored health care plan will be primary and coverage under this Plan will be secondary for benefits due to the spouse.

B. Qualified Plan – Enrollment Options
For purposes of the spousal coverage rules, a "qualified" employer-sponsored health care plan is a plan that:

1. Is insured, or self-insured by the employer, and subject to regulation by state or federal agencies such as the US Department of Labor or Internal Revenue Service; and

2. Offers industry recognized standard benefits for medically necessary hospitalization, surgery, outpatient medical treatment and prescription coverage.

In the event a Spouse has coverage options, a working Spouse is required to enroll in at least single (Spouse only) coverage at the standard benefit level of a qualified plan (not high-deductible or limited coverage), as well as prescription drug coverage if offered. The Trustees reserve the right to modify the provisions of this program at any time.

C. Exceptions

A working Spouse is not required to enroll in an employer-sponsored health care plan in order to maintain eligibility if the following situations apply:

1. If the Spouse is self-employed and has no other employees.
2. If the Spouse is not employed full time within the meaning of Section 4980H of the Internal Revenue Code (generally less than 30 hours per week or on average less than 130 hours per month).
3. If the Spouse's employer would not contribute 70% or more towards the cost of the spouse's health coverage.
4. If the Trustees determine that due to unusual and unforeseen circumstances, enrollment by the spouse would impose extreme hardship. If the Spouse's employer contributes at least 70% or more per month for the cost of the Spouse's coverage, enrollment will generally not be deemed an extreme hardship.

D. Facilitation of Enrollment

The Fund Administrator is authorized to terminate eligibility of a dependent Spouse for benefits from the Plan if necessary to enable to the Spouse to enroll in the Spouse's employer-sponsored health care coverage. The Fund Administrator is also authorized to reinstate eligibility in the Plan after the Spouse has enrolled in their employer-sponsored health care plan. Coverage will only be reinstated effective the first day of the following month after receipt of the completed and signed verification form. No retroactive coverage will be granted.

E. Verification of Enrollment

The Trustees will require written verification from a working Spouse's employer regarding satisfaction of all requirements of this Plan to maintain the working Spouse's eligibility. Verification will be required at least annually, however, the Trustees can initiate random audits more frequently.

F. Failure to Enroll

If a Covered Employee's working Spouse fails to enroll in an employer-sponsored health care plan when required, or if the Covered Employee, working Spouse or Spouse's employer fails to provide required information requested by the Plan, the Spouse's eligibility for benefits in this Plan will terminate

immediately. If the Spouse thereafter enrolls in the Spouse's employer-sponsored health care plan, or if the required information is received, the Spouse's eligibility under the Plan will be reinstated effective the first day of the following month after receipt of the required enrollment or information is completed. No retroactive coverage will be granted.

The program requires a working Spouse, who is not considered "Exempt" under the Plan, to enroll in the health care plan offered by their own employer as a condition of receiving benefits from the Plan. The working Spouse must enroll in employee only coverage (minimum), if offered, and if the employer contributes 70% or more per month towards the cost of health coverage. In addition to the basic coverage provided under a "qualified" plan, the working Spouse must obtain prescription drug coverage, if available. The working Spouse is not required to elect vision or dental coverage. If different plan types are offered, the working Spouse must elect an HMO, PPO, or POS plan rather than a high deductible plan of another type. If the only plan available is a high deductible health plan (HDHP), the working Spouse should enroll in the HDHP and decline the Health Saving Account (HAS) portion to remain eligible for dependent Spouse coverage in the Plan. A Spouse may not establish a new HSA, nor receive tax-free contributions to an existing HSA, while covered in both an HDHP and the Plan. (If a working Spouse enrolled in an HDHP elects to "Opt Out" of the Plan, the Spouse's rights with respect to an HSA will not be affected.)

Definitions:	
Self-Employed:	An individual, doing business as a sole-proprietor or partner, who either has no employees or offers no health coverage to employees.
Part-Time Employee:	Part-time is defined by the Plan, for the Spousal Coverage Program, as working an average of less than 30 hours per week.
Qualified Plan:	For purposes of the Spousal Coverage Program, a "Qualified Plan" means an employer-sponsored health plan that (i) offers, at minimum, coverage for hospitalization, medically necessary surgery, medical outpatient and physician services; and (ii) is subject to state or federal regulations of the insurer of an insured plan or the employer of a self-insured plan.
Open Enrollment:	The time or times during the year when an employee may normally enroll for coverage in an employer-sponsored health plan.
Waiting Period:	The period following initial employment that must elapse before an employee can commence coverage in an employer-sponsored health plan.
Opt-Out:	Voluntarily choosing to decline (or terminate) any spousal dependent coverage in the CM 518 Plan.

Exempt:	A Covered Employee's spouse who is not qualified to enroll in a health care plan through their own employer, or a Covered Employee's spouse who is not employed.
Non-Exempt:	A Covered Employee's spouse who is required to enroll in a health care plan coverage through their own employer if the employer contributes 70% or more per month towards the cost of health coverage.
Non-compliance:	A Covered Employee's spouse who is eligible to enroll in a health care plan through their own employer and chooses not to enroll in their own employer's plan, or a Covered Employee's spouse who does not properly complete the Verification Form for the Spousal Coverage Program.

G. Other Insurance

The working Spouse's employee health care plan will pay claims as "primary" and the Plan will pay claims as "secondary." If a working Spouse has coverage in the form of a Health Reimbursement Account (HRA), all charges covered by that HRA must be processed prior to submitting to the Plan for reimbursement. The Plan will pay as "primary" only if a Spouse is considered "Exempt" in the CM 518 Spousal Coverage Program.

H. Open Enrollment Period

A working Spouse who declined to enroll during their Employer's one-time Open Enrollment period should be allowed another Open Enrollment period once coverage has been terminated by the Plan. A Covered Person can contact the Fund Office for a letter of termination to present to the working Spouse's employer. When enrollment has been established with the employer's health care plan, the Plan will pay as "secondary."

I. Verification Form Required

All dependent Spouses eligible for coverage in the Plan must submit a fully completed and signed verification form showing either they are "Exempt" or they have obtained health coverage through their own employment. All dependent Spouse benefits under the Plan will be terminated (or suspended in the case of a new Spouse) from the time the form is due until the completed and signed form is received by the Fund Office. Coverage will only be reinstated the first day of the following month after receipt of the completed and signed verification form. No retroactive coverage will be granted.

J. Opting Out

Spouses may elect to "Opt Out" of coverage in the Plan by checking the appropriate box in Part E on the Verification Form for the Spousal Coverage Program. A dependent Spouse who elects to "Opt Out" of coverage is terminating their coverage in the Plan.

K. How the Claim is Paid

If a Spouse is eligible to enroll in an employer-sponsored health care plan AND does not elect coverage, any claims paid on the Spouse's behalf will be treated as though the Spouse has primary coverage and this Plan will pay all claims as secondary. If a Spouse is eligible to enroll in a "qualified Plan" AND elects coverage under that plan, this Plan will pay all claims "secondary."

L. Program Audit

There will be various types of audits conducted by the Plan to verify the availability of employer-sponsored health care coverage to a working spouse.

- Ongoing Dependent Re-enrollments – as the employment status of Spouses can change throughout the year, quarterly reminders could be mailed to households of married Covered Employees.

- Targeted Audits/Threshold Audit – When any non-working Spouse's year-to-date submitted claims exceed a pre-defined threshold, e.g., $5,000, the Fund Office would follow a protocol similar to that involving potential accident claims where potential subrogation issues apply. Specifically, the Fund Office would pend or deny any outstanding claims and mail the Spouse a targeted follow up letter requiring the return of updated re-enrollment paperwork before the claims could be released for processing.

M. Noncompliance – Recovery

In the event either a working Spouse's availability of outside employer health care coverage is discovered by the Fund Office after the Plan's last timely-completed (re)enrollment, or the Covered Employer or Spouse preemptively self-report any past misrepresented availability of outside employer-sponsored coverage, the Plan will limit its coverage to secondary on both a retrospective and prospective basis. The Fund will seek reimbursement of claims paid in error.

Section 2.08 – Dependents' Eligibility Rules

The following dependents are eligible for coverage under this Plan, provided the Participant through whom coverage attaches meets all of the requirements for his dependents to be eligible:

A. The lawful spouse of the Covered Employee.

B. A biological child, legally adopted child, child placed for adoption, stepchild of the Covered Employee or any other minor child (as qualified below), who:

1. Is under the age of 26; or

2. Any other unmarried minor child if the child is residing with the Covered Employee in a normal parent-child relationship and the Covered Employee has been appointed by the court as legal guardian of such child as well as been required to provide medical coverage for the child.

The term "placed for adoption" means the assumption and retention by a Participant of a legal obligation of a child in anticipation of the adoption of the child prior to that child's 18th birthday. The child's placement with the Participant ends upon the termination of such legal obligation.

C. A child for whom coverage must be provided because of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a court order, decree or an administrative order issued pursuant to a state procedure relating to child support that provides for a child's coverage under the Plan. The Fund Office shall be delegated the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA Section 609; 29 U.S.C. Section 1169 and the regulations promulgated therefrom, constitutes a QMSCO. QMSCOs other than National Medical Support Notices must contain specific information, must be submitted to the Plan Administrator and must be approved by the Trustees to be qualified. The Plan shall adopt written QMCSO qualification procedures and said procedures shall be available from the Fund Office upon written request.

D. An unmarried child over 26 years of age, if he is Totally Disabled because of a qualifying physical handicap or mental retardation. To be considered a qualified physical handicap or mental retardation under this definition, it must:

1. Occur before the child reaches age 19, and

2. Be certified by a Physician, and

3. Render the child incapable of self-sustaining employment as to make the child dependent upon the parents for financial support and maintenance.

Initial proof of such disability and financial dependency must be furnished to the Trustees within 31 days of the child's reaching 19 years of age. Subsequent proofs may be required by the Trustees after the child reaches age 26, but not more frequently than annually.

Section 2.09 – Effective Date of Dependents' Coverage

A Covered Employee or Retiree must be eligible for Benefits for his dependents to be eligible for coverage. Benefits for Eligible Dependents will become effective on the latest of the following dates:

A. On the date the Covered Employee's or Retiree's Benefits become effective, or

B. On the date the Covered Employee or Retiree first acquires an Eligible Dependent.

If a Covered Employee or Retiree acquires a dependent while he is eligible for Benefits, such dependent shall automatically become an Eligible Dependent. A Covered Employee or Retiree must give notice to the Fund Office within 90 days of acquiring an Eligible Dependent. If notice is received in the Fund Office after 90 days of acquiring an Eligible Dependent, coverage for the dependent will be effective on the first of the month following receipt of the enrollment information.

Coverage under this Plan is automatic upon your eligibility. However, by law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage: A Covered Employee and his Eligible Dependents may also enroll in this Plan if they have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and they lose eligibility for that coverage. However, the Covered Employee must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

The Covered Employee and Eligible Dependents may also enroll in this Plan if they become eligible for a premium assistance program through Medicaid or CHIP. However, the Covered Employee must request enrollment within 60 days after they are determined to be eligible for such assistance.

Section 2.10 – Eligibility for Retirees and Their Eligible Dependents
Retirees and their Eligible Dependents may be eligible for one of two Retiree Health Plans – Retiree Plan A or Retiree Plan B – if the Retiree meets the eligibility requirements for coverage set forth below.

A. If a Covered Employee satisfies Section 2.09 A 1 or a Retiree satisfies Section 2.09 A 2, then the Covered Employee or Retiree is eligible for continuing self-pay Benefit eligibility under Retiree Plan A of the Cement Masons and Plasterers Local 518 Health Care Fund. COBRA eligibility shall not be an approved transitional criterion for Retiree eligibility.

    1. A Covered Employee retires and is receiving benefits under the Kansas City Cement Masons Pension Fund or the Local 561 Retirement Plan, has earned at least 10 years of pension credit under the Kansas City Cement Masons Pension Fund, the Indiana State Council Plasterers and Cement Masons Pension Fund, the Omaha Construction Industry Pension Plan or the Local 561 Retirement Plan and has earned pension credit in each of the three Plan Years preceding the effective date of Retiree coverage under this Plan.

    2. A Retiree has an effective date of Retiree coverage under this Plan on or prior to April 1, 2005.

B. If a Covered Employee retires and is receiving benefits under the Kansas City Cement Masons Pension Fund, the Indiana State Council Plasterers and Cement Masons Pension Fund, the Omaha Construction Industry Pension Plan or the Local 561 Retirement Plan, is at least 60 years of age and is eligible under the Cement Masons and Plasterers Local 518 Health Care Fund on the date of

retirement because of eligibility earned for employment with contributing Employer(s), the Retiree will become eligible for continuing self-pay Benefit eligibility under Retiree Plan B of the Cement Masons and Plasterers Local 518 Health Care Fund. COBRA eligibility shall not be an approved transitional criterion for Retiree eligibility.

C. Retirees and their Eligible Dependents eligible for coverage under either Retiree Plan A or Retiree Plan B shall have the coverage set forth in the Schedule of Benefits as applicable to Retirees and their Eligible Dependents. There is no difference in coverage between Retiree Plan A and Retiree Plan B. However, a higher self-payment rate shall be applicable to Retiree Plan B.

