CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE PLAN | AK PLAN

Summary Plan Description
April 2019

ALASKA PLAN

Cement Masons & Plasterers Trust Funds

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (877) 367-0528 • Fax: (206) 505-9727 • Website: www.cementmasonstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 29, 2022

TO: All Eligible Plan Participants and Dependents of the Cement Masons and Plasterers Health and Welfare Plan

RE: Benefit Changes Effective June 1, 2022

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees has taken action to adopt the following changes to your Plan benefits:

Life Insurance, Accidental Death and Dismemberment

Effective June 1, 2022, the Plan is increasing the principal sum of the life insurance and accidental death and dismemberment benefit for active participants from $25,000 for Washington and $10,000 for Alaska **to $50,000 in both Washington and Alaska.** The dependent and retiree life insurance benefits remain unchanged.

Weekly Disability Benefits

Effective July 1, 2022, the Plan is increasing its weekly disability benefit from $250 per week **to $400 per week.** The benefit is limited to a maximum of 26 weeks for all disabling health conditions. For non-occupational hospitalization or injury, benefits shall be payable on the 1st day of the injury or hospitalization. For all other non-occupational illnesses, benefits shall be payable on the 8th day of the continuous illness.

Gene and Cellular Therapy

Effective June 1, 2022, the Plan will cover Medically Necessary Gene and Cellular Therapy services from a designated facility/provider. Coverage is provided subject to the Plan's annual deductible, copays, coinsurance, and annual coinsurance and out-of-pocket maximums. Gene and Cellular Therapy services and treatment must be preauthorized to be covered. Your provider should call Aetna at the number printed on the back of your ID card to preauthorize these services. Aetna designates facilities/providers for Gene and Cellular Therapy services. Services must be provided by an Aetna-approved facility/provider in order to be covered by the Plan. Coverage is subject to all other Plan limitations and exclusions.

Gene and Cellular Therapy — Includes gene and cellular based therapy techniques that modify and/or use a person's genes or cells to treat or cure disease. Gene and Cellular Therapy, as defined by the Plan, includes Medically Necessary gene and cellular based therapies provided by an approved Physician, including, but not limited to:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;
- All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9;
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen)
  - siRNA
  - mRNA
  - microRNA therapies

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (877) 367-0528, option 1. Please also refer to the Trust website for additional notices: www.cementmasonstrust.com.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Cement Masons & Plasterers Trust Funds

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Phone: (877) 367-0528 • Fax: (206) 505-9727 • Website: www.cementmasonstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

April 5, 2022

TO: All Eligible Plan Participants and Dependents of the Cement Masons and Plasterers Health and Welfare Plan

RE: April 1, 2022 Plan Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees has taken action to adopt the following changes to your Plan benefits effective April 1, 2022:

Dollar Bank Maximum. Currently, the maximum that can be accumulated in a Participant's Dollar Bank Account is $10,000. Effective April 1, 2022, this maximum is increased to $11,000. Any grandfathered amounts in excess of $11,000 will continue to be preserved per the Summary of Material Modification that was dated July 29, 2003. If you would like a copy of this Summary of Material Modification, please contact the Trust Administration Office.

Foot Orthotics. Effective April 1, 2022, the following benefit is added to the Washington Plan Booklet (this benefit is already included in the Alaska Plan Booklet).

> ***Orthotics.*** Foot orthotics or other supportive devices of the feet are limited to one pair per year of braces, splints, custom insoles or supports prescribed by a Physician for the treatment of an Illness or Injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany orthotics are not covered. Over the counter shoe inserts are not covered.

Any exclusions in the Booklets to the contrary are deleted.

Dental Personal Protective Equipment. Effective May 1, 2020, through June 30, 2022, appropriately billed charges by a licensed dental office for dental personal protective equipment will be covered up to $20 per visit.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (877) 367-0528, option 1. Please also refer to the Trust website for additional notices: www.cementmasonstrust.com.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan

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Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Cement Masons & Plasterers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

February 8, 2022

NOTICE REGARDING COVID TESTING

It's now almost two years since the Cement Masons and Plasterers Health and Welfare Trust first communicated with you regarding the COVID-19 pandemic. Unfortunately, the pandemic continues and we are again reaching out regarding the importance of testing in mitigating the spread of the virus. Below we describe multiple methods for you to access At-Home Over the Counter (OTC) test kits at no cost.

At-Home OTC Test Kits available from the Federal Government - All Americans are now able to request free at-home COVID-19 tests from the federal government. Currently the limit is 4 OTC tests per household.

To request your free OTC Test Kits from the Federal Government, visit COVIDTests.gov. These tests are completely free to order, with tests expected to ship within 7 to 12 days. This website also includes a resource to locate any of the 20,000+ sites nationwide offering no cost antigen and PCR tests to everyone.

At-Home OTC Test Kits available from Washington State – Washington State has announced that it, too will offer residents free tests. The State advises 5 tests will be shipped to your home, free of cost within one to two weeks of placing the order. To request your free OTC Test Kits from Washington state, visit www.sayyescovidhometest.org.

At-Home OTC Test Kits covered by the Plan - The Plan will also comply with recently released Federal government guidance requiring group health plans to cover 100% of the cost at-home OTC COVID-19 tests. This coverage is effective with tests purchased on or after January 15, 2022 and until the end of the National Emergency Period. The tests must have been authorized, cleared, or approved by the FDA and do not require a prescription or doctor's order.

Examples of FDA authorized, cleared, or approved OTC COVID-19 Antigen tests include, but are not limited to:

• BINAXNOW COVID-19 AG SELF TEST	• FLOWFLEX COVID-19 AG HOME TEST
• CARESTART COVID-19 AG HOME TEST	• IHEALTH COVID-19 AG RAPID TEST
• ELLUME COVID-19 HOME TEST	• QUICKVUE AT-HOME COVID-19 TEST

To obtain your tests at this time, you may use any pharmacy in the Sav-Rx network. It is recommended that you call ahead to confirm that the pharmacy has tests in stock. If the pharmacy has tests available, you should check out at the pharmacy counter and present your Sav-Rx member information. The test should be provided to you free of charge.

Please note that at this time Sav-Rx is working to ensure that its contracted retail and mail order pharmacies have an adequate supply of tests. Once the adequacy of the network is confirmed, all tests purchased at a non-Sav-Rx network pharmacy will be limited to $12. Accordingly, it is important that you try to purchase you tests at a Sav-Rx pharmacy.

If that test is not provided to you free of charge, you will need to submit a claim form and proof of purchase. To expedite your claim, we ask you to follow these steps:

1. Purchase the tests from any available retailer and keep the proof of purchase (an original receipt or photo of the receipt), including the purchase price and date of purchase.
2. Go to www.savrx.com and obtain the "Over-The-Counter (OTC) COVID-19 Test Kit Claim Reimbursement Request" form, which is located under "Reimbursement Forms." Use the Sav-Rx Group Number CM1602.
3. Complete the claim form and submit your claim (with receipt and photo) electronically to covidtest@savrx.com or a paper claim via ground mail to:

   ATTN: COVID-19 Test
   Sav-Rx
   224 N. Park Ave
   Fremont, NE 68025

The Plan will reimburse the cost of 8 tests per month per covered individual in your household. Although tests may be sold in packages containing more than one test, *each test is counted separately*. Please note shipping and handling fees will *not* be reimbursed by the Plan.

Tests are available for all Plan participants, including those eligible for Medicare. The Plan will cover tests purchased for personal use only. Tests purchased for employment purposes are **not** covered.

Please take advantage of the free tests available to you from both the Federal and State governments and feel free to contact the Trust Office if you have any questions.

For more information regarding OTC COVID-19 tests, you may be interested in checking out the Food and Drug Administration (FDA) website.

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Cement Masons & Plasterers Trust Funds

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Phone: (877) 367-0528 • Fax: (206) 505-9727 • Website: www.cementmasonstrust.com
Administered by
Welfare & Pension Administration Service, Inc.

December 20, 2021

To: All Plan Participants in the Cement Masons and Plasterers Health and Welfare Plan

Re: Benefit Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully and keep it with your benefit booklet for future reference.

Outpatient Office Visits

Effective **January 1, 2022**, in-network outpatient office visits are subject to a $20 copay. After the $20 copay, in-network office visits are paid in full are no longer subject to deductible or coinsurance. Out-of-network office visits continue to be subject to the deductible and coinsurance.

Alternative Care

Effective **January 1, 2022**, the $1,000 annual benefit maximum for alternative care is removed. Alternative care benefits include acupuncture, massage therapy, and naturopathic treatment and are limited to 26 combined visits per calendar year. In-network office benefits are subject to a $20 copay per visit. Visits are not subject to deductible or coinsurance. Out-of-network office visits continue to be subject to the deductible and coinsurance.

MAP Assistance Program

Effective **October 1, 2021**, the Trust provides counseling resources through the First Choice Health Member Assistance Program (MAP). MAP provides counseling, coaching and problem-solving services that are free, convenient, and confidential with a licensed behavioral health provider. The Member Assistance Program includes:

1. 24/7 Service Line by Licensed Counselors and Trained Call Center Staff for immediate assistance.
2. Counseling Services for up to 3 visits covered in full by the program every year. Additional visits may be covered by the Medical Plan, subject to Plan provisions and limitations. Counseling is provided for a variety of family, relationship, emotional, behavioral, mental health, and substance abuse concerns, including:
    - Anxiety/Depression/Other Concerns
    - Mental Health Issues
    - Couples/Relationships/Parenting
    - Crisis Support
    - Alcohol/Drug/Other Addictions
    - Grief and Loss
    - Work Conflict
    - Domestic Violence

In addition, MAP provides the following work-life resources:

- Legal and Financial
- Childcare and Eldercare
- Identity Theft
- Home Ownership

Additional information can be found in the enclosed flyers or by calling [add phone number].

Dental Personal Protective Equipment

Effective **May 1, 2020 through March 31, 2022,** appropriately billed charges by a licensed dental office for dental personal protective equipment will be covered up to $20 per visit.

Telemedicine Service

Effective **March 1, 2020 through December 31, 2022,** the Trust will cover medically necessary services provided by a physician or other covered provider via telephone or video conferencing. Benefits are subject to the Plan's applicable copays, deductibles and coinsurance based on the type of service being provided. This temporary benefit is subject to the following conditions:

- For a real-time interactive telephone or audio/video consultation (telehealth/telemedicine) to be covered, the telehealth/telemedicine consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.
- Reimbursement for use of a telemedicine service such as Teladoc (or regional telehealth service) for which the member paid out-of-pocket will be paid up to the allowed amount.
- Charges for missed appointments are not covered and are excluded from plan coverage.
- All visits and treatment must be appropriately documented and billed.

Benefit Clarification

If a Retiree or Dependent of a Retiree is eligible for Medicare Part B, benefits under the Plan are provided as if the Retiree or Dependent is enrolled in Medicare Part B, regardless of whether they actually enroll Medicare Part B. Accordingly, it is very important that you enroll in Medicare Part B when you are eligible. The Usual, Customary, and Reasonable Charge for out-of-network providers is not the same as the Reasonable Charge as defined in the outpatient dialysis provision. The Reasonable Charge for outpatient dialysis applies regardless of whether a provider is in-network or out-of-network.

If you have any question regarding the information outlined in this notice, please contact the Administration Office at (877) 367-0528, option 0.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents: divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Cement Masons & Plasterers Trust Funds

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Phone: (877) 367-0528 • Fax: (206) 441-9110 • Website: www.cementmasonstrust.com

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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Cement Masons & Plasterers Trust Funds

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Phone: (877) 367-0528 • Fax: (206) 505-9727 • Website: www.cementmasonstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

May 18, 2020

TO: All Eligible Plan Participants and Dependents of the Cement and Plasterers Health and Welfare Plan

RE: Response to Coronavirus (COVID-19) Outbreak

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees has taken action to make the following temporary changes to your Plan benefits in response to the COVID-19 pandemic:

Inpatient Hospitalizations for COVID-19

If you are hospitalized as a result of COVID-19, the Plan will waive your deductible and coinsurance for treatment provided between April 1, 2020 - June 30,2020, at an in-network facility.

Providence Hospital Anchorage

Providence Hospital in Anchorage has been temporarily designated as an in network (Preferred) facility for Plan participants in Alaska for treatment rendered between April 1, 2020 through May 31, 2020.

While Alaska Regional Hospital is still the primary in-network facility, Providence has been temporarily added. If you receive services at Providence Hospital instead of Alaska Regional Hospital between April 1, 2020 through May 31, 2020, non-network penalties will not apply.

Note: In most cases, the cost of services at Alaska Regional Hospital will be more competitive than the cost of services provided at Providence. If you have a choice of provider, Alaska Regional Hospital remains the lowest cost option for you and for the health plan.

We thank both Providence and Alaska Regional Hospitals for their exceptional service to our community and for their flexibility and willingness to work with the Plan during this difficult time.

Temporary Plan Change

- A temporary waiver will allow coverage for telephonic or other virtual care visits subject to the annual deductible and coinsurance benefits (treatment) or cost-share waived (testing), when applicable as visits relate to seeking a diagnosis or for treatment of COVID-19 as follows:
    1. For a real-time interactive telephone or audio/video consultation (telehealth/telemedicine) to be covered, the telehealth/telemedicine consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.

