Cement Masons & Plasterers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

March 26, 2021

TO: All Active Participants and Dependents of the Cement Masons and Plasterers Health and Welfare Trust

RE: Benefit Changes

This is a Summary of Material Modification describing a change adopted by the Board of Trustees of the Cement Masons and Plasterers Health and Welfare Plan ("Plan"). This information is VERY IMPORTANT to you and your Dependents. Please read it carefully and keep it with your booklet.

Continued Eligibility for Employees with a Work-Related Disability

The Plan allows employer contributions on behalf of certain employees who are temporarily totally disabled under workers' compensation laws. If, while an active participant under the Plan, you become temporarily totally disabled under applicable workers' compensation laws, your employer may elect to continue contributions on your behalf for up to a maximum of 18 weeks. In order to qualify under this provision, your employer must provide proof that you are not working and that you are receiving wages in lieu of workers' compensation time-loss benefits. If your employer covers you under this provision, then contributions must be paid as if you are working 40 hours per week/8 hours per day for the period in which you are not working as a result of the work-related disability. The Plan will require that your employer identify the contributions made pursuant to this provision.

If you return to work on active or light duty status, any subsequent work-related disability periods that occur within 6 months of your original disability period will be considered successive periods of work-related disability and the 18-week maximum coverage period will be reduced by the prior weeks for which your employer continued contributions. In no event is your employer permitted to make contributions under this provision for more than 18 weeks during any 12-month period.

Eligibility provided as a result of employer contributions for a work-related disability does not impact your right to elect COBRA continuation coverage. However, your COBRA continuation coverage will be reduced by the number of uninterrupted months you received coverage under this provision immediately preceding the election of COBRA.

If you are on "light duty" status, employer contributions are paid pursuant to the applicable collective bargaining agreement, rather than under this provision

Transplants

Effective April 1, 2021, transplants and transplant-related services and supplies are covered, including hospital and outpatient facility charges. A transplant recipient who is covered under this Plan and fulfills Medically Necessary criteria will be eligible for the following transplants:

- cornea
- kidney
- multivisceral
- heart
- pancreas
- islet cell

- lung
- liver
- small bowel
- bone marrow
- hematopoietic stem cell - Hematopoietic stem cells can be collected from either the bone marrow or the peripheral blood and may involve the following donors: autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or umbilical cord blood (only covered for certain conditions)
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- thymus tissue for FDA-approved treatments

Tendon and joint repairs or replacements and heart valves and pacemakers are not considered transplants.

Donor Organ Benefits

Effective April 1, 2021, donor organ procurement costs, including hospital or outpatient facility fees, are covered if the recipient is covered for the transplant under this Plan. Procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ and other such Medically Necessary procurement costs.

Benefits for all transplants and donors must be authorized in writing by Aetna in advance. Approval will be based on Medical Necessity, the Covered Person's medical condition, the PPO Provider's qualifications, appropriate medical indication for the transplant, and appropriate, proven medical procedures for the condition.

Service and supplies must be provided by a PPO Provider, and all services directly related to organ transplants must be coordinated by the PPO Provider. Aetna has designated certain transplant facilities as "Institutes of Excellence." Use of an Institute of Excellence may result in lower costs to you and the Plan. To locate and learn more about Institutes of Excellence please contact Aetna. Benefits are NOT provided when services and supplies are provided by a Non-PPO Provider.

Transplant benefits are subject to all plan conditions and limitations, and no benefits will be provided for the following:

- Nonhuman, artificial or mechanical transplants.
- Services or supplies in conjunction with experimental or investigational treatment.
- Lodging, food or transportation costs, unless otherwise specifically provided under this plan.
- Expenses for organ harvesting or storage, unless specifically approved in advance by Aetna on a case-by-case basis.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas, unless the organ donor is a family member of the person seeking the transplant; family member for this purpose means grandparent, parent, child , brother, sister, aunt, uncle, nephew, niece or cousin.
- Any expense incurred by or on account of donating human organ or tissue to a person who is not covered by the plan.

Important Information Relating to COVID-19 and Extension of Deadlines

The Department of Labor, on February 26, 2021, provided new guidance on the suspension of certain employee benefit time limitations during the COVID-19 Outbreak Period, which is the period beginning March 1, 2020 and ending 60 days after the national emergency ends. This supplemental notice explains how this affects your rights under the Plan.

Extensions of Time

Pursuant to federal guidance, the Plan has extended the following deadlines during the Outbreak Period beginning March 1, 2020:

- The 60-day period for individuals to notify the plan of a COBRA qualifying event.
- The 14-day period for plan administrators to provide an individual with a COBRA election notice.
- The 60-day period to elect COBRA continuation coverage after receiving a COBRA election notice.
- The date for making COBRA premium payments.
- The 30-day (or 60-day, as applicable) period to request special enrollment after a special enrollment event.
- The time limit for members to file a benefit claim, an appeal of an adverse benefit determination, or an external review request, under the plan's claims procedures.

The Department of Labor has authority to grant these extensions for **one year** only**.** The new Department of Labor notice dictates that the one-year extension should be applied separately to each deadline during the Outbreak Period. In effect, this adds one year to each one of the above deadlines until the Outbreak Period is over.

COBRA Examples

If you had a qualifying event in April 2020 and received a COBRA election notice on May 1, 2020, your 60-day period to elect COBRA coverage will begin running on May 1, 2021, one year later. You will have until June 29, 2021 to elect COBRA continuation coverage effective back to your qualifying event.

If you had a qualifying event in February 2021 and received a COBRA election notice on March 1, 2021, your 60-day period to elect COBRA coverage will begin one year later, on March 1, 2022, or at the end of the Outbreak period, whichever comes first.

COBRA premiums are generally due on the first of the month and subject to a 30-day grace period. During the Outbreak Period, the 30-day grace period for each monthly payment is extended by one year. For example, if you were receiving COBRA in April 2020, the 30-day grace period for the April premium payment begins on April 1, 2021, so your payment is due on April 30, 2021. The May 2020 premium payment similarly will be due by May 30, 2021, and so on.

Special Enrollment Examples

If you previously declined coverage for a dependent because the dependent had coverage under another employer health plan, but your dependent lost that coverage because of the end of that employment, then you have 30 days from the end of that coverage to request special enrollment for that dependent in the Plan. That 30-day time limit was suspended under the federal rule, but will begin or resume **one year** from the date of the event. For example, if your spouse's other employment-based coverage ended on January 1, 2021, you will have until January 30, 2022 to request special enrollment – one year, plus 30 days – unless the Outbreak Period ends earlier.

Important Note Regarding Retroactivity

Please note that while you may elect COBRA continuation coverage back to your COBRA qualifying event or special enrollment for a new dependent based on birth or adoption back to the date of birth or adoption, you must pay any required premiums for all months before retroactive coverage will be provided. Retroactive coverage must be continuous from the time of first retroactive eligibility. You may submit claims for services during the suspended period, but they will be pended until you make the necessary premium payments.

If you have any questions about how this information applies to you, please contact the Administration Office at (877) 367-0528 or (800) 331-6158, option 0.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Trust

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