Section 2.11 – COBRA Continuation Coverage

Federal law requires that sponsors of group health plans such as the Cement Masons and Plasterers Local 518 Health Care Fund offer Covered Employees and their Eligible Dependents a temporary extension of their health care coverage under the Plan, (called "COBRA Continuation Coverage") in exchange for self-contribution payments to the Plan. The right to an extension of health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Covered Employees and their Eligible Dependents can become eligible for COBRA Continuation Coverage when they would otherwise lose group health coverage.

A. **What is COBRA Continuation Coverage?**

If a Covered Person loses health care coverage due to a reduction in hours, termination of employment, or certain other events (called qualifying events), the Covered Person has the right to elect to continue health care coverage by making premium payments to the Plan.

1. COBRA Continuation Coverage will be offered to a Covered Employee if coverage under the Plan ends for the following reasons:

    a. The Covered Employee's hours of employment are reduced, or

    b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct.

2. COBRA Continuation Coverage will be offered to the spouse of a Covered Employee if coverage under the Plan ends for the following reasons:

    a. The Covered Employee's hours of employment are reduced;

    b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;

    c. The Covered Employee dies;

    d. The Covered Employee becomes enrolled in Medicare; or

    e. The Covered Employee and spouse become legally separated or divorce.

3. COBRA Continuation Coverage will be offered to an Eligible Dependent child if coverage under the Plan ends for the following reasons:

   a. The Covered Employee's hours of employment are reduced;

   b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;

   c. The Covered Employee dies;

   d. The Covered Employee becomes enrolled in Medicare;

   e. The Covered Employee and spouse become legally separated or divorce; or

   f. The dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

B. **How long will COBRA Continuation Coverage last?**

1. 18 months

   If the Covered Person loses coverage due to a reduction in the Covered Employee's hours, or due to the end of the Covered Employee's employment, COBRA Continuation Coverage is available for a maximum of up to 18 months.

2. 29 months

   If the Covered Person is disabled (as determined under Titles II or XVI of the Social Security Act) at the time his coverage would otherwise terminate because of a reduction of hours or termination of employment, or who becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, the Covered Person can receive up to an additional 11 months of COBRA Continuation Coverage, for a maximum total of 29 months of COBRA Continuation Coverage.

3. 36 months

   COBRA Continuation Coverage lasts up to 36 months if the Eligible Dependent's health care coverage ends due to:

   a. The Covered Employee and spouse become legally separated or divorce;

   b. The Covered Employee becomes enrolled in Medicare;

   c. The Covered Employee dies; or

   d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

4. Second Qualifying Event

COBRA Continuation Coverage may also be extended for up to 36 months if your family experiences another "qualifying event" while receiving COBRA Continuation Coverage. If, while receiving COBRA Continuation Coverage, one of the following qualifying events occurs, the Covered Person is eligible for an extension of COBRA Continuation Coverage up to a maximum period of 36 months:

a. The Covered Employee and spouse become legally separated or divorce;

b. The Covered Employee becomes enrolled in Medicare;

c. The Covered Employee dies; or

d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

C. **Keeping the Fund Office Informed of Changes**

In order to protect your family's rights, the Fund Office should be informed of any changes concerning your family. The Covered Person has the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or of a dependent child's loss of Eligible Dependent status. **Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in the Covered Employee's hours, termination of employment, enrollment in Medicare or Covered Employee's death, the Covered Person should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

In the event the Covered Person becomes disabled during the initial 60 day COBRA continuation period, it is the responsibility of the Covered Person to notify the Fund Office of the determination of disability. **Failure to notify the Fund Office of a disability determination may affect your right to extend the COBRA Continuation Coverage period due to disability.**

D. **Electing to Continue Coverage**

When the Fund Office is notified that coverage will end due to a qualifying event, the Covered Person will be notified of their right to choose the COBRA Continuation Coverage. The Fund Office will send a COBRA Election Notice containing information on how to continue health care coverage and the applicable COBRA premiums. The Covered Person will then have **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from receipt of the Election Notice to elect the Continuation Coverage. If the Covered Person does not elect the Continuation Coverage within the 60 day

election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the 60 day election period.

Each Eligible Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their Eligible Dependents.

If a Covered Employee or the spouse of a Covered Employee has a newborn child, or adopts a child, or has a child placed with him for adoption during the COBRA Continuation Coverage period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except for the Death and Accidental Death and Dismemberment Benefits.

E. Payments

The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees. For the first self-contribution payment for COBRA Continuation Coverage, the Covered Employee will be given credit for the actual hours contributed on the Covered Employee's behalf during the six month Work Period covered under the Eligibility Periods as set forth in Article II. After the first COBRA premium payment is made, all subsequent payments shall be determined by the Trustees but no deduction for hours shall be credited after the first payment is made.

After the Covered Person elects to receive COBRA Continuation Coverage, the first premium must be made within 45 days of the election. Failure to make the required premium payments within the initial 45 day period will result in the loss of the COBRA Continuation Coverage.

F. Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end if any of the following occur:

1. A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;

2. The Covered Person becomes covered under another group health plan;

3. The Covered Person becomes entitled to Medicare;

4. The Fund no longer provides group health care coverage; or

5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

Section 2.12 – FMLA (Family and Medical Leave Act of 1993)
Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), as amended, eligibility for Benefits shall be extended to Covered Persons if the Covered Employee has been granted unpaid leave by an Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund.

The FMLA requires the Employer to inform the Employee of his rights and obligations under this law. Employees should contact the local Wage and Hour Division of the United States Department of Labor with questions regarding the FMLA.

If the Covered Employee has been granted FMLA leave, the Employer must notify the Fund Office no later than ten days after the FMLA leave begins to prevent a loss of eligibility. The Employee may wish to notify the Fund Office when granted FMLA leave, but is not required to do so. The Employer will be asked to complete some forms to verify eligibility for Benefits while on leave. The Employer must pay for the extended eligibility before the Fund will provide Benefits.

The Employer will be required to pay the cost of coverage, as determined by the Fund's Consultant, for each week of FMLA leave. The Employer must pay the cost of coverage monthly, in advance.

The eligibility will not be extended during the FMLA leave if the Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions and a loss of eligibility will result.

Section 2.13 – USERRA (Uniformed Services Employment and Reemployment Rights Act)

A. **Effective Date**

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was signed into law on October 13, 1994 to protect the eligibility of an Employee and to offer contribution coverage to the Employee and his Eligible Dependents after the Employee enters into military service.

B. **Provisions**

1. Return to Work Coverage Guaranteed

USERRA requires an Employer or a multiemployer health care plan to protect any Benefits an Employee has already earned up to the time an Employee enters military service if he reapplies for work within prescribed time periods after an honorable discharge.

The Employee's eligibility status must be "frozen" when he enters military service and must be fully restored when he reapplies for work with the same Employer or in the case of a multiemployer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

When an Employee returns from service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered military service.

2. Continuation of Coverage While in the Military

USERRA requires a group health care plan to offer identical health care coverage **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to military service. In effect, military service is treated as if it is a "qualifying event" for COBRA Continuation Coverage purposes.

THE EMPLOYEE MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN HE KNOWS HE IS ENTERING MILITARY SERVICE.

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months begins with the initial date of entry into military service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office as soon as he knows he is entering military service if he wishes to take advantage of contribution coverage. Failure to notify the Fund Office may be taken as an indication that the Employee does not wish to purchase coverage for himself or his Eligible Dependents.

3. Reemployment Requirements When Returning from Service

For service of less than 31 days, a service member must apply for reemployment with a signatory Employer and submit the DD2-14 Form to the Fund Office at the beginning of the next regular scheduled work period on the first day after release from service with an honorable discharge, taking into account safe transportation plus an eight hour rest period.

For military service of 31 days or more but less than 181 days, a service member must file an application for reemployment with a signatory Employer and submit the DD2-14 Form to the Fund Office within 14 days (calendar days not work days) after his release from the service with an honorable discharge.

For service over 181 days, a service member must file an application for reemployment with a signatory Employer and submit the DD2-14 Form to the Fund Office within 90 days after release from service with an honorable discharge.

Section 2.14 – Extension of Benefits During Total Disability
When a Covered Person is Totally Disabled from a Sickness or accidental bodily injury which prevents him from engaging in any occupation or employment for compensation (wage) or profit at the time his coverage under the Plan terminates due to death, reduction in hours worked (including certain leaves of absence) or termination of employment of a Covered Employee, the Plan will extend Benefits beyond the date coverage otherwise terminates, but only for the Sickness or injury causing the Total Disability. This coverage, herein called Extended Benefits, is an alternative to COBRA Continuation Coverage, discussed in Section 2.11 of the Plan.

Extended Benefits cover charges incurred up to 90 days from the date coverage in the Plan otherwise terminates, but not beyond the date the Total Disability ends. There is no cost to the Covered Person for Extended Benefits.

The Plan shall have the right to require proof of Total Disability (without expense to the Plan) at least once every 30 days during any period of Extended Benefits provided under this provision. Total Disability, as used herein, means the active Covered Employee's complete inability, due solely to Sickness or injury, to perform his regular and customary work or the Eligible Dependent's complete inability, due solely to Sickness or injury, to engage in the normal activities of a person of the same sex and age.

ARTICLE III – DESCRIPTION OF BENEFITS

The Benefits listed in the table below are described in this Article. This table is only intended to give you a brief summary of medical Benefits available. Please refer to the Description of Benefits that begins immediately after the table to fully understand the Benefit and any specific maximums or limitations.

Death, Accidental Death and Dismemberment, Drug Testing, Prescription Drug Card and Vision Benefits are not summarized in this table. For complete information, please refer to the appropriate Section within this Article.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED PERSONS. PLEASE CONSULT THE SCHEDULE OF BENEFITS BEGINNING ON PAGE 11 TO DETERMINE IF YOU OR YOUR ELIGIBLE DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

Description of Covered Benefit	**Fund Coinsurance Amount** Coinsurance amounts are based on a percent of UCR Charge **In-Network**	 **Out-of-Network**	**Does your Coinsurance amount help meet your Out-of-Pocket Maximum?**	**Do you need to meet your Deductible Amount before receiving Benefit?**
Major Medical Benefit	85%	75%	Yes	Yes
Acupuncture Treatment Benefit *See Benefit Description for Specific Limitations*	85% up to $25 per visit and 15 visits each Calendar Year	75%	Yes	Yes
Alcohol and Drug Treatment Benefit	85%	75%	Yes	Yes
Chiropractic Treatment Benefit *See Benefit Description for Specific Limitations*	85% up to 1 visit per day and 30 visits each Calendar Year	75%	Yes	Yes
Dental Benefit *See Benefit Description for Specific Limitations*	80% up to $1,500 maximum each Calendar Year		Yes	No
Diagnostic X-Ray and Lab Benefit *See Benefit Description for Specific Limitations*	100% up to $100 maximum each Calendar Year		Yes	Yes
Emergency Room Service Benefit *Medical Emergency* *All Other* *See Benefit Description for Specific Limitations*	 90% 85% *Benefits are payable after the Emergency Room Additional Deductible.	 75%	 Yes Yes	 Yes *
Hospice Care Benefit *See Benefit Description for Specific Limitations*	85%	75%	Yes	Yes

Description of Covered Benefit	Fund Coinsurance Amount (Coinsurance amounts are based on a percent of UCR Charge) In-Network	Out-of-Network	Does your Coinsurance amount help meet your Out-of-Pocket Maximum?	Do you need to meet your Deductible Amount before receiving Benefit?
Maternity Benefit *See Benefit Description for Specific Limitations*	85%	75%	Yes	Yes
Mental Health Benefit *See Benefit Description for Specific Limitations*	85%	75%	Yes	Yes
Organ or Tissue Transplant Benefit *See Benefit Description for Specific Limitations*	85%	75%	Yes	Yes
Out-Patient Surgery Benefit *See Benefit Description for Specific Limitations*	85%	75%	Yes	Yes
Routine Physical Examination and Preventative Services Benefit *See Benefit Description for Specific Limitations*	100% up to $300 maximum each Calendar Year In-Network Expenses Incurred beyond maximum benefit and Out-of-Network Expenses Incurred will be payable under Major Medical Benefit.	75%	No	No
Second Surgical Opinion Benefit *See Benefit Description for Specific Limitations*	100%		No	No
Supplemental Accident Expense Benefit *See Benefit Description for Specific Limitations*	100% up to $200 maximum each Calendar Year Expenses Incurred beyond the maximum benefit will be covered under Major Medical Benefit.		Yes	No
Urgent Care Benefit	85%	75%	Yes	Yes
Telehealth Amwell Program *See Benefit Description for Specific Limitations*	$10 Co-Payment	0%	No	No

Section 3.01 – Death Benefit
(Covered Employee and Retiree Only - 24 hour coverage)

Upon the death of a Covered Employee or Retiree on or off the job (24 hour coverage) the Plan will pay the Benefit amount stated in the Schedule of Benefits to the Beneficiary designated by such Covered Employee or Retiree. If the Covered Employee or Retiree designates more than one Beneficiary without specifying their respective shares, the Death Benefit will be paid in equal shares. If at the time of death of any Covered Employee or Retiree there is no surviving designated Beneficiary, the amount of the Death Benefit shall be payable in a lump sum to the surviving person or

persons in the first of the following successive Beneficiaries which survive the deceased Covered Employee or Retiree:

A. Legal spouse;

B. Child or children (in equal shares);

C. Parents (in equal shares);

D. Brothers and sisters (in equal shares);

E. Estate.

A Covered Employee or Retiree may designate a new Beneficiary at any time by filing a written request for such change, with the Fund Office.