2. Reimbursed up to the allowed amount for use of a telemedicine service such as Teladoc (or regional telehealth service) for which member paid out of pocket for services.
3. Reimbursed at 100% of the allowed amount for all telephone or audio/video visits related to COVID-19 visits.

- Charges for missed appointments continue to not be covered and are excluded from plan coverage.

The following benefits continue to be available, should you need them:

- Medically necessary, FDA approved diagnostic testing for COVID-19 is covered by the Plan and is not subject to deductibles and coinsurance. Additionally, when a COVID-19 vaccine is available, it will also be covered by the Plan and will not be subject to deductibles and coinsurance.
- Active participants, COBRA participants, non-Medicare retirees, and their eligible dependents have access to **Teladoc** for 24/7 care via telephone at 1 (800) 835-2362 or video chat at no cost to you. Please visit Teladoc.com for more details.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (877) 367-0528, option 1. Please also refer to the Trust website for additional notices: www.cementmasonstrust.com.

If you have questions about your prescription drug benefits, please contact SavRx at (800) 228-3108.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan

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Cement Masons & Plasterers Trust Funds

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Phone: (877) 367-0528 • Fax: (206) 505-9727 • Website: www.cementmasonstrust.com
Administered by
Welfare & Pension Administration Service, Inc.

March 17, 2020

To: All Eligible Plan Participants and Dependents of the Cement Masons and Plasterers Health and Welfare Plan

RE: Response to Coronavirus (COVID-19) Outbreak

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

As you are aware, the country is presently experiencing an outbreak of Coronavirus, known as COVID-19. You may have also heard that some states are issuing emergency orders requiring all insured health plans to take certain steps to cover services related to COVID-19 testing. Even though this Plan is not required to comply with the emergency order, the Board of Trustees of the Cement Masons and Plasterers Health and Welfare Plan **(**"the Plan") is closely monitoring governmental recommendations and mandates.

In response to the Coronavirus Outbreak effective March 5, 2020 the Board of Trustees has adopted the following changes to the Plan's Medical and Prescription Drug Benefits which will stay in effect until the COVID-19 emergency orders are lifted:

- The Trust will waive any out-of-pocket costs associated with testing for COVID-19 for both PPO and non-PPO providers. This includes both the cost of the test as well as office visits or other provider charges related to the testing. For those testing positive, treatment of COVID-19 will still be subject to applicable cost sharing and PPO/non-PPO benefits depending on the provider's status.
- The Trust will temporarily suspend any prior authorization requirement for treatment or testing of COVID-19.
- Sav-Rx is **temporarily relaxing refill-too-soon guidelines** on 30-day maintenance medications at retail pharmacies and Sav-Rx Mail Order Pharmacy when 50% of the current supply has been exhausted. The waiver does not apply to opioids or controlled substances. You are encouraged to keep at least a 30-day supply of prescription medication at hand. You may also choose to use mail order to receive delivery of your medications at home.

Active participants, Non-Medicare Retirees and their eligible dependents have access to **Teladoc** for 24/7 care via telephone at (800) 835-2362 or video chat at no cost to you. A Teladoc doctor can discuss any symptoms you are having and help determine the right treatment or next steps, including providing a prescription if appropriate. Please visit **Teladoc.com** for more details.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (877) 367-0528, option 1. Please also reference the trust website, cementmasonstrust.com, for additional notices.

If you have questions about your prescription drug benefits, please contact Sav-Rx at (800) 228-3108 or visit the website at www.savrx.com.

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan

Quick Reference Chart

If a Participant or Dependent needs information, please check this Booklet first. If further help is needed, contact the office listed in the following Quick Reference Chart.

Information Needed	Whom to Contact
Trust Administration Office Name, Address & Telephone Numbers:	**WPAS, Inc.** P.O. Box 34203 Seattle, WA 98124 7525 SE 24th St, Suite 200 Mercer Island, WA 98040 www.cementmasonstrust.com
Eligibility—	(206) 441-7574 (877) 367-0528
Medical, dental, vision, weekly disability benefits & claims—	(206) 441-7574 (877) 367-0528
Life/AD&D benefits and claims—	(206) 441-7574 (877) 367-0528
Privacy Contact/Officer—	(206) 441-7574 (800) 331-6158
Prescription Drugs: Retail and Mail Order Network— AARP Medicare Rx Preferred—	**Sav-RX** (800) 228-3108 www.savrx.com **UnitedHealthcare** (888) 556-7049
Hospital UR Coordinator (for pre-authorization): Does not apply to Medicare retirees	**Aetna** (888) 632-3862
Medical Preferred Provider Organization (PPO) Network: Does not apply to Medicare retirees	**Aetna** www.aetna.com
Managed Vision Care:	**Vision Service Plan** (800) 877-7195 www,vsp.com
Planned Surgery Program	**BridgeHealth** (844) 249-8108 www.bridgehealth.com
Telemedicine	**Teladoc** 1-800-835-2362 www.Teladoc.com
Life & Accidental Death and Dismemberment Insurance:	**LifeMap Assurance Company** 100 S.W. Market St Portland, OR 97201 (800) 794-5390

Cement Masons and Plasterers Health and Welfare Trust

Plan Document and
Summary Plan Description
For Alaska Participants and Retirees

Revised Edition
April 1, 2019

Introduction

To all Participants and Dependents:

This booklet constitutes the Cement Masons and Plasterers Health and Welfare Trust's Plan for Alaska Participants and Retirees. It describes the benefits available to Participants and their Dependents who reside in Alaska as of April 1, 2019. The Trust maintains a separate Plan for Washington residents. Plan eligibility is based on the Participant's residence (see Defined Terms section for how this is determined). The Trust does not allow an individual Participant or Dependent to be eligible in both the Washington and Alaska Plans.

The Plan is funded by employer contributions called for under Collective Bargaining Agreements and Associate Agreements, and investment earnings thereon. Self-payments are also made for continuation coverage and Retiree Coverage. Funds are deposited into a tax exempt, nonprofit trust which is administered by the Board of Trustees. The medical, prescription drug, dental, vision, and weekly disability benefits provided by the Plan are self-insured. The Plan maintains stop-loss insurance to limit exposure on medical claims. Life insurance and accidental death and dismemberment benefits are insured.

The Plan will provide a higher level of benefits when using a Preferred Provider for medical care and the Network Pharmacy for prescription drugs.

Covered Persons must notify the Administration Office whenever there is a change in family status or address, including a change in address for a Dependent child.

Questions about eligibility or benefits should be directed to the Administration Office at the number listed in the Quick Reference Chart at the front of this booklet.

The Board of Trustees

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Important Information

The Board of Trustees has the authority to administer the Plan and to amend, modify or eliminate provisions of the Plan (in whole or in part) in such manner as they determine will promote efficiency, economy, better coverage, and better service for those affected thereby.

The Trustees also have the discretionary authority and exclusive right to construe the provisions of the Plan and to determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions.

The Trustees have authorized the Administration Office and other designated entities used by the Plan, to provide information relating to the amount of benefits, eligibility, and other Plan provisions. These designated entities may utilize their internal guidelines and medical protocols (including guidelines and protocols used for diagnosis, treatment, prescription or billing practices) in determining whether or not specific services or supplies are covered under the terms of the Plan. However, these designated entities do not have authority to change the provisions of the Plan. Any interpretation by the Administration Office or another designated entity is subject to review by the Board of Trustees. No individual Trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan, or commit the Trustees on any matter. Any construction or determination by the Trustees will be conclusive on all persons affected thereby, unless it can be shown that the interpretation or determination was an abuse of discretion.

IMPORTANT

Covered Person have a limited amount of time from the date expenses are incurred to submit claims for payment.

Detailed information concerning these time limits as well as the right to appeal denied claims can be found in the "How to File a Claim" and "Claim Procedures" sections of this Booklet.

Trust Fund Website

The Cement Masons and Plasterers Trust Funds have established a website to provide immediate access to Plan information. The website is www.cementmasonstrust.com and includes the following Trust related material:

- Forms – Enrollment Forms, Claim Forms, Legal Documents, and Notices
- Plan Booklets
- Links to Carriers, Preferred Provider Organizations, and other useful sites

This site also includes a login to the secure member location that allows Covered Persons to view personal benefit information. A personal identification number (PIN) and social security number or member identification number are needed to login to the secure location. To request a PIN, please complete a PIN Request Form which can be printed from the website. The PIN will be assigned; for security purposes, a Covered Person *may not* choose a PIN. The following personal benefit information is available on the member login:

- Personal Information – Name, address, gender, birth date, marital status, etc.
- Hours/Contributions – A statement showing recent Employers that reported hours and contributions to the Trust on the Participant's behalf.
- Claims Summary – A detailed summary of paid claims information. Participants only have access to their own personal paid claims history and that of Dependents under the age of 13. Dependents age 13 and over must request their own PIN.

Rewards Program

The Board of Trustees has adopted a rewards program for vigilant Covered Persons. If a Covered Person finds an error on a medical or dental Provider's bill that has been paid by the Trust, the Plan will pay the Covered Person 50% of the overcharged amount (based on the Plan's payment provisions) up to a maximum of $5,000 per occurrence.

Covered Persons receive an Explanation of Benefits from the Plan explaining the amount billed by the Provider and the amount paid by the Plan. Please review it carefully. On occasion, Providers fraudulently submit claims to the Plan for services that were never rendered. On other occasions, a Provider's billing office may read the Physician's notes incorrectly and bill for services that were not received. A Physician or hospital may also accidentally bill for the wrong services, or for another individual who shares a Covered Person's name but is not covered by the Plan. Whatever the case, Covered Persons can save the Plan money and earn a reward by looking over every Explanation of Benefits received.

If a Covered Person feels that services were erroneously billed, or for further information, please contact the Administration Office.

Eligibility Provisions—Active Participants

Establishment of Dollar Bank Account

The Plan uses a Dollar Bank system to determine eligibility of Active Participants. Each Participant is assigned a Dollar Bank Account into which Employer contributions are credited.

If a Participant works under a Collective Bargaining Agreement, the Dollar Bank Account is credited with Employer contributions made to the Trust on the Participant's behalf pursuant to the terms of that agreement.

Those not covered by a Collective Bargaining Agreement (which generally include owners, spouses of owners, and certain supervisory or management employees) may only participate under a written Associate Agreement between the Employer and the Trustees. Participation under an Associate Agreement is subject to the terms in that agreement and the Trustees' Rules for Associate Participation. If a Participant is covered under an Associate Agreement, the Dollar Bank Account is credited with the Employer contributions made to the Trust on the Participant's behalf pursuant to the terms of that agreement.

Initial Eligibility/When Coverage Begins

A Participant's initial eligibility commences on the first day of the second month following accumulation of sufficient contributions in the Participant's Dollar Bank Account to purchase two months of coverage at the current Dollar Bank deduction rate. The Dollar Bank deduction rate for a month of coverage is set by the Board of Trustees from time to time. The current Dollar Bank deduction rate is $1,131 for Alaska Participants. Only Employer contributions may be used to establish initial eligibility.

Here is how it works using the $1,131 Dollar Bank deduction rate for Alaska Participants:

Calendar Months				
1	2	3	4	5
If an Alaska Participant accumulates $2,262 in the Dollar Bank Account in three months			LAG	Initial eligibility commences the first day of this month

Enrollment

Before claims will be processed, a Participant must complete and return an enrollment form to the Administration Office with all supporting documentation. Dependents must also be enrolled prior to having claims processed. Enrollment forms are available on the Plan's website, www.cementmasonstrust.com. The Administration Office shall require enrollment documentation to verify dependent status (for example, a copy of a marriage certificate, birth certificate, adoption papers or divorce decree). Enrollment forms may also be obtained by contacting the Administration Office at the address or telephone number listed in the Quick Reference Chart at the front of this booklet.

Provided that all the requested enrollment documentation is received, coverage for your eligible dependents begins on the later of: 1) the date your coverage begins; or 2) the date your dependents first meet the definition of an eligible dependent as described in this section (for example: date of marriage, date of birth, date of adoption, etc.). Dependents will not be eligible for coverage until all requested enrollment documentation is provided. Please note: If requested enrollment documentation is not provided, the Plan will not pay claims until the documentation is received. Delayed enrollment documentation may result in the denial of claims. In no event will the Plan pay claims submitted or completed more than 12 months after the incurred date.

Continuing Eligibility

After becoming initially eligible, a Participant must continue to accumulate sufficient contributions in the Dollar Bank Account to purchase one month of coverage at the current Dollar Bank deduction rate. This will provide coverage on the first day of the second month following the deduction. For example, if there are sufficient contributions in a Participant's Dollar Bank Account based on hours worked in January, the deduction from the Dollar Bank Account in January will provide coverage for March. Contributions received in excess of the

amount needed to purchase a month of coverage are added to a Participant's Dollar Bank Account and apply toward future coverage during months of little or no employment. The maximum contributions that can accumulate in the Dollar Bank Account at any one time is set by the Board of Trustees from time to time. Currently, the maximum that can be accumulated in a Participant's Dollar Bank Account is $10,000.