The designated Beneficiary may disclaim the Death Benefit by completing a disclaimer approved by the Board of Trustees and submitting same to the Fund Office not later than 12 months after the death of the Covered Employee or Retiree. The designated Beneficiary will be deemed to have predeceased the Covered Employee or Retiree and such Benefit will be paid as provided above as though the Covered Employee or Retiree died without designating a Beneficiary.

Section 3.02 – Accidental Death & Dismemberment Benefit
(Covered Employee and Retiree Only - 24 hour coverage)

When bodily injury on or off the job (24 hour coverage) shall result in any of the following losses within 90 days after the date of Accident, the Plan will pay the amount stated in the Schedule of Benefits in accordance with the following chart:

Loss of:	**Benefit:**
Both Hands or Both Feet	Full amount
Entire Sight of Both Eyes	Full amount
One Hand **and** One Foot	Full amount
One Hand **or** One Foot **and** Entire Sight of One Eye	Full amount
One Hand or One Foot	½ Full amount
Entire Sight of One Eye	½ Full amount

"Loss" as used in this part with reference to hand or foot means complete severance through or above the wrist or ankle joint, and with reference to eye means the irrecoverable loss of the entire sight thereof. Benefits provided herein will not be paid for more than one of the losses (the greatest) sustained by the Covered Employee or Retiree as the result of any one Accident.

Benefits will not be payable for any loss caused by:

A. Injuries as a result of combat, war or act of war.

B. Aircraft, except when the Covered Employee or Retiree is a passenger in a licensed aircraft (other than chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier.

Section 3.03 – Drug Testing Benefit
(Covered Employee Only)
If a Covered Employee incurs expense for a drug test, the Plan will pay Benefits as set forth in the Schedule of Benefits. The Benefit shall NOT be subject to the Deductible Amount and shall be limited to one test per 12 month period.

Section 3.04 – Major Medical Benefit
Major Medical Benefits are payable at the applicable coinsurance rate for Expenses Incurred by the Covered Person as a result of injury or Sickness, which are in excess of the Deductible Amount, as stated in the Schedule of Benefits. The Major Medical Deductible Amount shall be as stated in the Schedule of Benefits. **Prior authorization is required for all CAT, PET and MRI scans. See page 8 for more information.**

A. **Deductible Amount**

The Deductible Amount, as stated in the Schedule of Benefits, is applied only once each calendar year for each Covered Person. Any covered charges applied toward the Deductible Amount in the last 90 days of a calendar year may be applied to the following calendar year.

B. **Major Medical Expenses Covered**

Medical expenses included under the Plan shall be payable according to the Schedule of Benefits for the Usual, Customary and Reasonable Charges outlined below for necessary medical care and services which are ordered and prescribed by a legally qualified Physician.

1. Charges made by a Hospital (as defined at Section 9.19); semi-private room only. In addition to Hospital room and board, the following miscellaneous Hospital expenses are included:

   a. Meals and special diet;

   b. General nursing services;

   c. Use of operating room, including cystoscopic room and cast room;

d. Anesthetic charges, whether administered by an authorized outside anesthetist or an employee of the Hospital;

e. Blood transfusions, including administration and blood typing;

f. Whole blood and blood plasma;

g. Oxygen;

h. All drugs, except those excluded under other Sections of the Plan, regardless of whether listed in the U.S. Pharmacopoeia, as long as they have to do with the cure and treatment of the patient;

i. Laboratory services;

j. X-ray examinations, use of radium and radioactive substances;

k. Basal metabolism examinations;

l. Electrocardiogram;

m. Electroencephalograms;

n. Physical therapy;

o. Dressing and casts;

p. X-ray and radiation treatments;

q. Special braces, ambulatory appliances and prosthetic appliances; and

r. Local ambulance service

2. Charges made by a registered graduate/licensed practical nurse for private duty service, but the nurse may not be related to the family of the person being treated.

3. Charges for the following:

a. By a Hospital or licensed ambulance service for necessary local transportation to and from a Hospital;

b. X-ray and lab services;

c. Anesthesia;

d. Administration and cost of blood or plasma;

e. Prescription drugs and medicines dispensed by a licensed Physician;

f. Licensed physiotherapist, including Speech and Occupational Therapy. The terms Physical, Speech and Occupational Therapist shall mean:

i) Physical Therapist & Speech Therapist

Services of a licensed Physical Therapist and Speech Therapist if Medically Necessary and is not treatment of a learning disorder, language disorder, remedial reading or special education or the result of developmental delays.

ii) Occupational Therapist

Services of an Occupational Therapist are limited to 120 days and only when ordered in connection with the following conditions: cerebral vascular accident, brain injuries, spinal injuries, amputations or loss of vision;

g. The purchase or rental of appliances and therapeutic equipment that meet the definition of Durable Medical Equipment as stated in Section 9.09. Such items include but are not limited to: braces, oxygen, Hospital type bed, artificial respirator, wheel chair. The cost of these items shall be limited to an amount determined by the Trustees;

h. Initial placement of lenses required because of cataract surgery;

i. Services for cosmetic and reconstructive surgery:

i) For injuries received while the Covered Person was eligible under the Plan.

ii) As a result of surgery for which Benefits are paid under the Plan.

iii) For reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all stages of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient;

j. Charges for dental services rendered by a Physician or dentist for treatment of an accidental injury to the jaws, sound natural teeth, mouth or face which occurred on or after the patient's eligibility date. Treatment must begin no later than 180 days following the date of the injury. Benefits will be paid on the same basis as any other Accident. However, Expenses Incurred as a result of chewing or biting will not be considered an Accident. Expenses Incurred that are covered under Major Medical **will not** be considered under Dental Benefits.

k. Expenses Incurred for In-Network routine physical examinations and preventative services and supplies above the Routine Physical Examination and Preventative Services Benefit calendar year Maximum (not subject to Deductible).

l. Expenses Incurred for Out-of-Network routine physical examinations and preventative services and supplies.

m. In addition to Subjection j, dental services when a dental condition is unsuccessfully resolved in a conventional dental office and the Covered Person provides written evidence from the treating physician, i.e. medical doctor (not the dentist) of an underlying medical condition that requires treatment to be performed in a medical facility. The medical facility where the services are provided must be an in-network facility with the Plan's preferred provider network. Such series will be paid at 85% by the Plan, after deductible under the major medical benefit. No benefits will be payable under the major medical benefit for any services provided in an out-of-network facility.

Section 3.05 – Acupuncture Treatment Benefit
Benefits shall be considered according to the Schedule of Benefits for acupuncture treatment when performed by a professional who is licensed.

A. **Limitations**
The Acupuncture Treatment Benefit shall be limited to a maximum of $25 per visit with a maximum of 15 visits per calendar year.

Section 3.06 – Alcohol and Drug Treatment Benefit
Eligible expenses for In-patient and Out-patient alcohol and drug treatment shall be considered according to the Schedule of Benefits and subject to all provisions and conditions as outlined under the Major Medical Benefit.

Section 3.07 – Chiropractic Treatment Benefit
When a Covered Person is treated by a chiropractor, Benefits for all related services, supplies and procedures will be paid according to the Schedule of Benefits for Usual, Customary and Reasonable Charges.

A. **Term of Treatment**

Benefits are payable for one manipulation per day with a maximum of 30 manipulations per calendar year.

B. **Limitations**

This Plan does not provide Benefits for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) allergy therapy, diet or hair analysis; or

2. Any diagnostic x-ray or laboratory procedure other than x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry; or

3. Nutritional or food supplements and/or vitamins which may be legally obtained without a Physician's prescription; or

4. Pillows, supports or similar devices; or

5. More than one treatment per day; or

6. Booklets.

Benefits for or related to treatment by a chiropractor are subject to the same terms, conditions and limitations governing individual Benefits for any other Sickness or Accident under this Plan.

Section 3.08 – Dental Benefit
When a Covered Person incurs a covered Dental Expense, the Plan will pay a percentage of all reasonable dental charges as stated in the Schedule of Benefits, subject to the Dental Benefit Calendar Year Maximum Benefit set forth in the Schedule of Benefits.

A. **Definitions**

The following definitions apply to the Dental Benefit:

1. Dentist – A duly licensed dentist or Physician who is operating within the scope of a dentist's or Physician's license.

2. Dental Hygienist – A duly licensed dental hygienist that works under the supervision of a Dentist.

3. Dental Expense – That part of a charge for dental services that meets all of the following:

   a. Is covered under the Dental Benefit; and

   b. Does not exceed the Prevailing Fee for the service; and

   c. Is incurred while the patient is eligible for the Dental Benefit.

4. Covered Percent – The portion of a Dental Expense which is payable under the Plan.

5. Calendar Year – January 1 through December 31 of each year.

6. Course of Dental Treatment – A planned program for the treatment of a dental condition that:

   a. May be done by one or more Dentists; and

   b. Is diagnosed by the attending Dentist by oral examination; and

   c. Begins on the date the Dentist first treats the condition.

7. Dental Treatment Plan – The attending Dentist's written report of recommended treatment on a form that is satisfactory to the Trustees. The report:

   a. Must itemize the dental procedures required; and

   b. Must show the charge for each procedure; and

   c. Must contain x-rays and any other diagnostic material as required by the Trustees.

8. Prevailing Fee – A charge for Dental Expense, which does not exceed the 90th percentile of the Plan's prevailing health care data.

B. **Limitations on Benefits**

Maximum Amount – The maximum amount paid for Dental Benefits during a Calendar Year will NOT exceed the amount set forth in the Schedule of Benefits. In addition, there is a limit of two preventive care visits per calendar year and expenses paid under Major Medical Benefits **will not be considered** under Dental Benefits.

Section 3.09 – Diagnostic X-Ray & Lab Benefit
Benefits are payable for x-ray and lab examinations for the diagnosis of an injury or Sickness up to the amount stated in the Schedule of Benefits for all such examinations made in a calendar year. **Prior authorization is required for all CAT, PET and MRI scans. See page 8 for more information.**

Section 3.10 – Emergency Room Service Benefit
UCR Charges will be paid according to the Schedule of Benefits (after Deductible) for a necessary medical emergency. To be considered a medical emergency, **ALL** of the following must be present:

A. Severe symptoms must occur. The symptoms must be so severe that immediate medical attention is required regardless of the time; and

B. The symptoms must occur suddenly and unexpectedly. A chronic condition which has existed for any period of time would not qualify unless the symptoms suddenly become so severe that immediate medical attention was required; and

C. Immediate medical attention must be obtained. If care is not obtained within 24 hours of the onset of the symptoms, the condition shall not be considered a medical emergency; and

D. The condition must be one for which immediate medical attention is normally required.

Section 3.11 – Hospice Care Benefit
Benefits on behalf of a Covered Person for covered services for Hospice Care shall be payable as set forth in the applicable Schedule of Benefits after the Deductible Amount is met.

Hospice care is a coordinated program intended to meet the special physical, psychological, spiritual and social needs of a terminally ill person and the immediate family. A terminally ill person is defined as one who (1) has no reasonable prospect of cure; and (2) as estimated by the Physician, has a life expectancy of less than six months.

Hospice services include providing the dying person with palliative and supportive medical nursing and other health services through home or In-patient care.

If Hospice Care is being given at home, short-term respite care is also covered under this benefit as long as it is provided in a Medicare-approved facility. Respite care is given to a hospice patient by another caregiver so that the usual caregiver can rest. This benefit includes transportation to and from the respite facility.

Allowed Charges include:

A. Room and board for confinement in a Hospice;

B. Physician services available by consultation;

C. Services and supplies furnished by the Hospice while the patient is confined therein;

D. Intermittent nursing care by a registered professional nurse or licensed practical nurse under the supervision of a Registered Nurse (RN);

E. Home Health Aide services and supplies;

F. Nutritional guidance given by a registered nutritionist; and

G. Counseling services by a licensed social worker or a licensed pastoral counselor.

Charges Not Allowed include:

A. Services or treatment provided more than six months from the date service commenced;

B. Care for patients with a greater than six month life expectancy;

C. Care beyond palliative care management;

D. Services or supplies for any medical condition other than the life threatening illness; and

E. Custodial Care or services, i.e., room and board or other institutional or nursing services which are provided to or for an Covered Person due to his/her age, mental or physical condition, mainly to aid the person in daily living; or

F. Medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Covered Person's medical condition.

Hospice Care benefits shall only be paid if the patient's attending Physician certifies, in writing, that the patient is terminally ill and that the patient's life expectancy is six months or less.

The Plan shall pay for Expenses of a qualified Hospice for covered Hospice services performed on an Eligible Person. Hospice benefits shall be payable whether the services were performed in a Hospice or at the patient's home. Please contact the Fund Office prior to incurring any Hospice Care expenses for confirmation of benefits available.

Section 3.12 – Maternity Benefit
(Female Employee and Dependent Spouse Only)

Maternity Benefits will be paid on the same basis as any other Sickness and subject to the Schedule of Benefits under the Plan.

The Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act") requires that the Plan shall not restrict any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following cesarean delivery. However, the Plan may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, agrees to an earlier discharge date for a mother and her newborn.

Also under the Newborns' Act, the Plan may NOT set the level of benefits or out-of-pocket expenses so that any later portion of the 48 hour (or 96 hours, as applicable) stay is treated in a manner less favorable to the mother or newborn than any other portion of the stay.

In addition, under the Newborns' Act, the Plan may NOT require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours, as applicable).

Section 3.13 – Mental Health Benefit
When a mental or nervous disorder causes an Eligible Person to incur expenses for inpatient Hospital or Physician charges or outpatient Physician charges, the Fund will pay Benefits according to the Schedule of Benefits after the Deductible Amount has been met.

For inpatient treatment, the Hospital must be a licensed facility specializing in the treatment of mental or nervous disorders. For both inpatient and outpatient treatment, care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.

Section 3.14 – Organ or Tissue Transplant Benefit
When a Covered Person requires treatment involving replacement of organs or tissue by transplantation from a donor, Benefits for all related services, supplies and procedures shall be paid according to the Schedule of Benefits and as further described in this Section.

<u>Deductible Amount and Coinsurance</u>
Eligible expenses shall be subject to the same Deductible Amount as for any other treatment for covered Sickness or injury and to the coinsurance rates as shown in the Schedule of Benefits. Expenses Incurred for Organ or Tissue Transplant Benefit will apply to the Deductible Amount.

A. **Eligible Expenses**

Benefits are payable under this Section for the Usual, Customary and Reasonable Charges related to one or more of the following transplant procedures, alone or in any combination of surgical episodes

1. Heart transplantation;

2. Lung transplantation;

3. Liver transplantation;

4. Kidney transplantation;

5. Bone marrow transplantation.

B. **Maximum Amount Payable**

All Benefits paid under the Organ or Tissue Transplant Benefit will be paid as stated in the Schedule of Benefits.

C. **Limitations**

Benefits for treatment involving replacement of organs or tissue by transplantation of organs or tissue shall not be payable for:

1. Artificial (mechanical) devices;

2. Transplantation of animal organs; or

3. Transplantation of any organ or tissue other than those specifically listed.

Unless specified, Benefits for treatment involving replacement of tissue by transplantation shall also be subject to the same conditions and limitations governing individual Benefits for treatment of any other Sickness or injury under this Plan.

Section 3.15 – Out-Patient Surgery Benefit
If surgery is recommended and can be performed on an Out-Patient basis, Benefits will be paid according to the Schedule of Benefits up to the Usual, Customary and Reasonable Charges.

Section 3.16 – Prescription Drug Card Benefit

A. **Retail Network**

The Plan has entered into an agreement with the Integrated Pharmacy Services (LDI) to provide both retail and mail order prescription drug benefits to Covered Persons. LDI has developed a network of retail pharmacies that have agreed to provide prescription medications to eligible persons at discounted prices. The network includes all national pharmacy chains except Wal-Mart, as well as many independent pharmacies.

B. **Retail Network Employee Co-Payments**

Upon presentation of the identification card at a network pharmacy, a Covered Person will be entitled to obtain a 30 day supply of the prescription medications after payment of the Employee Co-payment amount.

1. If a prescription is filled at a network retail pharmacy with a generic drug, the Employee Co-payment will be the lesser of $13 or the cost of the prescription.

2. If a prescription is filled at a network retail pharmacy with a brand name drug that is listed on the LDI Formulary and there is no medically-equivalent generic drug available, the Employee Co-payment will be **the greater of** (1) $18 or (2) 25% of the cost of the drug with a maximum of $196.

3. If a prescription is filled at a network retail pharmacy with a brand name drug that is listed on the LDI Formulary and there is a medically-equivalent generic drug available, the Employee Co-payment will be **the greater of** (1) $18 plus the difference in ingredient cost between the brand name drug and the medically-equivalent generic drug, or (2) 25% of the cost of the drug plus the difference in ingredient cost between the brand name drug and the medically-equivalent generic drug with a maximum Employee Co-payment of $196.

4. If a prescription is filled at a network retail pharmacy with a brand name drug that is not listed on the LDI Formulary and there is no medically-equivalent generic drug available, the Employee Co-payment will be **the greater of** (1) $37 or (2) 50% of the cost of the drug with a maximum Employee Co-payment of $326.

5. If a prescription is filled at a network retail pharmacy with a brand name drug that is not listed on the LDI Formulary and there is a medically-equivalent generic drug available, the Employee Co-payment will be **the greater of** (1) $37 plus the difference in ingredient cost between the brand name drug and the medically-equivalent generic drug, or (2) 50% of the cost of the drug plus the difference in ingredient cost between the brand name drug and the medically-equivalent generic drug with a maximum of $326.

C. **Mail Order Services**

If a Covered Person is using a medication on a long-term, ongoing basis to treat a Sickness or condition that requires continuous drug therapy, the Covered Person should use the mail order service. Mail order service will be restricted to a 90 day supply only. By using the mail order service, the Covered Person will be entitled to receive nothing less than a 90 day supply of the medication. Examples of Sicknesses or conditions requiring maintenance drugs include, but are not limited to: diabetes, high blood pressure, high cholesterol, hormone deficiency, allergies or pain. **The mail order program is intended for medication on a long-term, ongoing basis only and should not be used for occasional medications.**

An initial prescription for a medication on a long-term, ongoing basis may be filled at a retail pharmacy. In addition, two refills for that medication may be obtained from a retail pharmacy. Additional refills for such generic medications must be filled through the mail order service.

An initial prescription for brand name medication on a long-term, ongoing basis may be filled at a retail pharmacy. In addition, two refills for that medication may be obtained from a retail pharmacy. Refills for such brand name medications may be filled through the mail order service, although it is not mandatory.

Employee Co-Payments for prescriptions filled through the mail order service are as follows:

1. If a prescription is filled through the mail order service with a generic drug, the Employee Co-payment will be $21 for nothing less than a 90-day supply.

2. If a prescription is filled through the mail order service with a brand name drug that is listed on the LDI Formulary, the Employee Co-payment will be $34 for nothing less than a 90-day supply.

3. If a prescription is filled through the mail order service with a brand name drug that is listed on the LDI Formulary and there is a medically-equivalent generic drug available, the Employee Co-payment will be $34 plus the difference in ingredient cost between the brand name drug and the medically-equivalent generic drug for nothing less than a 90-day supply.

4. If a prescription is filled through the mail order service with a brand name drug that is not listed on the LDI Formulary, the Employee Co-payment will be $73 for nothing less than a 90-day supply.

D. **Pill Splitting**

At the option and request of the Covered Person, a prescription for tablets of a particular strength of a medication that has been designated by LDI as eligible for pill splitting may be filled by the pharmacist using one-half the prescribed number of tablets provided such tablets are twice the prescribed strength of that medication. Such prescription must be accompanied by instructions for the Covered Person to split each tablet.

E. **Specialty Drug Plan**

LDI operates a Specialty Drug Plan that covers injectables and other specialized medications. If a medication is prescribed that is included in the LDI Specialty Drug Plan, the pharmacist will work with the LDI Clinical Staff on availability and dispensing. The retail network Employee Co-payment schedule will apply and the maximum amount of medication to be provided with one Employee Co-payment is a 30-day supply.

F. **Prescription Drug Card Benefit – Step Therapy**

The Plan has implemented the LDI Step Therapy Program in an effort to maintain and preserve a high quality and cost-effective program for you. This program is mandatory for certain medication classes. The Step Therapy Program through LDI is designed to ensure you take the most cost-effective medications to treat certain conditions. The program promotes the use of generic medications because they are proven to be as safe and effective as brand name medications for most patients, but cost much less.

The Step Therapy Program groups certain medications into “steps”. Generic medications, which are the most cost effective, fall into the “first-step” category, preferred brand-name medications fall within the “second-step” category and non-preferred brand-name medications, which are the least cost effective, fall into the “third-step” category. The Step Therapy Program steers members to take first-step medications prior to coverage of a second step medication and to take a second step medication prior to coverage of a third step medication.

The medication classes which qualify for the Step Therapy Program include: Proton Pump Inhibitors, ARB antihypertensives, oral osteoporosis medications, cholesterol-lowering statins, sleep aids, SSRI antidepressants, and steroid nasal sprays.

You will be required to use the following procedures if you are currently taking any “second-step” or “third-step” prescriptions of the above medication classes:

1. Contact your Physician and share the step therapy information contained in your letter. Your Physician can decide which first-step medication is right for you.

2. If you have already tried one of the first-step medications and your Physician has determined that you require a different medication for medical reasons, then your Physician can call LDI at 1-866-516-3121 to request a prior authorization for you to continue taking the medication. The LDI Clinical Department can advise your Physician if a second-step medication is required. Just remember that you pay a higher co-pay for brand medications.

3. You have the option to take any medication that your Physician prescribes, however it may not be covered under the benefit plan if the proper steps are not taken first.

G. **Limitations**

1. Prescriptions for antidepressants written for Covered Persons under the age of 19 will not be covered by the Plan unless the pharmacist receives prior authorization from LDI to fill the prescription.

2. Diabetic supplies will only be covered by the Plan if they are purchased through mail order service.

3. The Plan does not cover birth control medications and devices. However, LDI will make its discount available to Covered Persons on certain contraceptives. The Covered Person will pay 100% of the cost of the medication, but should pay less with the discount. This will only apply to oral contraceptives, Ortho Evra/Nuvaring and Seasonale.

4. If a Covered Person has a prescription filled at a retail pharmacy that is not included in the LDI network, said person must pay for the full cost of the drug at the time of sale and the purchase is not eligible for reimbursement under the Plan.

   If a Covered Person has a prescription filled at a retail network pharmacy but does not present his identification card at the point of purchase, the receipt may be submitted to LDI for reimbursement. Payment will be made based on what LDI would have allowed if the transaction had been processed through the LDI system at the retail network pharmacy.

5. Notwithstanding any other provisions of the Plan to the contrary, the annual Prescription Drug Card Out-of-Pocket Limit covered under this Section 3.15, including drugs covered under the Specialty Drug Plan described in Subsection E, shall be $6,526 per calendar year per individual.

   This Prescription Drug Card Out-of-Pocket Limit is separate from, and unaffected by, the Calendar Year Out-of-Pocket Limit shown in Section 1.01 – Schedule of Benefits – Active and Retired Participant Program.

Section 3.17 – Routine Physical Examination and Preventative Services Benefit
Benefits are payable for routine physical examinations and preventative services and supplies (as described in this Section) up to the amount stated under the Schedule of Benefits made in a calendar year for the Usual, Customary and Reasonable Charges which are ordered and prescribed by a legally qualified Physician:

A. **Covered Services**

Benefits payable under the Routine Physical Examination and Preventative Services Benefit are:

1. Physicians' services and supplies including well baby examinations from birth to five years of age.

2. Lab and x-ray tests, including Pap smears and mammograms for females.

3. Immunizations or inoculations.

4. Any other diagnostic tests or procedures ordered by the examining Physician.

B. **Limitations**

Benefits under the Routine Physical Examination Benefit are **NOT** payable for:

1. Any examination or service provided for non-routine purposes.

2. Any treatment of a condition diagnosed as a result of a routine examination.

3. Flu shots.

Section 3.18 – Second Surgical Opinion Benefit (Third if Necessary)
When a Covered Person wishes to secure a second or third opinion to determine if a non-emergency surgical procedure is Medically Necessary, the Plan will pay the Physician's fee at 100% for the second or third opinion provided:

A. The Covered Person is examined in person by a board certified specialist; and

B. The specialist submits a written report of his findings and recommendations; and

C. The specialist that renders the second or third surgical opinion does not also perform the recommended surgical procedure; and

D. The specialist has no relationship with the Physician(s) who rendered prior opinions or who performs the surgery.

Section 3.19 – Supplemental Accident Expense Benefit
This Benefit will consider Expenses Incurred resulting from an Accident according to the Schedule of Benefits. If the Expenses Incurred resulting from an Accident exceed the Supplemental Accident Expense Benefit Calendar Year Maximum as stated in the Schedule of Benefits, the balance of the expenses will be considered under the Major Medical Benefit.

Section 3.20 – Vision Care Benefit
Vision Care Benefits under the Plan are provided through a contract with Vision Service Plan. Vision Service Plan has established a network of providers (optometrists, ophthalmologists and dispensing opticians) who agree to provide services in exchange for contracted fees. Benefits will be paid according to the Schedule of Benefits.

Section 3.21 – Urgent Care Benefit
When a Covered Person requires Urgent Care, Benefits will be paid according to the Schedule of Benefits for Usual, Customary and Reasonable Charges after the deductible.

In addition, the Telehealth Amwell Program is designed to give covered persons the capability to speak with a certified physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. The telemedicine benefit is available 24 hours a day, 7 days a week. This benefit is not meant for emergency situations but it can help in deciding whether a medical situation is an emergency. There is a $10 member Co-Payment per call as reflected in the Schedule of Benefits and it is not subject to deductible or coinsurance.

ARTICLE IV – BENEFIT EXCLUSIONS & LIMITATIONS

The Plan provides Benefits only for those Medically Necessary covered services and charges described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated at such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

In addition to any other limitations, either specific or general, set forth in the Plan, Benefits shall **NOT** be payable for any loss caused by, incurred for or resulting from:

1. Loss caused by accidental bodily injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit; or any accidental bodily injury or Sickness for which the Covered Person is entitled to any benefits under any Worker's Compensation or Occupational Disease Law. The Plan retains the option to withhold Benefits for any injury that may be questionable or compensable under any Worker's Compensation or Occupational Disease Law, until such time the Covered Person shows that they have made reasonable effort to exhaust their claim to Benefits under any Worker's Compensation or Occupational Disease Law.

2. Hospital, medical or surgical treatment provided because of loss from war or while in military service.

3. Any service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home, a place for long-term care or any institution of like character or for convalescent or custodial services.

4. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, impression casting for prosthetics and appliances, including prescriptions therefore; orthosis.

5. Services, procedures, treatments, drugs or medicines that are not customary and generally accepted by the medical profession and services or procedures that are Investigational or Experimental or for the purpose of research.

6. Services or supplies related to sex transformations or sexual dysfunction.

7. Visual analysis, eye examination for the correction of vision, eyeglasses, therapy or training for muscular imbalance of the eye, the fitting of glasses or orthotics, except for coverage provided by Vision Service Plan.

8. Any treatment, service or supply unless it is shown under covered eligible services. No payments are made for treatment or services for any injury or Sickness unless the Covered Person was eligible under the Plan at the time the treatment or services were provided.

9. Treatment by any method of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorder or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues related to that joint.

10. Any claim, expense or service caused by, resulting from, or contributed to by an attempt to commit or commission of an illegal act which is originally charged as a felony as defined under state or federal law, shall not be payable by the Plan.

11. Any Expense Incurred for obesity, including but not limited to: weight reduction programs, including drugs, surgical procedures, gastric bypass procedures, lipotomy or any procedure or complications therefrom.

12. No payments will be made for any treatment or service in connection with an elective abortion.

13. Hearing aids or the fitting thereof.

14. Service not ordered or performed by a licensed Physician.

15. Birth Control.

16. No payments will be made for any treatment or service in connection with a pregnancy of dependent children nor any expenses of the child of dependent children.

17. Dental treatments except where covered under the Dental Benefit or under the Major Medical Benefit as at Section 3.04 B.3.m. or where necessary to repair damage due to injury to natural teeth.

18. Child development classes or programs.

19. Personal items while in the Hospital, such as but not limited to, telephone, T.V., Hospital admission kits.

20. Speech therapy courses or treatments for dependent children, except where necessary to restore speech lost due to injury or Sickness.

21. Services or supplies provided by a provider or institution acting outside the scope of their license.

22. Services provided by a person who is a member of the eligible individual's immediate family or who normally resides in the household of the person being treated.

23. Services or supplies for which the patient is not required to pay.

24. A person providing services as an assistant surgeon who is not duly licensed to perform surgery.

25. Genetic or chromosomal testing, counseling or therapy.

26. Services or supplies for growth hormone medications and similar biopharmaceuticals unless they are determined to be Medically Necessary.

27. Body scans or screening exams unless they are Medically Necessary.

28. Travel, even though prescribed by a Physician.

29. Services or supplies without a diagnosis of injury or Sickness, except for as allowed under the Routine Physical Examination and Preventative Services Benefit.

30. Charges, Deductible Amounts or noncompliance penalties due to the failure of a Covered Person to use a preferred provider network when said individual is covered by the network, whether the penalty is for this Plan or another primary insurance carrier.

31. In-patient services at nursing homes or skilled nursing facilities.

32. Blood donations.

33. Recreational therapy, even though prescribed by a Physician.

34. Services or supplies to treat hair loss or to restore lost hair.

35. Expenses for CAT, PET and MRI scans that are not Medically Necessary, unless prior authorization was received as explained on page 8.

36. Services, supplies or treatment received outside of the United States, unless on an Emergency basis.

37. Services, supplies, medications or procedures related to infertility or the inability to conceive including, but not limited to pharmaceutical treatment, in vitro or in vivo fertilization, gamete intrafallopian transfer or other forms of reproductive technologies or artificial insemination.

ARTICLE V – MISCELLANEOUS PROVISIONS

The following topics are discussed under this Article on Miscellaneous Provisions:

Section 5.01 – Coordination of Benefits Provisions

A. **General Provisions**

The conditions of this provision of the Plan relating to "Coordination of Benefits" will be enforced on all claims and will be applicable to the total of any such claim to which this provision is applied, including claims under:

1. Group, blanket or franchise insurance coverage; or

2. Hospital or medical service organizations, group practice and other prepayment coverage; or

3. Any coverage under any labor-management trusteed plans, Union welfare plans, Employer organization plans, or Employee benefit organization plans; or

4. Any coverage under governmental programs or any coverage required or provided by any statute.

Benefits will be reduced under certain circumstances where an individual is covered under this Plan and under one or more other plans, but it is intended that the individual will be fully reimbursed for allowable expenses under the various plans to the extent combined Benefits equal 100% of the total allowable expenses.

B. **Benefit Determination**

As stated above, this Plan will coordinate Benefits with all group programs providing coverage to the Covered Person for all claims.

1. When the other group plan does not have a Coordination of Benefits Provision, they will be considered the primary carrier and must make benefit payment first before this Plan will consider payment.

2. When the other group plan does have Coordination of Benefits Provision, the order of benefit payments will be determined as follows:

The Covered Person **MUST** claim Benefits due from the "primary" plan determined by these rules for its share of eligible expenses, including Benefits or services available from prepayment coverage programs such as Health Maintenance Organizations. When this Plan is "secondary" according to the established order of benefit determination, the term "benefits payable under another plan" will include the benefits that would have been paid if the Covered Person made a proper claim on that plan or used its services. This Plan's liability and its Benefit payments will not increase simply because the Covered Person elects not to use the "primary" coverage.

This Plan will pay Benefits in accordance with any state law which provides that the state has acquired, pursuant to Title XIX of the Social Security Act (Medicaid), the rights to payment of Benefits under the Plan, and in accordance with any assignment of rights made by or on behalf of any Covered Person as required by the state plan for medical assistance approved under Title XIX of the Social Security Act in effect on August 10, 1993.

C. **When Claim is for a Covered Employee**

The Covered Employee must first submit all charges to the group with the earliest effective date. After the charges have been considered, copies of all charges and payment statements should then be submitted to the secondary plan for consideration.

D. **When Claim is for the Dependent Spouse**

1. The other plan – the plan covering the spouse as an employee – will, without exception, pay benefits first when the claim is on the spouse.

2. This Plan – which covers the spouse as an Eligible Dependent – will pay second and will coordinate with the other plan.

E. **When Claim is for a Dependent Child**

In claims involving children, the order of benefit payments will be as follows:

1. The Trustees have adopted, in principle, the coordination provision known as the "birthday rule" effective July 1, 1985. The "birthday rule" provides that:

   a. The plan covering the parent whose birthday occurs earliest in the calendar year will pay first.

b. The plan covering the parent whose birthday occurs later in the calendar year having Coordination of Benefits Provision will pay second.

2. Until the "birthday rule" is mandatory in all states, the Trustees have agreed to extend their prior practice to coordinate benefits with other plans that have not adopted the "birthday rule". The prior practice provides that:

a. The plan covering the natural father as an Employee will pay first.

b. The plan covering the natural mother as an Employee and having a Coordination of Benefits Provision will pay second.

If there is a divorce and/or remarriage, the financial and medical responsibility is generally stipulated by the court decree. If the decree does not stipulate the responsibility, or if one of the parents has remarried, there are special rules applied. The Participant must contact the Fund Office for further information.

For the purpose of determining the applicability and implementing the terms hereof or of any provisions of any other similar plan, the Trustees may, without consent of any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem to be necessary for such purposes and in so acting the Trustees shall be free from any liability that might arise in relation to such action. Any person claiming Benefits under the Plan shall furnish to the Trustees such information as may be reasonably necessary to implement this provision and the **TRUSTEES SHALL BE UNDER NO OBLIGATION TO FURNISH ANY BENEFIT UNDER THIS PLAN UNTIL SUCH INFORMATION HAS BEEN RECEIVED.**

Whenever payments which should have been made under this Plan in accordance herewith have been made under any other plans, the Trustees shall have the right, exercisable alone and in their sole discretion, to pay over to any organization making such other payments, any amount they shall determine to be warranted in order to satisfy the intent hereof, and amounts so paid shall be deemed to be Benefits paid under this Plan and, to the extent of such payments, the Trustees shall be fully discharged from liability under this Plan.

Special Note

If an Employee covered under this Plan has two group coverages, the plan with the earliest effective date must pay first. The plan covering the Employee for the shortest period of time will consider the balance due upon receipt of:

A. Copies of all itemized bills; and

B. Copies of the related payment statement(s).

In the event that both a husband and wife are eligible under this Plan as Covered Employees, Benefits shall be coordinated as if the spouse not submitting the claim had coverage under a different group plan.

Section 5.02 – Coordination with Medicare

Medicare has three relevant parts – Hospital Insurance (Part A), Medical Insurance (Part B) and Prescription Drug Coverage (Part D). Part A primarily covers In-Patient Hospital care, although other benefits are also provided and it is generally available to all individuals over age 65 at no cost. Part B covers Physician services, Out-Patient Hospital services and other medical supplies and is optional. Part D covers prescription drugs and is also optional. A Medicare participant must pay a monthly premium for Parts B and D.

The Plan coordinates expenses covered under Medicare Parts A and B only. It does not coordinate with Medicare Part D. The below paragraph refers to coordination with Parts A and B only. A Plan Participant or Beneficiary who enrolls for Medicare Part D will no longer by eligible for prescription drug coverage under this Plan, as of the date of the Part D enrollment. If a Plan Participant or Beneficiary does not enroll in Medicare Part D their prescriptions are covered under the Plan's Prescription Drug Card Benefit. The Plan coordinates expenses covered under Medicare Parts A and B via the Medicare Crossover Program.

The Plan shall pay Benefits secondary to Medicare Parts A and B to the full extent allowed by Section 1862(b) of the Social Security Act. In no event shall Expenses Incurred under the Plan, when added to Medicare benefits, exceed the amount the Plan would have paid had the Covered Person not been entitled to benefits under Parts A and B. For purposes of this Section, such individual shall be presumed to be covered by Parts A and B to the extent he has met all of the eligibility requirements and is otherwise entitled to benefits under Parts A and B regardless of whether he has actually enrolled in Parts A and B and all Expenses Incurred under the Plan will be treated as if provided through an In Network provider. The Plan's liability will not increase simply because the Covered Person did not elect Part B coverage. The Plan will reduce its payment by the amount Medicare would have paid. For Covered Persons who are entitled to Parts A and B benefits, the Plan shall require the submission of the Medicare explanation of benefits statement prior to the payment of any Benefits from the Plan.

In the event that a Covered Person is eligible under this Plan and Medicare, the following Coordination of Benefits provisions shall apply:

A. If a Participant is active or is covered by an "Hour Bank" and becomes eligible for Medicare due to End Stage Renal Disease (ESRD), the Plan shall be the primary payor during the initial 30 months of Medicare eligibility.

B. If a Participant is active and his dependent spouse or child becomes eligible for Medicare due to End Stage Renal Disease (ESRD), the Plan shall be the primary payor during the initial 30 months of Medicare eligibility.

C. If a Participant is retired and disabled and is eligible for Medicare due to the disability, Medicare shall be the primary payor and the Plan shall be the secondary payor.

D. If a Participant is retired and eligible for Medicare due to age, Medicare shall be the primary payor and the Plan shall be the secondary payor.

E. If a Covered Person is disabled and entitled to Medicare due to the disability and later becomes eligible for Medicare due to End Stage Renal Disease (ESRD), the payment order shall be determined in accordance with the dual eligibility provisions of the Medicare regulations.

F. If a Covered Person is entitled to Medicare due to age and later becomes eligible for Medicare due to End Stage Renal Disease (ESRD), the payment order shall be determined in accordance with the dual eligibility or entitlement provisions of the Medicare regulations.

If an End Stage Renal Disease (ESRD) patient loses Employee coverage during the initial 30 months for any reason, then Medicare shall become primary payer.

If a Covered Person is entitled to Medicare for any reason, the Plan shall pay its Benefits before Medicare **ONLY IF**:

A. A Covered Person has active Employee coverage and is age 65 or older;

B. A Covered Person has active Employee coverage and is entitled to Medicare due **SOLELY** to ESRD but only for the first 30 months after ESRD treatment commences;

C. A Covered Person has active Employee coverage, is under age 65 and becomes entitled to Medicare due to a disability other than ESRD.

When the rules above do not apply, the Plan shall pay its Benefits only after Medicare has paid its benefits.

Section 5.03 – Subrogation of Benefits

In the event the Plan provides Benefits for injury, Sickness or other loss (hereinafter the "injury") to any Covered Person, the Plan shall be automatically subrogated to all rights of recovery to any funds or monies that person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Covered Person," for this Section only) may have arising out of said injury, Sickness or other loss. Said recovery shall not be limited by characterization of loss and shall include recovery for personal injury, lost wages, loss of service, disability and claims for wrongful death, survivor or other claims under any state or federal law. The Plan is not limited or bound by any

judgment or settlement that apportions recovery among the various elements of damage. The Plan shall automatically have a first priority lien and shall be entitled to first dollar reimbursement from any recovery regardless of whether the Covered Person is made whole by said recovery. These rights of reimbursement and subrogation are reserved whether the admitted, determined and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any lawsuit, full or partial judgment, settlement or other recovery. The Plan shall be entitled to assert a lien against third parties, insurers, attorneys and other appropriate person or entities admitted, determined and/or alleged to be liable to the Covered Person in order to protect its right of subrogation.