The Board of Trustees may allocate a portion of the contributions received by the Trust for use as Trust reserves. Contributions allocated to reserves are not credited to a Participant's Dollar Bank Account.

Pay Stub Eligibility
The Participant may present pay stubs to the Administration Office as proof of coverage when a Participant would otherwise lose eligibility due an Employer being late in reporting contributions. The Participant may extend eligibility by providing pay stubs as proof of coverage for up to three months.

Money Follows the Man Reciprocity
The Plan is a party to the Operative Plasterers and Cements Masons International Association (OPCMIA) Trust Fund Reciprocity Agreement and other similar money-follows-the-man reciprocity agreements. The reciprocity agreements allow Participants to request a transfer of hours and contributions to the Participant's home trust when temporarily working in another area. The Trust maintains two Plans – one for Washington residents and one for Alaska residents. Benefits provided pursuant to reciprocity are based on the Plan covering the Participant's residence (see Defined Terms section for how this is determined). The Trust does not permit reciprocity between its Washington and Alaska Plans.

If a participant is working outside of Washington or Alaska, the Participant should contact the Administration Office to determine if a reciprocity agreement is in force in the area where the Participant is working. To request a transfer of hours and contributions, the Participant should contact the Local Union or Administration Office for an authorization form. The authorization form must be completed and returned to the Administration Office as soon as possible and generally no later than 60 days after beginning employment in another area. Participants who fail to file a timely authorization to transfer hours and contributions will be treated as not electing a transfer.

Termination of Coverage
A Participant's Dollar Bank coverage ends on the earliest of the following dates:

- On the first day of the second calendar month following the month in which the balance in the Dollar Bank Account is reduced below the cost of one full month of coverage (the current Dollar Bank deduction rate).

- On the last day of the month in which the Participant enters the Armed Services of the United States, except for periods of reservists training, unless the Participant elects to run-out the Dollar Bank Account. See "Uniformed Services (USERRA)" for details.

- On the date the Plan is terminated.

Reinstatement of Dollar Bank Coverage
If coverage ends because the Dollar Bank Account balance falls below the amount required for one month's coverage at the current Dollar Bank deduction rate, the balance, if any, is carried for 12 months.

If sufficient Employer contributions are added to a Participant's Dollar Bank Account to provide one month's coverage, coverage will be reinstated on the first day of the second month following accumulation of sufficient Employer contributions for one month's coverage. If a Participant's coverage is not reinstated during the 12 month period following the termination of Dollar Bank coverage, the balance of the Dollar Bank Account is forfeited and the Participant must satisfy the initial eligibility rules to again be covered. Months in which coverage is extended through self-payments are not counted in the running of the 12 month period. Nor can self-payments be used to reestablish initial eligibility.

For information regarding the right to make self-payments to a Dollar Bank Account, refer to “Continuation by Self-Payment.”

Eligibility Provisions—Dependents

An Active Participant's Dependents are eligible for medical, prescription drug, dental, and vision benefits if the Participant is eligible, provided the Dependent does not opt-out of such coverage. Dependents must be enrolled by the Participant before claims will be paid. Enrollment forms are available on the Plan's website, www.cementmasonstrust.com. Enrollment forms may also be obtained by contacting the Administration Office at the address or telephone number listed in the Quick Reference Chart at the front of this booklet.

A Retired Participant's Dependents are eligible for the same benefit coverage options elected by the Retiree, provided they are enrolled at the time the Retiree applies for coverage and have the required self-payment made on their behalf.

Definition of Dependent
A Dependent means one of the following:

- A Participant's spouse (unless legally separated). The Participant and spouse must be legally married under federal law.

- A Participant's children under the age of 26 who are:

  - Natural children.

  - A Participant's legally adopted children.

  - Children placed with the Participant for adoption before the adoption is finalized. "Placed for adoption" means the assumption and retention by the Participant of the legal obligation for the total or partial support of the child to be adopted in connection with adoption proceedings.

  - A Participant's stepchildren.

  - A foster child who has been legally placed with the Participant by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, provided such placement occurred before the child attained age 18, and the child depends on the Participant for support, and lives with the Participant in a regular parent-child relationship or attends school fulltime.

  - A child for whom the Participant has legal custody or is the legal guardian pursuant to a judgment, decree, or other order of a court of competent jurisdiction provided the Participant was awarded custody before the child attained age 18, and the child depends on the Participant for support, and lives with the Participant in a regular parent-child relationship or attend school fulltime.

Coverage is continued beyond age 26 for an unmarried Dependent child who is dependent on the Participant for support; is not capable of self-sustaining employment by reason of developmental, physical or mental disability; and was a Dependent child and so disabled at the time of reaching age 26. Written proof of such disability must be submitted to the Administration Office within 31 days of the child's attainment of age 26. The Plan, upon receipt of the proof, may require periodic examinations of the child by a Physician designated by the Plan, but not more often than once every two years. Coverage of a disabled Dependent child will end when the disability no longer exists, when the Participant's coverage ends, or when any required evidence of disability requested by the Plan is not submitted.

Qualified Medical Child Support Order
The Plan recognizes a Qualified Medical Child Support Order (QMCSO) and enrolls a Participant's natural Dependent children, adopted Dependent children, and Dependent children placed with the Participant for adoption as directed by the Order.

A QMCSO is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

- Provides child support or health benefit coverage to a Dependent child; or

- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the Participant does not enroll the Dependent child, then the non-Participant parent or State agency may enroll the child.

To be qualified, a QMCSO must clearly specify:

- The name and last known mailing address of the Participant;

- The name and mailing address of each Dependent child covered by the order or the name and mailing address of the State official issuing the order;

- A description of the type of coverage to be provided by the Plan to each such Dependent child;

- The period of coverage to which the order applies; and

- The name of each plan to which the order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a QMCSO to reimburse expenses claimed by a child or the custodial parent or legal guardian shall be made to the child or the custodial parent or legal guardian if so required by the QMCSO.

No Dependent child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

The Participant, the Dependent child's custodial parent, or the applicable state agency may submit a child support order to the Administration Office. If an order is received, the Administration Office will notify the Participant and each child named in the order. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a QMCSO. The order will then be reviewed to determine if it meets the definition of a QMCSO. Within a reasonable period of time, the Participant and each Dependent child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order. If the order is qualified, the notice will give instructions for enrolling each Dependent child named in the order. A copy of the entire QMCSO and any required self-payments will be subject to all provisions applicable to Dependent coverage under the Plan.

Opt-Out of Dependent Coverage

Adult Dependents (spouses and Dependent children age 18 or older) of Active Participants may elect to opt-out of Plan coverage. To make the election, a Dependent must submit a signed written request to the Administration Office at the address listed in the Quick Reference Chart at the front of this booklet.

The opt-out will be effective for all claims incurred on and after the first of the month following the month in which the opt-out request is received by the Administration Office. The opt-out will apply to all Plan coverage, including medical, prescription drug, dental, vision, and life insurance.

An opt-out of Plan coverage is not a COBRA qualifying event. A Dependent who opted out of coverage and is not enrolled in the Plan at the time of a COBRA qualifying event will not be eligible to re-enroll or to elect Continuation of Coverage by Self-Payment of COBRA.

A Dependent who opted out of coverage may re-enroll by submitting a written request to the Administration Office at the address listed in the Quick Reference Chart at the front of this booklet. In order to re-enroll, the Dependent must qualify as a Covered Dependent under the Plan. Re-enrollment will be effective the first day of the month following the month in which the enrollment request is received by the Administration Office, provided the Participant has Dollar Bank coverage on that date. If the Participant does not have Dollar Bank coverage, the Dependent's eligibility will be reinstated on the date the Participant's Dollar Bank eligibility is reinstated.

Participants may not unilaterally remove an adult Dependent from coverage without the adult Dependent's written consent. A minor child cannot opt-out of Plan coverage and cannot be removed from the Plan by an Active Participant or spouse of a Participant.

Termination of Dependent Coverage

A Dependent's coverage terminates on the earliest of the following dates:

- The last day of the month in which the Dependent no longer meets the definition of a Dependent.
- On the date the Participant's coverage ends because the Dollar Bank Account is reduced below the cost of one full month of coverage.
- In the case of the Participant's death, the date the Participant's coverage would have ended had he lived (but without accruing additional contributions following his death) because the Dollar Bank Account is reduced below the cost of one full month of coverage.
- In the case of a Dependent spouse, on the last day of the month in which the divorce or legal separation decree is final.
- The date the Plan terminates.

A Participant and spouse must notify the Administration Office of a divorce or legal separation. If the Participant or spouse fails to provide this notice, the Trust may take all necessary action to recover any overpaid benefits, which may include seeking reimbursement from the Participant, the spouse, and any Providers and offsetting future benefits of the Participant and the Participant's Dependents.

Family Medical Leave Act

A federal law known as the Family Medical Leave Act ("FMLA") may apply to family and medical leaves when a Participant works for an Employer that employs 50 or more employees within a 75-mile radius. To be eligible for FMLA coverage, a Participant must be covered under the Plan when the leave began and the Employer must make the required contributions during the leave. FMLA coverage is limited to 12 work weeks during a 12-month period while the Employee is on leave. Coverage terminates the earlier of the expiration of FMLA leave or the date the Participant gives notice to the Employer that the Participant does not intend to return to work at the end of FMLA leave.

Participants who think they may be eligible for a FMLA leave should contact their Employer immediately. An Employer must provide documentation to the Trust to confirm eligibility for FMLA leave, and make arrangements to pay the required contributions to continue coverage.

Following FMLA, the Plan's Continuation of Coverage Options may be available.

Continuation of Coverage Options

If coverage terminates because the Dollar Bank Account is reduced below the cost of one full month of coverage, there are several options for continuation of coverage.

One Month Extension of Coverage by Partial Self-Payment

If the Dollar Bank Account is reduced below the cost of one full month of coverage, a Participant may continue coverage for one month by self-paying the difference between the monthly Dollar Bank deduction rate and the Dollar Bank Account balance. The self-payment is only available if there is a balance of Employer contributions in the Participant's Dollar Bank Account. If the Participant's Dollar Bank is $0, a self-payment cannot be made. The self-payment is due at the Administration Office no later than the 20th day of the month prior to the month coverage would otherwise terminate. The self-payment coverage must be continuous; there cannot be a gap in coverage.

After one month of self-payment coverage, a Participant's Dollar Bank coverage will not be reinstated until sufficient Employer contributions are credited to the Dollar Bank to provide one-month of eligibility. If Dollar Bank coverage is not reinstated within 12 months following termination of the self-payment coverage, then the Participant must satisfy the initial eligibility rules to again become eligible for Dollar Bank coverage. Self-payments cannot be used to reestablish initial eligibility.

The one-month of partial self-payment coverage is again available after Dollar Bank coverage is reinstated based upon Employer contributions.

The one-month of partial self-payment coverage does not count in toward COBRA coverage.

Contact the Administration Office at the address and phone number listed in the Quick Reference Chart at the front of this booklet in order to request self-payment coverage.

If Dollar Bank coverage is not reinstated following the one month of partial self-payment coverage, continuation coverage may be available under the under COBRA or for the Dependents of Deceased Participants, under the 12-Month Waiver of Contributions. These additional continuation coverages are described below.

12-Month Waiver of Contributions for Dependents of Deceased Participant

If a Participant dies, Covered Dependents may continue to use the Dollar Bank. If there is a residual in the Dollar Bank Account, but it is not sufficient for a month of coverage, then Dollar Bank coverage may be extended for one-month by partial self-payment as described above under "One Month Extension of Coverage by Partial Self-Payment." Once the Dollar Bank Account is exhausted, Covered Dependents of a deceased Participant may apply for up to 12 months of extended medical and prescription drug coverage through a waiver of contributions. The waiver of contribution coverage is paid by the Plan.

To request a waiver of contributions, a Covered Dependent must contact the Administration Office at the address or phone number listed in the Quick Reference Chart at the front of this booklet. Waiver request must be made within 60 days of when coverage for the dependents would otherwise end with through exhaustion of the residual Dollar Bank Account.

The waiver of contributions coverage terminates on the earliest of:

- 12 months from the date such coverage commenced;
- In the case of a Dependent child, on the last day of the month in which the definition of Dependent is no longer satisfied;
- In the case of a surviving spouse, on the last day of the month in which the surviving spouse remarries.

The 12-month waiver of contributions runs concurrently with COBRA eligibility. Following termination of the waiver coverage, a Covered Dependent may elect COBRA coverage. The 12-month waiver of contributions is counted in determining the maximum coverage period for COBRA.

Continuation of Coverage by Self-Payment of COBRA
Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), "qualified beneficiaries" may extend benefits (except weekly disability) on a self-pay basis under certain circumstances called "qualifying events."

Qualified Beneficiaries. A qualified beneficiary means:

- Any individual who, on the day before a qualifying event, is covered under the Plan, either as an Active Participant or as a Dependent of an Active Participant or Retiree

- A child who is born to, adopted by, or placed for adoption with an Active Participant (as opposed to another family member) during COBRA, provided the child is enrolled and a copy of the birth certificate or adoption papers are provided to the Administration Office within 30 days of birth, adoption, or placement for adoption, and the appropriate self-payments are made. The child will have the same COBRA rights as a Dependent who was covered by the Plan before the qualifying event that resulted in the loss of coverage.