This right of subrogation is specifically and unequivocally pro tanto subrogation; that is, subrogation from the first dollar received by the Covered Person, and this pro tanto is specifically and unequivocally to take effect before the whole debt is paid to the Covered Person. The Plan's subrogation rights include without limitation, an automatic first priority lien upon the first dollar recovery from any judgment, settlement or payment of any kind to the Covered Person as well as all rights of recovery of a Covered Person to any payments made by or on behalf of an admitted, determined and/or alleged to be liable party including, but not limited to, a recovery:

A. Against any person, insurer, third party or other entity that is alleged to be in any way responsible for providing compensation, indemnification or Benefits for the injury;

B. From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;

C. Under uninsured or underinsured motorist insurance;

D. Under motor vehicle medical payment insurance and;

E. Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverages or insurance.

These rights of reimbursement and subrogation are reserved whether the admitted, determined and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement or other recovery.

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend shall execute and deliver such documents and papers (including, but not limited to a Benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund Office as the Plan may require to protect its rights of reimbursement and subrogation. The Covered Person

shall do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan or the joinder of the Trustees or Plan in any claim or action against the admitted, determined and/or alleged to be liable party or parties.

The Trustees are vested with full discretionary authority to determine eligibility for Benefits, to construe subrogation and other Plan provisions and to reduce or compromise the amount of the Plan's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, shall be binding on the Plan without the Plan's written approval thereof, and the Plan expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Plan's subrogation interest shall be deducted first from any recovery from any entity or source by or on behalf of the Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Plan, pursuant to the subrogation right, shall not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common law/state law doctrine purporting to reduce the amount of the Plan's recovery.

The Plan reserves the right to initiate an action in the name of the Covered Person or his guardian, conservator or next friend to recover its subrogation interest, and the Covered Person or his guardian, conservator or next friend will cooperate fully with the Plan in such instances.

In the event of any failure or refusal by the Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Fund Office, or (2) to take any other action requested by the Fund Office to protect the interest of the Plan, the Plan may withhold payment of Benefits or deduct the amount of any payments made from future claims of the Covered Person.

The Covered Person shall not do any act or engage in any negotiations that would reduce, compromise or prejudice the Plan's rights to first recovery from any third party. In the event the Covered Person recovers any amount by settlement or judgment from any person, party, corporation, insurance carrier, governmental agency or other responsible party which is admitted, determined and/or alleged to be liable to the Covered Person, (1) the Plan shall be repaid in an amount equal to the full amount of Benefits paid by the Plan; and (2) no further Benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Plan. If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Plan's right to subrogation, the amount of the Plan's claim shall be deemed to be held in constructive trust, and the Plan shall be entitled to seek restitution, impose a constructive trust or seek any other equitable or legal action against the Covered Person or any other party. In addition, the Plan reserves the right to offset and/or deduct any amounts paid as Benefits against future claims submitted by the Participant and his Eligible Dependents.

The Plan shall not pay or be held responsible for any portion of the Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Plan reserves the right to first dollar from any recovery to the full amount of Benefits paid by the Plan and hereby claims a first lien against the proceeds of any settlement or judgment and priority over any claim or lien of legal counsel, insurers, or any other third party. The Covered Person shall provide all of the above referenced parties with notice of the Plan's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Covered Person or his guardian, conservator or next friend, provided any such agreement is established in writing.

The "make whole" rule, any similar state law doctrine or the "common fund" doctrine is specifically and unequivocally rejected. The Plan's right of first dollar subrogation or reimbursement applies regardless of whether the Covered Person is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of a written agreement. Any person who is represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

The Plan has the right to offset any pending or future claims against any recovery by the eligible individual or Eligible Dependent to the extent the recovery exceeds the unreimbursed Benefits paid by the Plan, even if no Benefits have been paid by the Plan. The Plan will also have a lien to the extent of the Benefits paid, which may be filed with any party alleged, determined and/or alleged to be liable to the Covered Person on account of the loss incurred.

If the Covered Person, or his guardian, conservator or next friend does not attempt a recovery of the Benefits paid by the Plan or for which the Plan may be obligated, the Plan shall be entitled to institute legal action against the party or parties alleged, determined and/or alleged to be liable to the Covered Person in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to or on behalf of the Covered Person.

In an action brought by the Plan, the reasonable cost of recovery, including the Plan's attorneys' fees, shall first be deducted from any recovery by judgment or settlement against the party or parties deemed liable by admission, judicial and/or administrative determination, or allegedly liable to the Covered Person. The Plan's subrogation interest, to the full extent of Benefits paid or due as a result of the occurrence causing the injury or Sickness, shall next be deducted with the balance paid to the Covered Person.

Section 5.04 – Claims

In most cases, the provider will submit claims electronically to the appropriate PPO network. If you need to file your own claim, claim forms and instructions can be obtained from the Fund Office. If possible, call the Fund Office to request a claim form a few days before the Covered Person will need the form. After the form is completed, submit all claims in writing to the Board of Trustees at the following address: Cement Masons and Plasterers Local 518 Health Care Fund, 6405 Metcalf, Suite 200, Overland Park, KS 66202.

A fully completed claim as described in Section 5.05 must be received by the Fund Office or PPO within one year of the date of service and shall be required on each initial claim. Written proof of loss must be submitted to the Fund Office within 12 months after the termination of a period for which the Plan is liable and in case of claim for any other loss within 12 months after the date of such loss.

Benefits for loss of life, if any, shall be paid to the Covered Employee's Beneficiary, if surviving the Covered Employee or otherwise as stated under Death Benefit in Section 3.01, upon proof of such claim. Any payment made by the Plan in good faith under this provision shall fully discharge the Plan.

The Plan shall have the right and opportunity to examine the person whose injury or Sickness is the basis of claim when and as often as it may reasonably require during pendency of a claim hereunder by a Physician the Plan chooses.

The Trustees shall have full authority to determine all questions of nature, amount and duration of Benefits to be provided based on what is estimated the Plan can provide without undue depletion or excessive accumulation. Provided, however, that no Benefits other than health, Sickness, Accident, hospitalization, medical, life, vision and related benefits may be provided for under this Plan.

The Trustees shall have full authority to determine the Benefits and adopt rules that shall be binding on the Union, Covered Persons and Beneficiaries.

Section 5.05 – Claims and Appeal Procedure
The following procedures to process Claims and appeals will apply to any Claim filed with the Cement Masons and Plasterers Local 518 Health Care Fund (Plan). These procedures have been adopted to comply with regulations issued by the U.S. Department of Labor, at 29 CFR 2560.503-1

The Trustees are both the Plan Administrator and the fiduciary responsible for all Benefit determinations on appeal. The Trustees may delegate all fiduciary responsibility for Claims determination to an Appeal Committee. Such Appeal Committee shall meet once each calendar quarter at regularly scheduled times.

The Trustees or Appeal Committee shall have the authority to interpret, construe and apply all terms of the Combination Summary Plan Description and Plan Document, the Trust Agreement and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of Benefits, in making an initial Benefit determination and a determination on appeal.

Under Federal law, Covered Person or Beneficiary has the right to bring a civil action under Section 502(a) of the Employee Retirement Security Act of 1974, as amended, ("ERISA") if dissatisfied with an adverse benefit determination. Before

bringing such an action, the Covered Person or Beneficiary must exhaust the Plan's Claims and Appeal Procedures. Any such legal action against the Plan under ERISA must be filed within two years of the date of the decision of the Trustees on appeal.

A. **Definitions**

1. Medical Claim:

a. A Medical Claim for Benefits is:
A written or Health Insurance Portability and Accountability Act (HIPAA) compliant electronic post-service request for payment of Benefits from the Plan:

i. Made by a Claimant;

ii. Received by the Fund Office or applicable PPO within one year of the date of service; and

iii. Includes all of the following:

- Participant's name;
- ID#;
- Address;
- Patient name/date of birth/relationship to Participant;
- Claimant authorization to pay/or not;
- ICD-9 diagnosis code;
- Date of service;
- Place of service;
- CPT procedure codes;
- Charges;
- Provider federal ID number/name and address;
- Patient account number.

b. A Claim is not:

i. A verbal inquiry about whether a specific service is a covered Benefit;

ii. A voluntary pre-service determination of whether a treatment, service or product is covered;

iii. An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Plan.

iv. An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Claimant to file a Claim after the denial.

2. Disability Claim: A Disability Claim is a claim for Benefits for Active Disabled Employees Hours Credit as described in Section 2.06 or Accidental Death & Dismemberment Benefits described in Section 3.02.

3. Claimant: A Claimant is:

   a. An eligible Participant in the Plan;

   b. An eligible Participant's Eligible Dependent, as described in Section 2.07; or

   c. The duly appointed Authorized Representative of a Covered Person, as described below.

4. Authorized Representative: An Authorized Representative is a person who is specially designated by the Claimant. In order to designate an Authorized Representative, the Claimant must present to the Fund Office a written statement designating an Authorized Representative. The statement must include:

   a. The name, telephone number and mailing address of the Authorized Representative;

   b. The name, mailing address, date of birth and social security number of the Claimant;

   c. A statement describing the Claim(s)/appeal(s) for which the designated person has authority to act on behalf of the Claimant; and

   d. The signature of the eligible Participant or, in the case of an eligible Participant's Eligible Dependent, the individual or a minor child's parent or legal guardian.

   The Trustees have the sole discretion to determine whether a Claimant has properly designated an Authorized Representative.

   Assigning a health care provider the right to receive Benefits does not make the provider an Authorized Representative. Any individual wishing to designate a health care provider as an Authorized Representative must provide the Fund Office with a separate written statement designating the provider as such. However, a Claimant may not assign payment of any

claim to an out-of-network health care provider. For your convenience, a "Designation of Authorized Representative" form is available at the Fund Office.

If a Claimant has designated an Authorized Representative, the Authorized Representative will receive all information and notifications, and will be authorized to act on behalf of the Claimant, with respect to all aspects of the Claim. This includes, but is not limited to, the initial determination, request for documents, appeals, and any other communication regarding the Claim. The authorization will remain in effect unless or until the Claimant provides the Fund Office with written notification that restricts or cancels the authorization.

The Plan only processes post-service Claims. The Plan does not require pre-approval of services. Therefore, the Plan does not process pre-service Claims. Post-service Claims are not urgent Claims. Therefore, the Plan does not process urgent Claims. All Claims must be submitted in writing or electronically in compliance with HIPAA. Verbal inquiries regarding eligibility or coverage are not Claims.

5. Days: Days, for purposes of computing any time period under this Section 5.05, shall mean calendar days.

B. **Time Periods for Initial Determination**

1. Medical Claims

The Plan shall make its initial benefit determination within 30 days. The Plan may extend this initial benefit determination period 15 days. The Plan shall notify the Claimant within the first 30 days, if an extension will apply. If additional information is needed to process the Claim, the Plan will give the Claimant 45 days to provide this additional information. The request for additional information may include notice to the Claimant that the Claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

2. Disability Claims

The Plan shall make its initial benefit determination within 45 days. The Fund may extend this initial benefit determination up to two times of 30 days each. The Plan shall notify the Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the Claim, the Plan will give the Claimant 45 days to provide this additional information. The request for additional information may include notice to the Claimant that the Claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

C. **Notice of Initial Determination**

The Plan shall issue a written or HIPAA electronic notice of benefit determination, which may be a denial of Benefits, that is an adverse benefit determination. This notice is also called an Explanation of Benefits, or EOB. This notice shall contain:

1. The specific reason or reasons for the adverse benefit determination;

2. Reference to the specific benefit provisions on which the adverse benefit determination is based;

3. 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;

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

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

6. If the adverse benefit determination is based on a Medically Necessary or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Benefit Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge to the Claimant upon request.

D. **Time Periods for Appeals – Medical and Disability Claims**

A request for review (an appeal) must be submitted in writing to the Fund Office no later than 180 days after the Claimant's receipt of the notice of adverse benefit determination. The Trustees may delegate to an Appeal Committee the authority to make all benefit determinations on appeal. The Fund Office shall issue a benefit determination on appeal no later than the next regularly scheduled quarterly meeting of the Appeal Committee of the Trustees. Except that if the appeal is received by the Fund Office less than 30 days before the next quarterly Appeal Committee meeting, a benefit determination on appeal

shall be made no later than the second quarterly committee meeting after receipt of the appeal. In addition, if due to circumstances beyond the control of the Plan a decision cannot be made, the Plan may extend the period to make a benefit determination until the next quarterly meeting. If the Claimant requests a hearing, a benefit determination shall be made no later than the third Appeal Committee meeting after receipt of the appeal.

The Plan shall issue its decision no later than five days following the benefit determination.

E. **Claimant's Rights on Appeal**

1. As stated in Section 5.05 D, the Claimant shall have 180 days following receipt of a notice of an adverse benefit determination within which to appeal the determination.

2. The review on appeal shall not give deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

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

5. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under Section 5.05 E 3 shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual.

6. The written decision of the Appeal Committee shall be final, binding and conclusive upon the Claimant.

7. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action including an action or

proceedings before any court, administrative agency or arbitrator (legal body). Generally, such legal bodies require a Claimant to follow and exhaust the Plan's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Plan's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

Content of Notice of Benefit Determination on Appeal

The Plan Administrator shall provide a Claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii) and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the Claimant –

1. The specific reason or reasons for the adverse benefit determination.

2. Reference to the specific benefit provisions on which the adverse benefit determination is based.

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Claimant's Claim for Benefits.

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

5. If the adverse benefit determination is based on a Medically Necessary or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request, and

6. A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

B. **Hearing Procedure**

The Trustees have established the following procedures for hearings:

1. The Claimant and/or designated Authorized Representative shall be afforded an opportunity to appear before the Appeal Committee and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the Claim.

2. The proceeding of the hearing shall be preserved by means of tape recordings, stenographic or court reporter's records.

3. In conducting the hearing, the Appeal Committee shall not be bound by the usual common law or statutory rules of evidence.

4. The Claimant or Authorized Representative shall have the right to review the tape recording of the hearing, obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to.

5. There shall be copies made of all documents and records introduced at the hearing, and the copies shall be attached to the record of the hearing and made a part thereof. Instead of attaching copies of the documents and records, reference may be made to them on the tape recording, and the tape recording and the copies shall be retained on the Claimant's file.

6. All information upon which the Appeal Committee bases its decision shall be disclosed to the Claimant or Authorized Representative at the hearing or in a written decision.

C. **Limitation On When a Lawsuit May Be Filed to Obtain Benefits**

A Claimant many not start a lawsuit to obtain benefits until after: (1) you have requested an appeal and a final decision has been reached on appeal, or (2) until the appropriate timeframe describe in the claim and appeal section of the Plan has elapsed since you filed a request for appeal and you have not received a final decision or notice from the Trustees that an extension will be necessary to reach a final decision.

For claims incurred on or after August 5, 2015, any lawsuit brought against the Plan must be initiated no more than two years after the date of: (1) a determination denying the claim for benefits or (2) the time for a decision on an appeal has expired.

Section 5.06 – Fraudulent Claim Warning

Any person who knowingly and with intent to defraud files a statement of claim with the Fund or assists anyone else in filing such a statement of claim which contains any material with false information, or conceals relevant claim information for the purpose of obtaining payment of said claim, the claim shall be denied and the eligibility of such person for Benefits from the Fund may be suspended for a minimum period of one year with reinstatement subject to review and approval by the Board of Trustees. In the event any claim is paid as the result of such a fraudulent statement or submission, the amount of the claim paid will be recovered with interest and the Participant's/dependent's eligibility for all Benefits from the Fund may be indefinitely suspended.

For example, if the Participant is married and becomes divorced, the Participant must notify the Fund Office immediately. If you fail to do so and your former spouse incurs medical expenses which are PAID by the Plan, you may be held liable for those Benefit payments. If you let any individual who is not eligible under the Plan as a dependent use your Plan identification card to obtain Benefits, you may be held liable for the Benefits paid by the Plan. If the Plan has to initiate legal actions against you, your Eligible Dependent or former spouse to recover monies paid by the Plan for expenses which should not have been paid due to fraud, then you may be required to pay for the Plan's attorney's fees.

Participating in fraudulent activity or facilitating others who are not eligible for Benefits under the Plan to obtain Benefits from the Plan is considered fraud and could subject you and the ineligible individuals who fraudulently obtain Benefits from the Plan to criminal prosecution. Further, in the event such claims are paid for the benefit of ineligible individuals due to your active or passive participation in a fraudulent act (i.e. failing to report to the Fund Office a divorce or the use of an ineligible individual of your Plan identification card) your eligibility may be suspended and/or the Plan may offset any such Benefits paid against any future Benefits to which you or your Eligible Dependents may be entitled. In other words, the Plan may not pay Benefits to which you may be entitled until the amount of Benefits that were improperly paid have been offset in full against any Benefits the Plan would otherwise have paid.

ARTICLE VI – PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

A. This Section describes the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued by the Secretary of Health & Human Services (The Privacy Rule). The Privacy Rule is incorporated herein by reference.

B. All capitalized terms have the meaning as stated in this Combination Summary Plan Description and Plan Document or The Privacy Rule.

C. The information in this Section discusses the required and permitted uses and disclosures of Protected Health Information (PHI) by the Trustees.

D. PHI may be used by and disclosed to the Trustees for purposes of general administration of the Plan, including, but not limited to the following:

1. Underwriting and budgeting; and

2. Claims review and processing; and

3. Amending or modifying the Plan of Benefits (Plan design); and

4. Claims assistance; and

5. Eligibility review; and

6. Any and all general administration of the Plan.

E. PHI may be disclosed to the Trustees as authorized by an individual.

F. The Plan shall make reasonable efforts to limit disclosure and use of PHI to the Trustees to the minimum necessary to accomplish the intended use or disclosure.

G. The Trustees:

1. Shall not use or further disclose PHI other than as permitted or required by this Combination Summary Plan Description and Plan Document or as required by law.

2. Shall comply with verification procedures of the group health plan.

3. Shall ensure adequate separation between the group health plan and the Trustees as follows:

   a. Describe those Employees or classes of Employees or other persons under the control of the Trustees to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to treatment, payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

   b. Restrict the access to and use by such Employees and other persons described in paragraph (G)(3)(a) of this Article VI to the Plan administration functions that the Trustees perform for the group health plan; and

   c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (G)(3)(a) of this Article VI with the Plan Document provisions required by this paragraph.

4. Shall not use or disclose PHI for employment related decisions.

5. Shall ensure that any agents, including a subcontractor, to whom the Trustees provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

6. Shall not use or disclose the information in connection with any other benefit or employee benefit Plan of the Trustees unless authorized by the individual or pursuant to a business associate contract.

7. Shall report to the Plan any use or disclosure of the information that is inconsistent with the allowed uses or disclosures of which it becomes aware.

8. Shall make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.

9. Shall make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporation into any amendments to PHI in accordance with HIPAA.

10. Shall make available to the Plan the information required to provide an accounting of disclosures.

11. Shall make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA, and

12. Shall return or destroy all PHI received from the Plan that the Trustees maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

H. Each Trustee shall certify compliance with The Privacy Rule and the Privacy Policy of the Cement Masons and Plasterers Local 518 Health Care Fund.

I. For additional information concerning the Privacy Rule, refer to the Plan's Privacy Notice effective April 14, 2003, which can be obtained from the Fund Office.

J. Security of electronic PHI

1. Definitions

a. The term *protected health information* ("PHI") has the same meaning as stated in The Privacy Rule.

b. The term *electronic protected health information* ("electronic PHI") means PHI that is transmitted or maintained in electronic form.

2. In addition to complying with the provisions of the Fund's HIPAA Privacy Manual, the members of the Board of Trustees shall:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that nay member of the Board of Trustees creates, receives, maintains or transmits on behalf of the Plan;

b. Ensure that the adequate separation discussed above in Section G 3, specific to electronic PHI, is supported by reasonable and appropriate security measures;

c. Ensure that any agent, including a subcontractor, to whom any member of the Board of Trustees provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

d. Report to the Plan any security incident of which any member of the Board of Trustees becomes aware concerning electronic PHI.

ARTICLE VII – ADMINISTRATION OF THE PLAN

The following topics are discussed under this Article on Administration of the Plan:

Section 7.01 – Benefits
The Trustees shall have full authority to determine all questions of nature, amount and duration of Benefits to be provided based on what is estimated the Plan can provide without undue depletion or excessive accumulation. Provided, however, that no benefits other than health, Sickness, Accident, hospitalization, medical, life, vision and related benefits may be provided for or paid for under this Plan.

Section 7.02 – Recipients of Benefits
Benefits may be provided in accordance with Section 7.01 only for a Covered Person or Beneficiary.

Section 7.03 – Eligibility Requirements for Benefits
The Trustees shall have full authority to determine eligibility requirements for Benefits and adopt rules and regulations setting forth the same, which shall be binding on the Association, the Employers, the Union, Participants, their Eligible Dependents and Beneficiaries.

Section 7.04 – Determination of Benefits
The Trustees shall have full authority to make determinations that shall be final and binding upon all parties as to the rights of any Covered Person or Beneficiary to Benefits, including any rights any individual may have to request a hearing with respect to any determination.

Section 7.05 – Method of Providing Benefits
The Benefits shall be provided and maintained by such means as the Trustees shall determine in their sole discretion.

Section 7.06 – Encumbrance of Benefits
No monies, property or equity of any nature whatsoever in the Fund, or policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through such Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge, and any attempt to cause the same to be subject thereto shall be null and void. Provided, however, that Benefits may be assigned by the Covered Person to the health care provider which furnished services for which Benefits are payable.

Section 7.07 – Construction of Terms
Wherever any words are used in this Plan in the masculine gender, they shall be construed as though they were also in the feminine or neutral gender in all situations where they would so apply; and wherever any words are used in this Plan in the singular form, they shall be construed as though they were used in the plural form in all situations where they would so apply, and wherever any words are used in this Plan in the plural form they shall be construed as though they were also used in the singular form in all situations where they would so apply.

Section 7.08 – No Reversion to Employers
The Employers shall have no right, title or interest in the contributions made by them to the Health Care Fund and no part of the Health Care Fund shall revert to the Employers.

Section 7.09 – Right of Recovery
If the Plan makes inadvertent, mistaken or excessive payment of Benefits, the Trustees or their representative shall have the right to recover such types of payments.

Section 7.10 – Amendments
The provisions of this Plan Document may be amended from time to time by the Trustees and such amendments shall be effective when voted upon by a majority of such Trustees provided that such amendments shall be made consistent with the objectives and purposes of the Trust.

Section 7.11 – Termination of Plan
This Plan may be terminated by an instrument in writing executed by all the Trustees and the parties hereto.

Section 7.12 – Procedure of Termination
In the event of the termination of this Plan, the Trustees shall apply the Fund to pay or provide for the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion; best effectuate the purposes of the Fund. Provided, however, that no part of the corpus or income of the Fund shall be used for or diverted to purposes other than for the exclusive benefit of the Covered Persons, Beneficiaries, administrative expenses or other payments in accordance with the provisions of the Fund. Under no circumstances shall any portion of the corpus or income of the Fund, directly or indirectly, revert or accrue to the benefit of the Employers, the Association or the Union.

Section 7.13 – Notification of Termination
Upon termination of the Plan in accordance with this Article, the Trustees shall forthwith notify the Participants, the Association and the Union and all other necessary parties, and the Trustees shall continue as Trustees for the purpose of winding up the affairs of the Fund.

Section 7.14 – Severability
Should any provision in the Plan or rules and regulations adopted hereunder be deemed invalid or illegal or held to adversely affect the provisions herein and therein contained unless such illegality shall make impossible or impractical the functioning of the Fund and the Plan, and in such case the appropriate parties shall immediately adopt a new provision to take the place of the illegal or invalid provision.

Section 7.15 – Reciprocity and Portability
The Trustees may in accordance with Article IX, Section 5 of the Trust Agreement enter into or amend portability or reciprocity agreements with other welfare funds.

Section 7.16 – Trustees' Authority
The Trustees of the Plan shall have the authority to revise, interpret, construe and apply the provisions of the Plan document including, but not limited to, provisions relating to the eligibility for, entitlement to and/or the nature, amount and duration of Benefits.

Section 7.17 – Medical Examination
No medical examination shall be required to obtain coverage for Benefits initially. However, the Trustees shall have the right, through a medical examiner of their choosing, to examine a Covered Person as often as they may reasonably require during the pendency of a claim and the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

ARTICLE VIII – IMPORTANT INFORMATION

Section 8.01 – Name of this Plan
The name of the Plan is the Cement Masons and Plasterers Local 518 Health Care Fund.

Section 8.02 – Type of Plan
The Plan provides hospitalization, medical, death, accidental death and dismemberment, maternity and vision Benefits, and other Benefits as listed on the Schedule of Benefits and in the Description of Benefits.

This Plan believes this it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (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 that law was enacted. Being a grandfathered health plan means that your Plan may not 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 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 the Fund Office.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 8.03 – Type of Administration
Although the Trustees are legally designated as both the Plan Sponsor and Plan Administrator, they have designated certain administrative functions to those with special expertise in Fund Administration. Under contract, the Trustees have hired a professional Administrative Manager. The Administrative Manager maintains the eligibility records, accounts for Employer contributions, makes Benefit payments authorized by the Trustees, keeps Participants informed about Plan changes, files government reports and handles other administrative activities under the direction of the Trustees.

The Administrative Manager is:

TIC International Corporation
6405 Metcalf, Suite 200
Overland Park, Kansas 66202
(913) 236-5490 or (800) 542-4482

Section 8.04 – Collective Bargaining Agreements
The Plan is maintained under the terms of a Collective Bargaining Agreement negotiated by the Union with participating Employers. These agreements set forth the conditions under which participating Employers are required to contribute to your Plan and the rates of contributions. You may examine these agreements at the Fund Office or any other approved location or you may request, in writing, to receive copies of the Collective Bargaining Agreements described in this Section for a reasonable charge. You may also obtain, upon written request, information from the Fund Office as to whether a particular Employer or Union participates in the Plan and if so, the address of the Employer or Union.

Section 8.05 – Source of Contributions
The primary source of financing for the Benefits provided under this Plan and for the expense of Fund operations is Employer contributions. The rate of contributions is contained in the Collective Bargaining Agreement negotiated by the Union with participating Employers. No money is ever deducted from your paycheck to pay for the Plan.

A portion of the Plan assets is invested to provide additional Fund income.

Section 8.06 – Funding Medium for the Accumulation of Plan Assets
All contributions and investment earnings are accumulated in a Trust Fund. Benefits are paid from the Trust Fund. Some Plan assets are invested, primarily in short-term, high quality securities.

Section 8.07 – Circumstances that may Result in Loss of Eligibility or Benefits
Throughout this Benefit Booklet we have tried to bring to your attention those circumstances that might lead to a loss of your eligibility and to describe any limitations, exclusions or restrictions applicable to specific Benefits. We urge you to familiarize yourself with this information, especially as it relates to the requirements that must be met in order to maintain your eligibility for Benefits. Refer to Eligibility Rules in Article II of this Benefit Booklet.