Dependents, other than those listed above, who are newly acquired during a period of COBRA, may be enrolled in COBRA by submitting an enrollment form to the Administration Office within 30 days of becoming a Dependent. The forms are available by contacting the Administration Office at the address or telephone number listed in the Quick Reference Chart at the front of this booklet. Such newly acquired Dependents will not be considered qualified beneficiaries.

Only qualified beneficiaries may extend COBRA when there is a second qualifying event.

An individual ceases to be a qualified beneficiary if COBRA is not timely elected, or when the Plan's obligation to provide COBRA otherwise ends.

18-Month Qualifying Events. An Active Participant or the Participant's Dependents may elect COBRA for a maximum of 18 months following the date coverage would otherwise end due to one of the following qualifying events:

- The Participant's termination of employment; or

- The Participant's layoff or reduction in hours of employment.

If Social Security determines that a qualified beneficiary is totally disabled either before the 18-month qualifying event or within the first 60 days of COBRA, the disabled individual and all qualified beneficiaries may extend COBRA an additional 11 months beyond the original 18 months, to a maximum of 29 months. In order to qualify for this extension, the qualified beneficiary must notify the Administration Office in writing before expiration of the initial 18 months of COBRA. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination. For an individual who has extended COBRA beyond the initial 18 months, COBRA will end on the earlier of 29 months from the qualifying event, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

36-Month Qualifying Events. A Dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

- Death of the Active Participant or Retiree;

- Divorce between the Participant or Retiree and Dependent spouse; or

- The Dependent child ceases to meet the Plan's definition of "Dependent."

In the event of the death of a Participant, an eligible Dependent surviving spouse and Dependent children may be eligible to continue coverage beyond the initial 36 months. See "Self-Payment of Coverage Following COBRA for Dependents of Deceased Participant."

Second Qualifying Event. An 18-month period of COBRA may be extended an additional 18 months, for a total of 36 months, for the affected qualified beneficiary (spouse or child), if one of the 36-month period qualifying events occurs during the first 18 months of COBRA. In no event will COBRA extend beyond 36 months from the date coverage was first lost due to the initial qualifying event. This extension applies only if the qualified beneficiary notifies the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. In the absence of such notice, COBRA will terminate.

Medicare Entitlement. If an Active Participant has an 18-month qualifying event after becoming entitled to Medicare, the Participant's Dependents may continue COBRA until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction in hours; or

- 36 months from the date the Participant became entitled to Medicare.

Notice Requirements. The Plan offers COBRA only after it has been notified of a qualifying event. A qualified beneficiary is responsible for notifying the Administration Office of a qualifying event that is a divorce or child losing dependent status. **The qualified beneficiary must provide this notice to the Administration Office in writing within 60 days of the later of the date of the qualifying event; or the date coverage would be terminated as a result of the qualifying event; or the date this booklet or other notice is provided describing the procedure for electing COBRA**. The notice must identify the individual who has experienced a qualifying event, the Participant or Retiree's name, and the qualifying event which occurred. If the Administration Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA.

If a child is born to, adopted by, or placed for adoption with the Participant during a period of COBRA, the Participant must notify the Administration Office in writing within 30 days of the birth, adoption or placement for adoption, and provide a copy of the child's birth certificate or adoption papers. If the Administration Office is not notified in a timely manner, the child will lose the right to receive COBRA.

In order to qualify for a Social Security disability extension, the qualified beneficiary must notify the Administration Office in writing before the end of the initial 18 months of COBRA. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Administration Office in writing within 30 days of the determination.

A qualified beneficiary who first becomes covered under any other group health plan, including Medicare, after the date of the election of COBRA, must notify the Administration Office in writing of the other coverage.

Required notices should be sent to the Administration Office at the following address:

Cement Masons and Plasterers Health and Welfare Plan
P.O. Box 34203
Seattle, WA 98124-1203

The Administration Office will notify qualified beneficiaries of loss of coverage due to termination of employment, reduction in work hours, or the employee's death. However, qualified beneficiaries are encouraged to inform the Administration Office of any qualifying event to best ensure prompt handling of COBRA rights.

Election of COBRA. When the Administration Office is notified of a qualifying event, an election form is mailed to the qualified beneficiaries. The election form must be completed and returned to the Administration Office within 60 days of the later of the termination of coverage, or the date the application was sent. If the election form is not sent to the Administration Office by this date, the qualified beneficiaries will lose the right to elect COBRA.

Each qualified beneficiary has an independent right to elect COBRA. A Participant or spouse may elect COBRA on behalf of other qualified beneficiaries in the family. A parent or legal guardian may elect COBRA on behalf of a minor child.

COBRA Benefit Options. The following benefit options are available under COBRA:

- Medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment, dependent life insurance;

- Medical, prescription drug, life insurance, accidental death and dismemberment, dependent life insurance.

Weekly disability benefits are not available under COBRA.

Cost and Payment. There is a cost for COBRA. Information regarding the cost will be sent with the election forms. The first payment is due 45 days from the date the timely election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments must be made monthly to continue COBRA. All payments must be sent to the Administration Office.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date coverage would have otherwise terminated, until the appropriate COBRA payments have been made. COBRA terminates if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment, or any subsequent payment is not made in a timely fashion, COBRA terminates.

Termination of COBRA. COBRA ends on the first of the dates indicated below:

- The last day of the month the maximum coverage period for the qualifying event has ended (18, 29, or 36 months). The coverage period for Dependents under the "12-Month Waiver of Contributions for Dependents of Deceased Participants" is counted in determining the maximum coverage period for COBRA.

- The last date for which the self-payment was paid, or when the qualified beneficiary does not make the next payment in full when due. Payments must be made within 30 days of the due date.

- The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan which does not contain any exclusion or limitation that actually applies to any pre-existing condition of the qualified beneficiary.

- The date the qualified beneficiary becomes entitled to Medicare after the date of election of COBRA.

- The last day of the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled as determined by Social Security. This applies only to the 19th through 29th months of disability extended COBRA.

- The date the Trust no longer provides group health coverage.

COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Retiree Medical. Participants and their Dependents who qualify for both COBRA and Retiree Medical may elect COBRA in lieu of Retiree Medical. Following termination of COBRA, the Participant and eligible Dependents may apply for Retiree Medical, provided that there is no gap in coverage between the COBRA coverage and the Retiree Medical coverage. If COBRA is declined in favor of Retiree Medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

Self-Payment of Coverage Following COBRA for Dependents of Deceased Participants
In addition to COBRA, Dependents of a deceased Participant whose COBRA benefits have been exhausted may apply for continuation of coverage through self-payment of monthly contributions. To be eligible for self-payment coverage, a Dependent must be eligible for benefits from the Plan at the time of the Participant's death. An application for self-payment coverage is available by contacting the Administration Office. The completed application must be returned to the Administration Office, at the address listed in the Quick Reference Chart at the front of this booklet, no later than 60 days following the date COBRA is exhausted, or the Dependent will lose the right to elect such coverage. Self-payment coverage must be continuous from the date COBRA coverage ended. Additionally, the surviving Dependent must:

- Submit timely self-payments no later than the 15th day of the month prior to the month to be covered in the amount set by the Trust; and

- Continue to meet the definition of Dependent.

Coverage for surviving Covered Dependents will end on the earliest of the following dates:

- The last day of the month for which a timely self-payment is made.

- In the case of a surviving Dependent spouse, the last day of the month in which the spouse becomes eligible to be covered under another group health plan, except Medicare.

- In the case of a surviving Dependent spouse, the last day of the month in which the spouse remarries.

- In the case of a Dependent child, the last day of the month in which the definition Dependent is no longer satisfied.

Uniformed Services (USERRA)
Under the Uniformed Services Employment and Reemployment Rights Act (USERRA"), an Active Participant with Dollar Bank coverage who leaves employment with an Employer for USERRA qualified military service may elect to:

- Run-out the Dollar Bank;

- Freeze the Dollar Bank until a return from military service; or

- Extend coverage after it would otherwise terminate by making self-payments for USERRA continuation coverage. This option is available regardless of whether the Participant elects to run-out or freeze the Dollar Bank.

Election of USERRA Continuation Coverage. After timely notification to the Administration Office of military service, a Participant will be sent an election form to affirmatively elect USERRA continuation coverage. The completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. A

Participant who fails to return the election forms by the due date, will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage. If a Participant provides timely notice and properly elects to freeze the Dollar Bank, it will be frozen the first of the month following the month in which the Participant begins military service.

If a Participant properly elects to freeze the Dollar Bank and thereafter elects USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which military service begins, provided the required self-payments are made.

If a Participant decides to run-out the Dollar Bank before commencing USERRA continuation coverage, or works under a flat rate agreement, USERRA continuation coverage will begin immediately following the date coverage would otherwise end, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the month in which a Participant's Dollar Bank was frozen, or coverage would have otherwise ended because of entry into military service.

- The last day of the month in which a Participant fails to return to employment or apply for a position of reemployment within the time required by USERRA.

- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage. A Participant may elect to self-pay for USERRA continuation coverage for himself, himself and his Dependents, or only for Dependents. The following benefit options are available under USERRA:

- Medical, prescription drug, dental, vision, life insurance, accidental death and dismemberment, and dependent life insurance.

- Medical, prescription drug, life insurance, accidental death and dismemberment, and dependent life insurance.

Weekly disability benefits are not available under USERRA continuation coverage.

Once a Participant elects a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated Participants. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments. If military leave is less than 31 days, coverage is continued at no cost.

If military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify a Participant of the self-payment amount when it sends the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date Dollar Bank coverage would have otherwise ended (or was frozen).

Reinstatement of Eligibility Following Military Service. Participants are responsible for notifying the Administration Office of discharge from military service, and reemployment with an Employer. Notification must be in writing and it should include a copy of the discharge papers.

If a Participant properly elected to freeze the Dollar Bank upon entry into military service, the balance in the Dollar Bank will be carried over until the Employee is discharged from military service. Frozen Dollar Bank eligibility will be reinstated the first of the month in which the Participant is discharged. Following reinstatement, Dollar Bank eligibility will terminate on the first day of the second calendar month following the month in which the balance in the Dollar Bank Account is reduced below the cost of one full month of coverage based on the current Dollar Bank deduction rate. The Participant is responsible for notifying the Administration Office of a discharge from the military.

If a Participant returns to employment with an Employer immediately following military service or within the time period specified by USERRA, eligibility will be reinstated on the first day of the second month after the Participant's Dollar Bank has the minimum required for a month of coverage. Pending reinstatement of Dollar Bank eligibility, the Participant may make self-payments for coverage. If the Participant elected to freeze the Dollar Bank when military service commenced, and the Participant returns to employment within the time period required by USERRA, the Participant may make self-payments to reinstate Dollar Bank eligibility before the previously frozen Dollar Bank runs out.

To request self-pay continuation coverage after leaving military service, a Participant must notify the Administration Office within 30 days following a return to employment. After timely notification, the Administration Office will provide an election form. The completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the date it was mailed to the Participant. The initial payment to continue coverage must be included with the completed election form, and cover all months through which the first payment is made. The self-payment rate is the same as the COBRA rate. The coverage provided will be that stated under USERRA continuation coverage.

The self-pay coverage must be continuous, and must commence the later of the first of the month in which the Participant returns to employment within the time specified by USERRA or the first of the month following the termination of the previously frozen Dollar Bank eligibility. The reinstated coverage terminates on the earliest of completion of 18 consecutive months of reinstated coverage, reinstatement of Dollar Bank eligibility based upon hours worked, or the last day of the month for which a timely self-payment is not received or postmarked. Self-pay coverage runs concurrently with any COBRA coverage.

If a Participant is on the out-of-work list at the local union, it is considered a return to employment with an Employer for purposes of making self-payments for coverage.

A Participant who returns to employment should contact the Administration Office within the time period required by USERRA, regardless of whether self-payments for coverage will be made, so that the Dollar Bank may be credited with any dollars that remained in the Dollar Bank when military service commenced, and eligibility can be reinstated without satisfying the rules for initial eligibility.

Relationship of USERRA Continuation Coverage to COBRA. A Participant may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If a Participant elects USERRA continuation coverage, COBRA may not be elected when USERRA continuation coverage ends.

Health Insurance Marketplace
Instead of enrolling in COBRA, there may be other more affordable coverage options available through the Health Insurance Marketplace. Participants or Dependents who enroll in coverage through the Marketplace may qualify for lower monthly premiums and lower out-of-pocket costs than under COBRA.

Participants or Dependents who elect COBRA can switch to a Marketplace plan during the Marketplace open enrollment. Participants and Dependents may also be able to end COBRA early and switch to a Marketplace plan if there is an event that gives rise to a special enrollment period, such as marriage or birth of a child. However, if COBRA is terminated early without an event that gives rise to a special enrollment, then Marketplace coverage is not available until the next Marketplace open enrollment period.

Once COBRA is exhausted and expires, special enrollment is also available through the Marketplace, even if the open enrollment ended.

If a Market Place plan is selected instead of COBRA then COBRA may not thereafter be elected unless there is a new COBRA qualifying event.

For information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in a particular geographic area who can provide information about the different options, visit www.HealthCare.gov.

Conversion Options
There is no individual or group conversion option for medical, prescription drug, dental, vision, weekly disability or accidental death and dismemberment coverage provided by the Plan. For conversion of life insurance benefits, see the section on "Life Insurance, Dependent Life Insurance, & Accidental Death and Dismemberment—Active Participants Only."

Eligibility Provisions—Retired Participants

The Board of Trustees is providing Retiree benefits to the extent that money is currently available to pay the cost of such benefits. The Board of Trustees retains full and exclusive authority at its discretion to determine the expenditures of such money for the benefits. Retiree benefits may be terminated or modified at any time by the Board of Trustees.

Eligibility for Retiree Coverage
Participants with a retirement effective date on or after October 1, 2019 must satisfy the following requirements to be eligible for Retiree Coverage.

- The Retiree must be at least 55 years of age, or under age 55 and disabled. For purposes of eligibility for Retiree Coverage, a Retiree is considered disabled if the Retiree is entitled to Medicare due to disability; and

- The Retiree must qualify for retirement from the Cement Masons and Plasterers Retirement Plan or the Washington-Idaho Cement Masons-Employers Retirement Plan, and no longer qualify as an Active Participant in this Plan. If the Retiree was promoted to a position within the International Union, the Retiree must terminate all employment with the International Union; and

- The Retiree must have coverage in either this Plan or another group health plan in the month immediately preceding the month Retiree Coverage begins; and

- The Retiree must satisfy at least two of the three following criteria:

    1. During the 60-month period immediately preceding the Retiree's retirement effective date from the Cement Masons and Plasterers Retirement Plan or Washington-Idaho Cement Masons-Employers Retirement Plan (or during the 60 month period immediately preceding the promotion date to the International Union staff) the Retiree accumulated 3,750 hours in work for which contributions are required to this Plan; or

    2. During the 60-month period immediately preceding the Retiree's retirement effective date from the Cement Masons and Plasterers Retirement Plan or Washington-Idaho Cement Masons-Employers Retirement Plan (or during the 60 month period immediately preceding the promotion date to the International Union staff) the Retiree had at least 48 months of Plan eligibility; or

    3. Immediately preceding the Retiree's retirement effective date from the Cement Masons and Plasterers Retirement Plan or Washington-Idaho Cement Masons-Employers Retirement Plan (or during the 60 month period immediately preceding the promotion date to the International Union staff) the Retiree had at least 10,000 hours reported to the Plan.

    If the Retiree worked under an Alaska collective bargaining agreement or under a Local 72 or 478 collective bargaining agreement, hours for which contributions were required to the Washington-Idaho Cement Masons-Employers Retirement Plan or the Alaska Trowel Trades Pension Trust may be used to help satisfy the above-requirements. Associate participation will be calculated based on hours reported each month. For disabled Retirees only, 1 and 2 above will be counted from the earlier of the retirement effective date or the date Social Security determines the Retiree was disabled

Disabled Retirees under age 63 who do not satisfy the first bullet above (because they are not eligible for Medicare) may elect COBRA while their disability application is pending. If COBRA is elected and has not been exhausted, eligibility for Retiree Coverage will begin when the Disabled Retiree becomes eligible for Medicare.

Enrollment
Retiree Coverage is not automatic. Eligible Retirees must apply for coverage by the later of:

- The 10th day of the month following the Retiree's retirement effective date under the Cement Masons and Plasterers Retirement Plan or the Washington-Idaho Cement Masons-Employers Retirement Plan; or

- The first of the month after Active coverage or COBRA coverage runs out.

If, before the application period ends, the Retiree notifies the Administration Office in writing that Retiree Medical Coverage is being declined because of other group health insurance coverage, the Retiree and Dependents may enroll within 30 calendar days after the other group coverage ends.

Self-Payments for Retiree Medical
A self-payment is required for Retiree Coverage for the Retiree and Covered Dependents. To maintain Retiree Coverage, the self-payments must be submitted to the Administration Office on a timely basis. The self-payment rate is adjusted periodically by the Trustees. The rates are higher for Retirees under age 63. The rates also vary depending upon the benefit option elected. The rate schedule is provided at the time of retirement.

Dependent Eligibility for Retiree Coverage
A Retiree's Dependents, as defined under "Definition of Dependent," are eligible for Retiree Coverage. Dependents must be enrolled at the time of the Retiree's enrollment in Retiree Coverage. A Dependent may not be enrolled at a later date, except under the provisions for "Special Enrollment for Newly Acquired Dependents."

Special Enrollment for Newly Acquired Dependents
If a Retiree is enrolled in Retiree Coverage and acquires a new Dependent as the result of marriage, birth, adoption, or placement for adoption, the newly acquired Dependent may be enrolled within 30 days after the marriage, birth, adoption or placement for adoption. If a newly acquired Dependent is not enrolled within the 30-day period, the Dependent will not be eligible for Retiree Coverage.

Benefit Options
The Plan provides medical and prescription drug coverage option for Retirees and their Dependents.

Dental, vision, weekly disability, life and accidental death and dismemberment benefits are excluded.

Medicare eligible Retirees and Medicare eligible Dependent spouses electing prescription drug coverage may select either of the following options for prescription drug coverage:

- The Plan's self-funded Prescription Drug Program provided through Sav-RX. Retirees electing this option will have primary coverage provided by the Plan; or

- The AARP Medicare RX Preferred - Medicare Part D program insured by UnitedHealthcare with supplemental self-funded coverage through Sav-RX. Retirees and their Dependents electing this option will have primary prescription drug coverage provided by UnitedHealthcare.

For more information on prescription drug coverage, refer to the sections in this booklet on the "Plan's Prescription Drug Program – Sav-RX" and "AARP Medicare Rx Preferred Prescription Drug Program—Medicare Eligibles."

Medicare Enrollment
In order to receive full Plan benefits, a Retiree and a Dependent spouse MUST enroll in Medicare Parts A and B or Plan C when eligible for that coverage. Even if COBRA is elected in lieu of Retiree Coverage, a Retiree and a Dependent spouse are expected to enroll in Medicare. This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A, B, or C if a Retiree or Dependent

spouse fails to enroll. Participants and Dependents who have End-Stage Renal Disease should also enroll in Medicare when eligible.

Those under age 65 and covered by Medicare must submit proof of Medicare eligibility. Please notify the Administration Office in writing within 30 days of receipt of notification of Medicare eligibility.

Refer to the section on "Coordination of Benefits" for information on how Plan benefits are coordinated with Medicare.

12-month Waiver of Self-Payments for Dependents of a Deceased Retiree
If a Retiree dies, Covered Dependents may apply for a 12-month waiver of self-payments, which are then paid by the Plan. Only medical and prescription drug coverage is provided during the waiver.

To request a waiver of contributions, a Covered Dependent must contact the Administration Office at the address or phone number listed in the Quick Reference Chart at the front of this booklet.

The waiver of contributions terminates on the earliest of:

- 12 months from the date the waiver commenced;
- In the case of a Dependent child, on the last day of the month in which the definition of Dependent is no longer satisfied;
- In the case of a surviving spouse, on the last day of the month in which the surviving spouse remarries or becomes covered under another group plan.

Following termination of the waiver, a Covered Dependent may resume self-payments for Retiree Coverage, provided the Dependent continues to satisfy the definition of Dependent, and in the case of a surviving spouse, the spouse has not remarried. Upon resumption of self-payments, the benefit options in effect prior to the waiver will be reinstated.

Termination of Retiree Coverage
Retiree Coverage ends the earlier of:

- The day the Trust ceases providing Retiree Coverage or terminates the Plan;
- The first day of the month for which the required self-payment is not received;
- In the case of a Retiree under age 55 and the Retiree's Dependents, the last day of the month the Retiree ceases to be entitled to Medicare due to disability;
- In the case of a Dependent, the last day of the month in which the Dependent no longer meets the definition of a Dependent;
- In the case of a Dependent who is a surviving spouse, the last day of the month in which the surviving spouse remarries.

A Dependent may apply for COBRA continuation coverage if Retiree Coverage terminates because the Dependent no longer satisfies the definition of Dependent.

Medical Benefits

The Plan provides medical benefits for Covered Persons for the necessary treatment of non-occupational Injury or Illness.

Benefits are based on the Allowable Charge for Covered Services. For PPO Providers, the Allowable Charge is the negotiated rate. For Non-PPO Providers the Allowable Charge is the lesser of the Usual, Customary and Reasonable (UCR) Charge and the actual charge.

The Plan, its third-party administrator, its utilization review organization, and other designated entities used by the Plan may utilize internal guidelines or medical protocols (including guidelines and protocols used for diagnosis, treatment, prescription or billing practices) in determining whether or not specific services or supplies are covered.

Preferred Provider Organization (PPO) Network

For hospitals, surgical centers and outpatient therapy providers within Anchorage, the Plan's PPO Network is limited to Alaska Regional Hospital, Matsu Medical Center, Surgery Center of Anchorage, Alaska Hand Rehabilitation, Ascension Physical Therapy and Chugach Physical Therapy. The Allowable Charge will be limited to the rate available at the PPO provider for services received at Non-PPO providers within the Municipality of Anchorage when services are available at these PPO Network providers. Amounts charged in excess of the Allowable Charge may be balanced billed to a Covered Person and will not apply to the Annual Medical Out of Pocket Maximum.

For all other types of facilities and geographical regions, the Trust has contracted with Aetna to provide a PPO network. PPO Providers have agreed to provide Covered Persons with services and supplies at negotiated rates (does not apply to Medicare Retirees).

When services are provided by a PPO Provider, the Plan generally pays a higher percentage of Covered Services than it does when services are provided by a Non-PPO Provider. In addition, a Non-PPO Provider may balance bill a Covered Person for the difference between the billed charges and the Allowable Charge. Therefore, in most cases, a Covered Person's out-of-pocket costs are higher when services are provided by a Non-PPO Provider then when services are provided by a PPO Provider.

It is important to confirm the status of a Provider before services are rendered. If more than one Provider will be involved in treatment, the status of all Providers should be confirmed. For example, if surgery is being scheduled, higher benefits are provided if all Providers (Physician, assistance surgeon, and anesthesiologist) are PPO Providers. A Covered Person should also inquire whether any freestanding lab or x-ray services used by a Physician or facility are PPO Providers.

If Medicare is the primary insurance, a Covered Person need not use an Aetna PPO Provider. Medicare already has special negotiated rates with most Providers.

The list of PPO Providers is available at www.aetna.com/docfind (select Aetna Choice® POS II (Open Access). Please note, for hospitals and surgical centers within Anchorage, the Plan's PPO Network is limited to Alaska Regional Hospital, Matsu Medical Center and Surgery Center of Anchorage.

Other Direct Contracted Providers

Please note, the Plan has certain direct contracts with various providers in Alaska, these include:

- Chugach Physical Therapy*
- Ascension Physical Therapy*
- Guardian Flight
- Alaska Regional LifeFlight Corporation
- Coalition Health Center in Fairbanks

- Alaska Hand Rehab*
- New Frontier Anesthesia

* The Plan's PPO Network for Outpatient Therapy in Anchorage is limited to these direct contracted providers.

Calendar Year Deductible
The medical deductible is the amount of the Allowable Charge that each Covered Person must satisfy each calendar year (January 1 through December 31) before most medical benefits are payable by the Plan. The calendar year deductible for medical benefits is:

Actives	
Individual	$500
Family	$1,500

Retirees	
Individual	$2,000
Family	$4,000

Once the individual deductible is satisfied by a Covered Person, no further deductible will be required from the Covered Person. Once the family deductible is reached for Covered Persons in the family, no further deductible amounts will be required for any family member for the rest of that calendar year.

Charges Not Applied to the Deductible. Certain charges do not apply to the deductible, including: any penalty for failure to obtain preauthorization; any penalty for emergency room treatment; balance billed charges; charges in excess of the Allowable Charge; and expenses not covered or otherwise excluded.

Services Not Requiring Deductible. There is no deductible for covered Preventive Care Services, BridgeHealth, Teladoc and home health care services.

Coinsurance
Coinsurance is the Covered Person's share of the Allowable Charge after the deductible is satisfied. Unless otherwise stated in this Plan, the coinsurance rates for Covered Services are as follows:

Actives		
	Plan Pays:	**Covered Person Pays:**
PPO/Non-PPO Coinsurance	80% of Allowable Charge	20% of Allowable Charge
Anchorage Non-PPO hospitals, surgical centers and outpatient therapy	60% of Allowable Charge	40% of Allowable Charge

Retirees		
	Plan Pays:	**Covered Person Pays:**
PPO/Non-PPO Coinsurance	70% of Allowable Charge	30% of Allowable Charge
Anchorage Non-PPO hospitals, surgical centers and outpatient therapy	70% of Allowable Charge	30% of Allowable Charge

Exceptions. The following exceptions apply to coinsurance:

- Coinsurance for Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage is 40% of the Allowable Charge (Plan pays 60% of Allowable Charge; Covered Person pays 40% of Allowable Charge) for Actives or 30%. Plan pays 70% of Allowable Charge; Covered Person pays 30% of Allowable Charge for Retirees. This applies to all inpatient admissions, outpatient surgery, diagnostic testing, imagery, rehabilitative and habilitative therapies.