Section 8.08 – Agent for Service of Legal Process
Every effort will be made by the Trustees of this Plan to resolve any disagreements with Participants promptly and equitably.

If, however, you and your attorney feel that some legal action may be necessary, the following person has been designated by the Board of Trustees as its agent for service of legal process:

Michael G. Newbold
Arnold, Newbold, Winter, Jackson and Jacoby, P.C.
1125 Grand Boulevard, Suite 1600
Kansas City, MO 64106

Service of legal process may also be made upon any Plan Trustee or the Plan Administrative Manager.

Section 8.09 – Plan Identification Numbers
When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to identify the Cement Masons and Plasterers Local 518 Health Care Fund.

Employer Identification Number (EIN) assigned by the Internal Revenue Service is: 43-6039075.

Plan Number assigned by the Internal Revenue Service is: 501.

Section 8.10 – Fiscal Year & Plan Year
The financial records of this Plan are kept on the basis of the fiscal year, which ends on July 31. The Plan Year is August 1 - July 31.

Section 8.11 – Participant Rights Under the Employee Retirement Income Security Act (ERISA)
ERISA stands for the Employee Retirement Income Security Act, which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Cement Masons and Plasterers Local 518 Health Care Fund. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken the steps necessary to assure full compliance with ERISA.

ERISA requires that Participants and Beneficiaries be provided with certain information about their benefits, how they may qualify for Benefits and the procedures to follow, which are presented in the preceding pages of this Benefit Booklet.

ERISA also requires that Participants and Beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

YOUR ERISA RIGHTS AS A PARTICIPANT

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA.

ERISA sets forth certain minimum standards for the design and operation of privately sponsored welfare and pension plans. The law also spells out certain rights and protections to which you are entitled as a Participant.

The Trustees of the Cement Masons and Plasterers Local 518 Health Care Fund want you to be fully aware of your rights and for this reason, a statement of your rights follows.

Receive Information About Your Plan and Benefits

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

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

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

Receive notice that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Receive notice that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's Interim HIPAA regulations, as updated. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or (8) disability.

Receive notice that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits

or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable.

Receive notice that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

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 Combination Summary Plan Description and Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

We hope this Benefit Booklet has provided you with the most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, you should contact the Trustees by writing to:

Cement Masons and Plasterers Local 518 Health Care Fund Office
6405 Metcalf, Suite 200
Overland Park, KS 66202

Or, call the Fund Office at (913) 236-5490 or (800) 542-4482.

ARTICLE IX – DEFINITIONS

The following definitions are included in this Article:

Section 9.01 – Accident
The term "Accident" shall mean an injury, such as a cut, break, sprain or bruise occurring from an unexpected, undesirable and unavoidable act. This does not include overuse of muscles resulting in strains or sprains.

Section 9.02 – Association
The term "Association" as used herein shall mean The Builders' Association.

Section 9.03 – Beneficiary
The term "Beneficiary" shall mean a person, trust or living trust designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or may become, entitled to receive any type of Benefit from this Fund.

The spouse is the automatic Beneficiary if the Participant is married. If the Participant is not married or ceases to be married, the Beneficiary will be the person or persons designated by the Participant. The designation of a Beneficiary by a Participant or the change of a Beneficiary designation by a Participant must be in writing on such form as

the Trustees shall prescribe and shall become effective only when filed with the Fund Office. A former spouse will only be a Beneficiary if so designated by the Participant after the date of divorce.

When a Participant dies without designating a Beneficiary, any Death Benefit shall be paid to the living legal spouse. If there is no living legal spouse, the Death Benefit shall be paid in equal shares to the Participant's living children. If there are no living children, the Death Benefit shall be paid in equal shares to the Participant's living parents. If there are no living parents, the Death Benefit shall be paid in equal shares to the Participant's living siblings. If there are no living siblings, the Death Benefit shall be paid to the Participant's estate.

Section 9.04 – Benefits
The term "Benefits" shall mean the health and welfare Benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Trustees.

Section 9.05 – COBRA Continuation Coverage
The term "COBRA Continuation Coverage" shall mean a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requiring all health and welfare funds sponsoring group health plans to offer Employees and their families the opportunity for a temporary extension of health coverage under certain circumstances if they become ineligible for coverage under the Plan.

Section 9.06 – Collective Bargaining Agreement
The term "Collective Bargaining Agreement" shall mean the labor agreement between the Union and the Association and any other Employer, group of Employers or association of Employers.

Section 9.07 – Covered Employee
The term "Covered Employee" shall mean an Employee for whom contributions are required to be made to the Fund as provided by a Collective Bargaining Agreement and who is covered according to the provisions set forth under Article II - Eligibility Rules.

Section 9.08 – Covered Person
The term "Covered Person" means either the Covered Employee or the Eligible Dependent as defined in Section 9.11.

Section 9.09 – Durable Medical Equipment
The term "Durable Medical Equipment" shall mean equipment that meets all of the following criteria:

A. Is certified, in writing, by the prescribing Physician as Medically Necessary in the treatment, habilitation or rehabilitation of a patient,

B. Is clearly related to and necessary for the treatment, habilitation, or training of persons with the specified condition,

C. Must improve the function of a malformed body member or retard further deterioration of the patient's condition,

D. Would NOT be necessary in the absence of an Illness or physical or mental disability,

E. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,

F. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),

G. Is appropriate for and intended for use in the home.

Section 9.10 – Effective Date of Individual Coverage
The term "Effective Date of Individual Coverage" shall mean the date Employee and Eligible Dependent coverage will be effective pursuant to the Eligibility Rules shown in Article II.

Coverage will be provided for the newborn child during the mother's Hospital maternity confinement, provided this dependent meets the Eligibility Rules shown in Article II.

Section 9.11 – Eligible Dependent
The term "Eligible Dependent" shall mean a person who satisfies the Dependents' Eligibility Rules as shown in Section 2.07.

Section 9.12 – Eligibility Rules
The term "Eligibility Rules" shall mean the requirements to become eligible for Benefits for Employees and their Eligible Dependents, Retirees and their Eligible Dependents, Totally Disabled Employees and their Eligible Dependents, and Employees and dependents under COBRA Continuation Coverage.

Section 9.13 – Employee
The term "Employee" shall mean:

A. Any person who is employed by an Employer as defined in Section 9.15 and for whom the Employer is required to make contributions into the Trust Fund;

B. Any full-time Employee of the Union or of a participating Union;

C. Any full-time Employee of the Association;

D. Any full-time Employee of the Trustees; or

E. Any other Employee of an Employer who has been accepted as such by the parties hereto and the Trustees.

Section 9.14 – Employee Co-payment
The term "Employee Co-payment" shall mean the amount the Employee must pay for a specified Benefit (typically applies to Vision and Prescription Drug Card Benefits but can vary), usually at the time of service. Employee Co-payments will not be applied to the Deductible or Out-of-Pocket Maximum, and are payable even if the Out-of-Pocket Maximum is met.

Section 9.15 – Employer
The term "Employer" shall mean:

A. Any member of the Association who is a party to, or otherwise bound by, a Collective Bargaining Agreement with the Union requiring contributions to be made to the Trust Fund as provided by a Collective Bargaining Agreement with respect to Employees represented by the Union;

B. Any Employer who is a non-member of the Association who has signed a Stipulation in accordance with Annex "A" of the Trust Agreement or in a form otherwise approved by the Trustees;

C. Any other Employer, association of Employers or group of Employers who have been accepted and approved by the Trustees; or

D. The Trustees of the Union, participating Unions and the Association as to Employees of the Association solely for the purpose of making the required contributions to the Trust Fund. The Union, participating Unions or the Trustees shall not participate in the selection of any Association Trustees.

Section 9.16 – ERISA
The term "ERISA" as used herein shall mean the Employee Retirement Income Security Act of 1974, any amendments as may be made from time to time, and any regulations promulgated pursuant to the provisions of the said Act.

Section 9.17 – Expense Incurred
The term "Expense Incurred" shall mean only those charges made for services and supplies that are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care. All Expenses Incurred will be considered under Usual, Customary and Reasonable Charges basis in the given geographical area which is no higher than the 90th percentile of prevailing health care charged data.

Section 9.18 – Hospital

A. The term “Hospital” shall mean only those facilities or institutions which meet all of the following criteria:

1. Are licensed as a Hospital by the state or by the county or municipality where the facility or institution is located.

2. Operate primarily for the active care of the sick and injured and not for custodial care or educational service.

3. Provide 24 hour-a-day, on the premises, nursing services by registered nurses (R.N.).

4. Have a staff of one or more Physicians available at all times.

5. Provide organized facilities for diagnosis and surgery on its premises.

6. Are not primarily clinics, nursing, rest or convalescent homes or extended care facilities.

7. Maintain permanent and full time facilities for bed care of 50 or more resident patients.

B. For purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits, the term “Hospital” shall mean (a) facilities or institutions as defined in Section 9.18 paragraph A, or (b) a facility licensed by the appropriate state governmental authority and is certified under Medicare as a participating Hospital for the treatment of mental and nervous disorders or alcohol or substance abuse disorders.

Section 9.19 – In-Patient

The term “In-Patient” means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

Section 9.20 – Investigational or Experimental

The term “Investigational” or “Experimental” as used herein, shall mean any treatment, procedure, facility, equipment, device, supply, drug or medicines (hereinafter collectively referred to as “treatment”) or the use thereof which falls within any of the following categories:

A. Which is considered by any government agency or subdivision, including but not limited to the Food and Drug Administration, the office of Health Technology Assessment, or the HCFA Medicare Coverage Issues Manual to be:

1. Experimental or Investigational;
2. Not considered reasonable and necessary;

B. Which is not covered under Medicare reimbursement laws, regulations or interpretations; or

C. Which is not commonly and customarily recognized by the medical profession as appropriate and necessary for the condition being treated.

Determination of whether a treatment is Experimental or Investigational will be made by the Trustees in their sole discretion and will be conclusive. The Trustees reserve the right, in their sole discretion, to change the treatments considered to be Experimental or Investigational, from time to time.

Section 9.21 – Local Union or Union
The terms "Local Union" or "Union" shall mean Operative Plasterers and Cement Masons International Association, Local No. 518.

Section 9.22 – Medically Necessary
The term "Medically Necessary" shall mean services or supplies which the Trustees and/or an independent review panel believe:

A. Is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; and

B. Could not have been omitted without adversely affecting the Covered Person's condition or quality of medical care.

Section 9.23 – Out-Patient
The term "Out-Patient" shall mean a person who receives Hospital services and treatments but is not an In-Patient and who is not charged room and board.

Section 9.24 – Participant
The term "Participant" shall mean any Employee or former Employee of an Employer who is, or may become eligible to receive any type of Benefit from this Fund or whose beneficiaries may become eligible to receive any such Benefit.

Section 9.25 – Physician
The term "Physician" shall be understood to include medical doctors, osteopaths, dentists, podiatrists, chiropractors, and psychologists with a Ph.D., when practicing within the scope of their licenses.

Section 9.26 – Plan
The term "Plan" shall mean the Schedule of Benefits and the rules and regulations of the Plan and the Trust Fund as established heretofore, or as shall be established from time to time by amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

Section 9.27 – Retiree
The term “Retiree” refers to a Covered Employee who has satisfied the conditions of Section 2.09 and was eligible for Benefits under the Cement Masons and Plasterers Local 518 Health Care Fund on the date of retirement.

Section 9.28 – Sickness
The term “Sickness” shall mean an illness, pain or a fever not caused by an Accident as defined in Section 9.01.

Section 9.29 – Totally Disabled and Total Disability
The terms “Totally Disabled” and “Total Disability”, unless otherwise specifically defined, shall mean a disability, resulting solely from a Sickness or accidental bodily injury, which prevents the Covered Employee from engaging in any occupation for compensation or profit or prevents the Covered Employee’s Eligible Dependent(s) from engaging in substantially all the normal activities of a person of like age and sex in good health. The Covered Person must be under the regular care and actual attendance of a Physician.

Section 9.30 – Trust Agreement
The term “Trust Agreement” shall mean the amended Trust Agreement establishing the authority to maintain this Health Care Fund.

Section 9.31 – Trustees
The term “Trustees” shall mean the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the “Administrator”, the “Plan Sponsor” and the “Named Fiduciaries” of the Trust and of the Employee Benefit Plan established and maintained under the authority of the Trust Agreement.

Section 9.32 – Trust Fund, Fund or Health Care Fund
The terms “Trust Fund”, “Fund” or “Health Care Fund” shall mean the Trust Fund created pursuant to the Trust Agreement and shall mean generally the monies or other things of value that comprise the corpus and additions to the Trust Fund.

Section 9.33 – Usual, Customary and Reasonable Charge (UCR Charge)
The term “Usual, Customary and Reasonable Charge (UCR Charge)” means that the charge, by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the lesser of the Blue Cross Blue Shield in-network rate or 90th percentile of prevailing health care charged data. The area reference is the zip code for the general level of charges being made by a Physician of similar training and experience.

Every effort has been made to assure that the information contained in this Combined Plan Document and Summary Plan Description is accurate and up to date as of the time of its printing. You will be notified, in writing, of any changes in the Plan that may affect your Benefits or rights under the Plan.

SIGNATURE PAGE

IN WITNESS WHEREOF, we have hereunto affixed our signatures and approved this restated Combination Plan Document and Summary Plan Description this 28th day of February 2017.

APPROVED:

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