- Coinsurance is not provided until the deductible is satisfied.

- Coinsurance is not provided until any applicable emergency room penalty is satisfied.

- Penalties for failure to obtain preauthorization when required are paid by the Covered Person without coinsurance from the Plan and are not counted in the out-of-pocket maximum.

- Preventive Care Services are paid at 100% of the Allowable Charge for without deductible or coinsurance.

- Allowable Charges for home private duty nursing are paid at 50% coinsurance.

- Expenses that exceed the UCR Charge are not Allowable Charges and are paid by the Covered Person without coinsurance from the Plan and are not counted in the out-of-pocket maximum.

- Expenses that exceed the frequency of visits or other Plan limitations are not considered Allowable Charges and are paid by the Covered Person without coinsurance from the Plan and are not counted in the out-of-pocket maximum.

- Covered Services provided by a Non-PPO hospital, surgical center or outpatient therapy Provider in Anchorage are paid at the PPO coinsurance rate (80%/100% of the UCR Charge for Actives and 70%/100% of the UCR Charge for Retirees) for services unavailable at a PPO or if the Covered Person had no choice in the selection of the Provider and did not know the Provider was a Non-PPO Provider. The Covered Person's 20% coinsurance share applies to the deductible and out-of-pocket maximum for PPO Providers. Amounts in excess of the Allowable Charge (balanced billed amounts above UCR) do not apply to the out-of-pocket maximum. The Covered Person must submit proof that there was no choice in Provider selection and the Covered Person did not know a Non-PPO Provider would be used.

- Covered Services at a Non-PPO hospital for treatment of an emergency medical condition are paid at the PPO coinsurance rate (80%/100% of UCR Actives and 70%/100% Retirees). There is a $400 penalty for non-emergency services received at an emergency room.

Annual Medical Out-of-Pocket Maximum

The annual medical out-of-pocket maximum is the most a Covered Person pays each calendar year toward medical Covered Services. This means that once a Covered Person reaches the annual medical out-of-pocket maximum, the Plan pays 100% of Allowable Charges for Covered Services for the remainder of the calendar year.

For Actives, the annual medical out-of-pocket maximum for PPO-Providers and Non-PPO Providers outside of Anchorage is:

Annual Medical Out-of-Pocket Maximum	
Each Covered Person	$3,500
Covered Family	$7,000

The annual medical out-of-pocket maximum for Non-PPO hospital, surgical center and outpatient therapy Providers in Anchorage is:

Annual Medical Out-of-Pocket Maximum	
Each Covered Person	$7,000
Covered Family	$14,000

For Retirees, the annual medical out-of-pocket maximum for PPO-Providers and Non-PPO Providers is:

Annual Medical Out-of-Pocket Maximum	
Each Covered Person	$3,500
Covered Family	$7,000

The annual medical out-of-pocket maximum is adjusted from time to time by the Trustees.

The annual medical out-of-pocket maximum generally includes the medical deductible and the coinsurance amount on Covered Services. **The following are not counted in the medical out-of-pocket maximum:**

- Expenses for private duty nursing.
- Penalty for an emergency room visit for non-emergency medical conditions.
- Amounts in excess of the Allowable Charge at a PPO when utilizing a non-PPO Provider in Anchorage.
- Penalty for failure to obtain preauthorization of services requiring preauthorization.
- Expenses that are in excess of the Plan limits.
- Expenses not covered by the Plan.
- Dental and vision expenses, including any deductibles, copayments and coinsurance.
- Prescription drug expenses when the drug is dispensed by a retail or mail order pharmacy. See "Prescription Drug Program" for the prescription drug out-of-pocket maximum.

Preauthorization

It is important to understand whether medical services are considered "Medically Necessary" by the Plan before receiving those services. The Plan only provides benefits for services that are determined to be Medically Necessary. To assist in this process, the Plan requires preauthorization of Medical Necessity for most hospital stays, inpatient confinements, and surgeries. This program is intended to ensure a Covered Person is hospitalized, or receives certain services, only when Medically Necessary, and for the appropriate length of stay when admitted. Aetna is the Plan's Utilization Review ("UR") Coordinator providing preauthorization services.

Preauthorization will only determine Medical Necessity. A Covered Person must contact the Administration Office to confirm eligibility for coverage or to determine whether a particular service or supply is covered or has coverage limitations.

> **Important:** Preauthorization is not required if a Covered Person has other primary coverage that is group health coverage or Medicare.

Services Requiring Preauthorization.

The Plan requires review of all hospital, treatment center confinements and surgeries. It is your responsibility to initiate the review. If your inpatient confinement or outpatient surgery is not reviewed according to these procedures, your benefits will be reduced to 50% of the Allowable Expense, not subject to the Annual Out-of-Pocket Maximum.

Preauthorization may be requested by contacting Aetna at (888) 632-3862.

Effect on Benefits

1. Reviewed and Certified: Expenses for inpatient confinements and outpatient surgery which are certified by Aetna (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions but see item 3 below.
2. Not Reviewed: If the inpatient confinement or outpatient surgery is not reviewed timely (see Rules for a Hospital Review, below), any benefits payable will be reduced to 50% of the Allowable Charge, not subject to the Annual Out-of-Pocket Maximum. No benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.
3. Reviewed and Not Certified: If the inpatient confinement is reviewed timely, but inpatient care is not certified as Medically Necessary:
   - Benefits for hospital room and board will not be payable; and
   - Expenses for other covered hospital services will be considered according to Plan provisions.

Certification does not automatically mean benefits are payable. No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

Rules for Inpatient Confinement Review

1. For a Non-emergency Admission. Your health care provider must notify Aetna by phone prior to the scheduled hospital admission. Aetna will send you, the physician, and the hospital written notice of certification or non-certification of the hospital admission. Please allow sufficient time to process your hospital review – do not wait until the last minute to contact Aetna.
2. For an Emergency Admission. Your provider must notify Aetna by phone no later than the second business day following admission. Aetna will send you, the physician, and the hospital written notice of certification or non-certification of the hospital admission.
3. For Continued Confinement. If your physician is considering lengthening your hospital stay past the period which was originally certified, your provider must call Aetna to request certification of the additional days.

Exception

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims. The precertification requirement is waived for normal deliveries, post-partum tubal ligations, and vasectomies.

Second Surgical Opinion

On occasion, the Plan may request that you obtain a second surgical opinion. You are responsible for scheduling your own appointment. The second surgical opinion must be rendered by a board-certified surgeon or specialist who is not financially associated with your doctor.

The Allowable Charge of the second surgical opinion consultation, including additional diagnostic tests if required, are paid at 100% by the Plan if the Plan recommends a second surgical opinion. No Deductible applies.

If the second opinion does not agree with the first, you may obtain a third opinion. The cost of the third opinion will also be paid by the Plan.

Utilization Management

Utilization management begins once an admission or procedure is preauthorized. Utilization management includes concurrent review of the hospitalization or services requested by the attending Physician; on-going certification of services; and planning for discharge from a medical care facility and for completion of medical treatment.

A case manager will monitor a Covered Person's stay or use of other medical services, and coordinate the scheduled release or an extension of the stay or extension or cessation of the use of other medical services with the patient, attending Physician, and/or hospital.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to extend an admission for a longer length of time than has been preauthorized, the attending Physician must request the additional services or days.

To coordinate utilization management, the Provider must contact Aetna at (888) 632-3862.

Individual Case Management
If you have injuries or an illness that may extend for some time, the Plan provides for services through case management. For example, if you are facing an extended period of care or treatment and these services may be accomplished in a skilled nursing facility or in your home, the case management program may be helpful in facilitating and coordinating this care. This can be beneficial to you because these settings may offer cost savings as well as other advantages to you and your family.

When reviewing claims for the case management program, the case management provider always works with you, your family, and your physician so you receive close, personal attention.

Through case management, the case management provider can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures, or suggestions for cost-effective use of existing Plan provisions such as home health care and convalescent facilities. In order to be considered for payment under the Plan, the alternative care must result in savings without detracting from the quality of care. You, your provider, and the Plan must approve alternate care before it is provided in order to be covered by the Plan.

Case management is voluntary. There is no penalty for not participating in case management or for leaving the case management program during its course. If you have questions regarding case management and it's possible application to you, call the Administration Office.

BridgeHealth Surgery Benefit
The Trust has contracted with BridgeHealth to provide non-Medicare eligible participants with access to high quality providers across the United States who perform certain surgeries. This includes access to centers of excellence as well as surgeons who are highly rated within their specialty in the United States for their specialty.

You should contact BridgeHealth or BridgeHealth may contact you, if you have any planned non-emergent major surgeries, such as:

- Cardiac
- General Surgery
- Orthopedic
- Spine
- Vascular
- Neurologic
- Women's Health

Upon acceptance of your case, the following enhanced Plan provisions will apply when you utilize a BridgeHealth network provider:

- Your medical deductible and coinsurance will be waived;
- Preauthorization requirements will be waived (although Plan exclusions will continue to apply);
- A BridgeHealth Care Coordinator will help coordinate all aspects of your surgery by helping collect the required medical records, assisting with provider selection and making travel arrangements; and
- The Trust will cover related lodging, transportation and per diem. For the most part, these expenses will be covered directly as part of BridgeHealth's negotiated case rate.

Exclusions – The following items are excluded:

- Travel for medical treatment outside of the BridgeHealth program;
- Vacations or travel where the primary purpose is not for medical treatment;
- Travel expenses for which the member was not responsible to pay or which were not actually incurred (airfare purchased using frequent flyer miles, donated lodging, etc. …).

To obtain more information about this benefit after September 1, 2019, contact BridgeHealth at (800) 680-1366 and identify yourself as a participant in the Cement Masons and Plasterers Health and Welfare Plan or go online at *www.BridgeHealthMedical.com*.

BridgeHealth is an independent third-party contractor to the Trust. Neither the Trust nor BridgeHealth provide medical services and neither are engaged in the practice of medicine. The BridgeHealth Surgery Benefit program is entirely voluntary.

Covered Medical Services
Covered Services are the services or supplies received by a Covered Person for which benefits are provided under the Plan for Medically Necessary treatment of an Injury or Illness. Covered Services also include certain preventive care services. Benefits for Covered Services are subject to the limitations, exclusions, and other provisions of this Plan.

The following are Covered Services:

Alternative Care. Benefits are provided for acupuncture, massage therapy, and naturopathic treatment when treatment is by a Provider acting within the scope of their license and treatment is Medically Necessary and for a covered Illness, Injury or trauma. The maximum benefit for all services provided under this benefit is limited to $1,000 per Covered Person, per calendar year. Supplements, vitamins or educational services are not covered.

Ambulance Transportation.

- ***Air Transportation/Air Ambulance.*** Benefits are provided for professional air ambulance company services when transport is to the nearest facility that is available and equipped to furnish the services and immediate and rapid transport is required due to the nature and severity of the Covered Person's Illness or Injury. Medical Necessity and appropriateness is only established when the Covered Person's condition is such that use of any other method of transportation poses a threat to the Covered Person's survival or seriously endangers the patient's health.

- ***Ground Ambulance Transportation.*** Benefits are provided for professional ground ambulance services when transport is to or from the nearest facility available with the appropriate services and when necessary to protect the Covered Person's life or health.

Transportation within the United States by a professional ground ambulance is also covered if:

- Special and unique Covered Services are required which cannot be provided by a local Physician, and
- Transportation is Medically Necessary, and
- Transportation is to the nearest Hospital equipped to furnish the services.

Anesthesia. Benefits are provided for anesthesia and its administration during a covered medical or surgical procedure in an appropriate treatment setting.

Assistant Surgeon. Benefits are provided for surgical assistance by a Physician or physician assistant (PA).

Preauthorization is required for inpatient admissions and some surgical services.

Birthing Center. Benefits are provided for a Covered Participant or Covered Dependent spouse for services and supplies for childbirth at a Birthing Center if each of the following is satisfied:

- The Covered Participant or Covered Dependent spouse uses a Birthing Center instead of a Hospital; and the services and supplies would be covered if provided by a Hospital.

- The pregnancy satisfies the definition of an Illness.

- The pregnancy ends in a full-term delivery or live birth (not a miscarriage or abortion).

Regular Hospital benefits apply if the Covered Participant or Covered Dependent spouse is transferred to a Hospital.

Benefits are not provided for a Dependent child.

Blood and Blood Plasma and its Administration. Benefits are provided for blood and blood plasma and its administration associated with Covered Services.

Contact Lenses, Lens Implant, Eyeglasses. Benefits are provided for the initial placement of contact lenses, initial lens implant, or first pair of eyeglasses if required because of cataract surgery.

Dental Services. Benefits are provided for dental services for the repair of an accidental Injury to natural teeth that are whole and functionally sound. The repair must be within one year of the Injury, provided the Trustees in their discretion may extend the benefit period for successive one-year periods, beginning with the end of the first one-year period, if there are documented medical reasons why the repair cannot be completed within one year of the Injury. A Covered Person will be required to submit substantiating medical documentation to the Plan prior to consideration of any one-year extension. Benefits for dental work qualifying under this provision will be paid first under the Medical Benefits, then under the applicable Dental Benefits of this Plan.

Diagnostic imagery and laboratory tests. Benefits are provided for diagnostic imagery and laboratory tests. Charges for routine/preventive imagery and laboratory tests may be covered under the "Preventive Care" benefit. Coinsurance for Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage is 40% of the Allowable Charge (Plan pays 60% of Allowable Charge; Covered Person pays 40% of Allowable Charge) for Actives or 30% (Plan pays 70% of Allowable Charge; Covered Person pays 30% of Allowable Charge for Retirees.

Dialysis. Benefits for outpatient dialysis provided by a PPO or Non-PPO Providers are paid pursuant to the Plan's Dialysis Benefit Program (the "Dialysis Program"). The Dialysis Program is the exclusive means for determining the amount of Plan benefits and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan participants reside may allow such providers to exercise control over prices for dialysis-related products and services,
(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan participants,
(3) evidence of (i) significant inflation of the prices charged to Plan participants by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan participants to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan participants, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan participants' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Participants for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all PPO and Non-PPO Provider dialysis-related claims received by the Plan.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review. In making this review, the Plan shall consider factors including:

i. Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) Following the review, the Plan may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Participant, to the following payment limitations, under the following conditions:

i. Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Participant, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Maximum Benefit. The maximum Plan benefit payable for dialysis-related claims subject to the payment limitation shall be the Plan's Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iii. Plan's Reasonable Charge. The Plan shall determine the Plan's Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

(5) Provider Agreements. If a dialysis Provider, acceptable to the Participant, is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the Provider, provided that such agreement must identify this section of the Plan and clearly state that such agreement is intended to supersede this section.

(6) Discretion. The Board of Trustees shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

Durable Medical Equipment. Benefits are provided on a monthly rental basis or purchase of covered durable medical equipment not to exceed the total purchase price. Rental of wheelchair, hospital bed, and other durable medical equipment and supplies, is covered only when:

- Prescribed by a Physician;
- Of no further use when medical need ends;
- Usable only by the patient;

- Not primarily for the comfort or hygiene of the patient;
- Not for exercise;
- Manufactured solely for medical use;
- Approved as effective and usual and customary treatment of the condition as determined by the Plan;
- Not for prevention purposes; and
- Appropriate for use in general daily living and not for specific activities such as running or swimming.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Deluxe items are not covered.

Formula for Treatment of Phenylketonuria. Benefits are provided for formula Medically Necessary for treatment of phenylketonuria.

Habilitative Care Services. Benefits are provided for habilitative care services when Medically Necessary to treat mental health disorders identified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) and physical or structural birth defect (congenital anomaly). To be covered, services must be prescribed and documented to either improve function or maintain function where significant deterioration in function would result without therapy. Function means the ability to execute skills required for activities of daily living which would be normal and expected based on the age of the patient. The patient must be under the care of a Physician during the time the habilitative services are being provided, and all services must be provided by a Physician acting within the legal scope of their license. A formal treatment plan may be required upon request and will be required after the 25th visit. Periodic re-evaluations will also be required.

Covered Services under this benefit include:

- Neurological and psychological testing, evaluations and assessments.

- Speech, occupational and physical therapy when provided as part of a formal written treatment plan.

- Neurodevelopmental therapy when provided as part of a formal written treatment plan.

- Applied Behavior Analysis (ABA) therapy for individuals diagnosed with Autism Spectrum Disorder (ASD) when the following conditions are met:

    - A documented comprehensive individual treatment plan is developed based on a functional analysis completed within 6 months of the beginning of treatment;

    - Routine evaluation of data on a regular basis and documentation of demonstrable progress against targeted goals at least once every six months; and

    - The ABA services are provided by, or are under the supervision of, a program manager who is a Board Certified Behavior Analyst (BCBA) or a Physician or Provider whose legal scope of license includes behavior analysis; and

    - Psychotherapy, which may include ABA services.

Hair Prosthesis Benefit. For hair prosthesis and related services if the prosthesis is required to cover hair loss from a covered injury or illness or from treatment of covered injury or illness. The maximum allowance is for one hair prosthesis and related services (i.e. fitting, styling) up to $1,000 ever 12 calendar months).

Hearing Benefit. For hearing evaluation examination and hearing aid device, the Plan will pay 100% of the Allowable Expense up to a maximum of $3,500 per ear in a period of 3 consecutive calendar years**.**

Certification that hearing loss may be lessened by the use of a hearing aid must be submitted to the Administration Office from the examining physician. This benefit is available to Active Participants and dependent(s) only. Retirees and Retiree dependent(s) are not eligible for hearing benefits.

Home Health Care. Benefits are provided for services of a Home Health Care Agency, but not to exceed 130 visits in any calendar year. Each visit by a member of the home health care team is considered one home health care visit. Home health care is not subject to the deductible.

Home health care benefits are subject to the following conditions:

- Home health care must be prescribed by a physician.
- The service provider must be a Medicare-approved agency.
- The services must be in place of a covered confinement in a hospital.
- Custodial care is not covered.
- The patient's physician must establish and periodically review a written treatment plan which describes the care to be provided.

Hospice Care. This program is designed to minimize the emotional trauma associated with terminal illness. In a hospice program, the terminally ill patient receives health care benefits at home, or in an impatient facility for short periods. The Plan provides hospice care benefits for a terminally ill patient with a life expectancy of 6 months or less.

Hospice care is covered, subject to the following conditions:

- Hospice care must be prescribed by a physician.
- The service provider must be a Medicare-approved agency.
- The services must be in place of a covered confinement in a hospital.
- Custodial care is not covered.
- The patient's physician must establish and periodically review a written treatment plan which describes the care to be provided.

Preauthorization is required for inpatient hospice care.

Any requirements in the Plan that the care be part of an active plan of medical treatment that is reasonably expected to reduce the disability will not apply to hospice care services.

Hospital Services and Supplies. Benefits are provided for inpatient and outpatient Hospital services and supplies, including: room and board; Hospital charges for outpatient treatment for accidental Injury or Illness; and Hospital charges for outpatient physical, speech, occupational, rehabilitation or respiratory therapy services. The following limitations apply:

- There is a $400 penalty for emergency room care, unless treatment is for an emergency medical condition.

- Charges for a semi-private room are limited to the Hospital's average semi-private room rate.

- Charges for intensive care or coronary care units are limited to 300% of the average semi-private room rate of the Hospital where the Covered Person is confined.

- Preauthorization is required for inpatient confinement and for certain outpatient procedures.

- There is a $250 penalty for confinement to a Non-PPO hospital in Anchorage.

Coinsurance for Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage is 40% of the Allowable Charge (Plan pays 60% of Allowable Charge; Covered Person pays 40% of Allowable

Charge) for Actives or 30% (Plan pays 70% of Allowable Charge; Covered Person pays 30% of Allowable Charge for Retirees.

Mental Health Services. Benefits are provided for inpatient and outpatient treatment of mental Illness, including treatment by a Physician, licensed psychologist, certified social worker, certified mental health counselor, community mental health agency or Hospital. All treatment provided by a residential treatment center, other than outpatient treatment, is considered inpatient treatment. Preauthorization is required for inpatient treatment.

Newborn Care. Benefits are provided for charges by a Hospital for routine newborn care, including nursery and related services and supplies and routine care. The parent of the newborn must be a Covered Participant or Covered Dependent spouse under the Plan at the time of birth and the newborn child must be a Covered Dependent.

Nursing Services. Benefits are provided for home private duty nursing services at 50% of Allowable Charges. Services must be provided by a registered nurse or licensed practical nurse in the Covered Person's home. Home private duty nursing services are covered when the Covered Person is under the care of a Physician, who provides a periodic confirmation, as requested by the plan, that without private duty nursing services, confinement in a Hospital or skilled nursing facility would be required. Preauthorization is required.

***Orthotics*.** Foot orthotics or other supportive devices of the feet are limited to one pair per year of braces, splints, custom insoles or supports prescribed by a Physician for the treatment of an Illness or Injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany orthotics are not covered. Over the counter shoe inserts are not covered.

Oxygen. Benefits are provided for oxygen and rental of equipment for its administration.

Physician Services.

- ***Physician Office Visit.*** Benefits are provided for professional fees of a Physician for an office visit for the examination, diagnosis and treatment of an Illness or Injury.

- ***Physician Services Outside an Office Setting.*** Benefits are provided for professional fees of a Physician for services received in a Hospital, emergency room (ER), urgent care facility or other covered health care facility.

Pregnancy Care.

- ***Female Participants and Dependent Spouse.*** Benefits are provided for care and treatment of pregnancy of a Participant or Dependent spouse on the same basis as for any other Illness or Injury. The expenses must be incurred while the individual is a Covered Person under the Plan. Benefits are not provided for Dependent children, except as provided below.

  Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Caesarian section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child. However, this will not prohibit the mother's or newborn's attending Physician, after consultation with the mother, from discharging the mother or her newborn earlier. Preauthorization is required for a Hospital stay that exceeds the above lengths of stay.

- ***Dependent Child.*** Benefits for pregnancy care of a Dependent child are limited to those routine prenatal services listed under the Women's Preventive Care Act. Refer to www.healthcare.gov/ preventive-care-benefits/ for a complete listing of services.

Prenatal Testing. Benefits are provided for prenatal testing for congenital disorders of the fetus by means of screening and diagnostic procedures.

Preventive Care Services.

- Preventive Care Services are paid at 100% of the Allowable Charge for without deductible or coinsurance.

The following services are covered:

- Services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings, and counseling in defined areas. A complete list of these services and screenings can be reviewed at **www.uspreventiveservicestaskforce.org**.

- Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at **www.cdc.gov/vaccines**.

- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).

- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at **www.hrsa.gov/womens-guidelines.**

Prosthetic Devices. Benefits are provided for prosthetic devices to replace natural limbs and eyes when:

- Medically Necessary;

- Ordered by the patient's Physician;

- Approved as effective and usual and customary treatment of the condition as determined by the Plan;

- Appropriate for use in general daily living and not for specific activities such as running or swimming; and

- Manufactured solely for medical use.

Preauthorization is required.

Examples of noncovered items include, but are not limited to:

- Deluxe equipment; and

- Items not intended to be worn for all activities of daily living, such as for exercise, sports or swimming.

Reconstructive Breast Surgery. Benefits are provided for Reconstructive Surgery of the breast following or coinciding with a mastectomy that is performed as a result of an Illness or Injury. In accordance with the Women's Health and Cancer Rights Act of 1998, such benefits include reconstruction of the breast on which a mastectomy was performed, one surgery on the other breast to produce symmetrical appearance following a mastectomy, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Benefits are not provided for reconstructive breast surgery for complications arising from a cosmetic augmentation or reduction mammoplasty.

Rehabilitative Therapy.

- ***Outpatient Rehabilitative Therapy.*** Benefits are provided for outpatient rehabilitative therapy (physical, occupational and speech therapy) to the extent that the therapy will significantly restore and improve a lost

function(s) following a severe Illness, Injury or surgery. No benefits will be provided for care that is custodial in nature, or when no significant clinical improvement is expected as a result of the therapy.

The services must be provided under the referral and direction of the attending Physician and administered by a licensed Provider acting within the scope of their license. The Covered Person must continue under the care of the attending Physician during the time the therapy is being provided. Benefits are subject to the following provisions:

- Benefits are limited to up to a maximum of 40 treatments each calendar year.
- Treatment must be provided by a licensed physical, occupational or speech therapist.
- Treatment must begin within one year of the date of the onset of the condition being treated.
- Treatment must be ordered by a Physician and a written treatment program may be required by the Administration Office. (A treatment program will be required after the 25th visit.)

- ***Inpatient Rehabilitative Therapy.*** Benefits are provided for inpatient Rehabilitative Facility care when Medically Necessary to restore and improve function previously normal but lost due to Illness or Injury. Benefits are subject to the following provisions:
  - Confinement must occur within one year from the date of onset of the condition.
  - Confinement must be authorized by a Physician and a written treatment plan must be submitted to the Administration Office by the Physician prior to admittance.
  - Preauthorization is required for inpatient facility services.

Safety Glasses. Covered at 80% of the Allowable Charge to a maximum of $100, once every 3 years. This benefit is available to Active and Retiree participants only and is not available to dependents.

Skilled Nursing Care Facility. Benefits are provided for skilled nursing care facility services, up to a maximum of 120 days for each period of confinement. A new period of confinement is not considered to begin until at least 60 days after the last confinement ended. Care must be under the supervision of a Physician, who must certify that Hospital confinement would be necessary in the absence of confinement in a skilled nursing facility. Preauthorization is required.

Spinal Treatment (non-surgical). Non-surgical Spinal Treatment by a covered Provider is paid at 80% of Allowable Charges up to a maximum of 25 visits per calendar year.

Sterilization. Benefits are provided for sterilization of male Covered Persons at 100% of the PPO Allowed Amount without deductible or coinsurance. Non PPO providers are covered at 70% after deductible. Benefits for female Covered Persons are under Preventive Care.

Substance Use Disorder. Benefits are provided for substance abuse treatment, including charges of a Provider, Hospital or Approved Treatment Facility. Inpatient treatment requires preauthorization by the UR Coordinator.

Transplants, Organ and Bone Marrow.

- ***Transplant.*** Benefits are provided for services and supplies of a covered transplant, subject to the following limitations:
  - Benefits are only provided for services and supplies received after the Covered Person has been eligible under the Plan for a period of 12 consecutive months, including any months in which self-payments

were made for coverage. This 12-month waiting period must only be satisfied once by a Covered Person, regardless of whether eligibility is intermittently terminated.
- 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. Benefits are NOT provided when services and supplies are provided by a Non-PPO Provider.
- Preauthorization is required.
- Proposed transplants will not be covered if considered Experimental or Investigational for the Covered Person's condition.

Preauthorization approval for transplants is based on the following criteria, as well as the UR Coordinator's internal guidelines and protocol:

- A written recommendation with supporting documentation received from the PPO Provider.
- The request for the transplant is based on Medical Necessity.
- The requested procedure and associated protocol is not Experimental or Investigational treatment of the condition.
- The procedure is performed at a facility, and by a Provider, approved by the UR Coordinator.
- Upon evaluation, the Covered Person is accepted into the approved facility's transplant program and complies with all program requirements.

- ***Recipient Services.*** Covered transplant recipient services include:

  - Medical and surgical services directly related to the transplant procedure and follow-up care.
  - Diagnostic tests and exams directly related to the transplant procedure and follow-up care.
  - Facility fees and pharmaceutical fees.
  - Anti-rejection drugs.

- ***Donor Services.*** Donor organ procurement costs are covered provided the organ recipient is a Covered Person and the transplant is covered. Donor organ procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and such other Medically Necessary procurement costs as determined by the Plan.

- ***What is Not Covered.*** The Plan does not cover:

  - Animal to human transplants.
  - Artificial or mechanical devices designed to replace human organs.
  - Experimental or Investigational procedures.
  - Services provided by a Non-PPO Provider or in a Non-PPO transplant facility.
  - Transplant expenses when government funding of any kind is available.
  - Transplant expenses when the recipient is not a Covered Person.
  - Lodging, food or transportation costs.
  - Living (non-cadaver) donor transplants of the lung or other organs (except kidney or liver), including selective islet cell transplants of the pancreas.
  - Donor organ procurement costs when benefits are available through other group coverage or when the recipient is not a Covered Person.
  - Procurement costs and services incurred outside the United States.
  - Heart Transplants.

Corneal, skin, tendon, joint replacements, heart valves, pacemakers and bone transplants are not considered organ transplants and are covered subject to "Hospital Services and Supplies" and "Physician Services," and not the transplant benefits of the Plan.

X-ray, Radium, and Radioactive Isotope Therapy. Benefits are provided for x-ray, radium, and radioactive isotope therapy.

Medical Expenses Not Covered/Exclusions
In addition to specific limitations stated elsewhere in this Plan, no Medical Benefits are payable for any expense incurred for or in connection with or resulting from direct complications of the following:

- Routine eye examinations, lenses and frames, and the fitting thereof. Refer to "Vision Care Benefits" for vision services covered by the Plan.

- Dental services, except as provided under "Dental Services" for injuries to sound natural teeth. Refer to "Dental Care Benefits" for dental services otherwise covered by the Plan.

- Contact lenses, except for initial placement of contact lenses required because of cataract surgery and initial lens implant required because of cataract surgery. Refer to "Vision Care Benefits" for vision services and supplies otherwise covered by the Plan.

- Eye refraction or the fitting or cost of visual aids; visual therapy, training or orthoptics; radial keratotomy, or similar surgery to correct vision, except for corneal graft or when visual acuity cannot be improved to at least 20/70 in the better eye by use of any lens. Refer to "Vision Care Benefits" for vision services and supplies otherwise covered by the Plan.

- Fitting or cost of hearing aids for Retiree Participants and dependent(s) of Retiree Participants.

- Habilitative services except as specifically provided.

- Conditions, services, and supplies listed under General Exclusions and Limitations.

Plan's Prescription Drug Program – Sav-RX

Eligibility

Active Participants and their Dependents are eligible for prescription drug benefits. Retired Participants and their Covered Dependents are eligible for prescription drug benefits only if prescription drug coverage was elected at the time of enrollment for Retiree benefits.

Medicare eligible Retirees and Medicare eligible Dependent spouses have the option of enrolling in the AARP Medicare Rx Preferred Program instead of the Plan's Prescription Drug Program. The AARP Medicare Rx Preferred Program is a Medicare Part D plan fully insured by United Healthcare, with supplemental benefits provided by Sav-RX. Medicare eligible Participants should refer to "AARP Medicare Rx Prescription Drug Program—Medicare Eligibles" for further information.

Medicare eligible Retirees and Dependent Spouses should refer to "AARP Medicare Rx Prescription Drug Program—Medicare Eligibles" for the Medicare Part D Prescription Drug Program that may be selected in lieu of the Plan's Prescription Drug Program.

Formulary

This Plan's Prescription Drug Program includes a voluntary program designed to encourage the use of more economical Generic and Preferred Brand-Name prescription drugs when a prescription is filled. Sav-RX has a list of preferred drugs, called a Formulary. The preferred drugs on the Formulary are chosen because they are the cost effective and clinically appropriate medications. If a prescription that is not on the Formulary is presented at a pharmacy, a Covered Person can decide whether to have the prescription filled or have the pharmacist contact the prescribing Physician for approval of an alternative drug which is on the Formulary. This program is voluntary and the change to a Formulary drug must be approved by the Covered Person and the prescribing Physician.

Options for Filling a Prescription

Prescriptions may be filled using either the retail pharmacy program or the mail order pharmacy program. Both programs are administered by Sav-RX.

Retail Pharmacy Program

The retail pharmacy program provides a 34-day supply of covered medications per prescription or refill at a pharmacy. The retail program is for short-term and immediate prescription drug needs. Prescriptions may be filled at a pharmacy in the Sav-RX network, or at another pharmacy.

Using a Sav-RX Network Participating Pharmacy. Covered Persons using a pharmacy in the Sav-RX network have the advantage of receiving discounted prices with no claim forms to file. At Sav-RX participating pharmacies, the pharmacist will use a computerized system to confirm a Covered Person's eligibility for benefits and determine the discounted cost of the prescription. Covered Persons simply present the prescription identification card and pay the coinsurance amount. To find a participating pharmacy call Sav-RX customer service, toll free, at (800) 228-3108 or go to www.savrx.com.

Using a Non-Participating Pharmacy. At a non-participating pharmacy, Covered Persons must pay the full cost of the prescription and file a claim with Sav-RX for reimbursement. The amount reimbursed will be the Plan's contracted pharmacy rate, less the Covered Person's coinsurance, based on the drug's Formulary status. The contracted pharmacy rate may be less than the amount charged by the non-participating pharmacy. Claim forms are available from the Administration Office or on the Plan's website. Claims must be submitted for reimbursement within one year from the date of the prescription. Claims submitted or completed more than one year from the date of the prescription will not be considered for payment and are excluded from coverage. The address for submitting paper claims is:

Sav-RX Prescription Services
P.O. Box 8
Fremont, NE 68026

Mail Order Program
The mail order program provides a 90-day supply of covered medications per prescription or refill. The mail order feature saves time through home delivery. Covered Persons may also achieve savings when ordering an extended supply due to deeper discounts available through the mail order program. The mail order program is designed for maintenance medications for ongoing or chronic conditions. Most medications are available through the mail order service (even refrigerated medications).

Using the Mail Order Program. Follow these steps to use the mail order program.

- Ask the Physician for two prescriptions: one for a 34-day supply for use at the retail pharmacy while the mail order prescription is being filled; and the second for a 90-day supply at mail order with 3 refills.

- Contact the Administration Office at the telephone number shown in the Quick Reference Chart at the front of this booklet and request a mail service order form. The form is also available on the Plan's website at www.cementmasonstrust.com.

- Contact Sav-RX at (800) 228-3108 to obtain the amount of the coinsurance for the prescription.

- Submit the completed mail service order form along with a check for the coinsurance amount to the address on the mail service order form. The filled prescription should be received within approximately 2 weeks. Refills can be ordered by telephone, at (800) 228-3108, by mail, or on the Internet at www.SavRX.com.

Specialty Medications
Specialty Medications are high-cost drugs including, but not limited to, infused or injectable drugs that usually require special storage, handling and close monitoring. Specialty Medications are generally prescribed to people with ongoing or complex medical conditions and payment is based on the drug's Formulary status (generic, Formulary Preferred Brand or Non-Formulary Non-Preferred Brand). Specialty Medications require prior authorization, are limited to a 30 day supply and are allowed one retail fill. Thereafter, the Sav-Rx Mail Order Specialty Pharmacy must be used. For assistance when ordering Specialty Medications, please contact Sav-RX at (800) 228-3108.

A Covered Person must notify the Administration Office upon enrollment in a co-pay assistance program with a drug manufacturer or a third party. Amounts paid by a drug manufacturer or a third party as part of a specialty drug co-pay assistance program will not apply to the annual out-of-pocket maximum.

Coinsurance for Outpatient Prescription Drugs
Coinsurance for outpatient prescription drugs is the percentage of the charge for each outpatient prescription that a Covered Person must pay. The coinsurance is the same for both the retail and mail order pharmacy.

Outpatient prescription drug claims are not subject to the calendar year deductible, coinsurance and out-of-pocket maximums for medical benefits. Medical deductibles, co-insurance and out-of-pocket maximums do not apply to outpatient prescription drugs.

A Covered Person is responsible for paying coinsurance at the time the medication is dispensed.

Coinsurance Percentage. The Plan's share of the coinsurance is calculated on the Plan's contracted discounted rate. If a non-participating pharmacy is used, a Covered Person is responsible for the difference between the cost of the prescription and the Plan's contracted discounted rate. Only the coinsurance applicable to the Plan's contracted rate will apply towards the applicable out-of-pocket maximum. Charges exceeding the Plan's contracted rate and the associated coinsurance will not be applied to the out-of-pocket maximum.

The Covered Person is also responsible for coinsurance up to the applicable out-of-pocket maximum based on the drug tier.
The coinsurance percentage paid by a Covered Person is as follows:

Tier	Formulary Status	Coinsurance
Tier 1	All Generic Drugs	20% coinsurance
Tier 2	Formulary Preferred Brand Name Drugs	30% coinsurance
Tier 3	Non-Formulary Non-Preferred Brand Name Drugs	40% coinsurance

Annual Out-of-Pocket Maximum for Prescription Drugs
The annual out-of-pocket maximum for prescription drugs is the most coinsurance a Covered Person pays each calendar year toward covered Tier 1 and Tier 2 prescription drugs. This means that once a Covered Person reaches the annual prescription drug out-of-pocket maximum, the Plan pays 100% of the contracted discounted charge for covered Tier 1 and Tier 2 prescription drugs.

The out-of-pocket maximum for prescription drugs is separate from the out-of-pocket maximum on medical benefits. The annual out-of-pocket maximum may be adjusted from time to time by the Trustees. The current annual out-of-pocket maximum on Tier 1 and Tier 2 prescription drugs is:

Annual Prescription Drug Out-of-Pocket Maximum	
Each Covered Person	$3,000
Covered Family	$6,000

Only the coinsurance for Generic drugs (Tier 1) and Formulary Preferred Brand-Name drugs (Tier 2) accumulates towards the annual prescription drug out-of-pocket maximum. Coinsurance for Non-Preferred Brand Name drugs (Tier 3) does not accumulate toward the prescription drug out-of-pocket maximum. A Covered Person's coinsurance on Tier 3 drugs will be 40% even once the Covered Person reaches the annual out-of-pocket maximum for Tier 1 and Tier 2 drugs.

Regardless of whether a drug is in Tier 1, 2, or 3, a Covered Person is responsible for the difference between the cost of the prescription at a non-participating pharmacy and the contracted discounted rate used for participating pharmacies, and that difference is not included in the out-of-pocket maximum.

Coinsurance for Preventive Care Prescription Drugs
Coinsurance does not apply to certain preventive care drugs. The Plan pays 100% for Generic Drugs and for Brand Name Drugs that do not have a generic equivalent. For Brand Name Drugs that have a generic equivalent, the difference in price between the Brand Name Drug and the Generic Drug equivalent will be the responsibility of the Covered Person.

Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender, age and/or other limits may apply. **Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.**

A complete and up-to-date list of preventive care drugs can be found at **www.hhs.gov/healthcare**. This list may be subject to change.

Quantity Limits
Prescriptions that exceed FDA guidelines are subject to prior authorization in order to guard against abuse and misuse of medications. If a prescription exceeds the guidelines, the prescribing Physician may submit medical information in support of the increased quantity directly to Sav-RX.

Step Therapy
For certain Brand Name target medications, Covered Persons will be required to try a Generic Drug prior to the Plan providing coverage for the targeted Brand Name medication.

Medications Requiring Prior Authorization
The following medications require prior authorization from the Plan. Contact Sav-RX at (800) 228-3108 for procedures to prior authorize these medications.

- Growth Hormones.
- Oral contraceptives for Dependent children.
- Specialty Medications, including injectables.
- Transplant drugs

Covered Prescription Drugs
The Pharmacy Drug Program covers the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- FDA-approved drugs which by federal or state law require a prescription. These are known as legend drugs.
- Compounded medications where at least one ingredient is a covered prescription drug.
- Injectable prescription medications for self-administration, including insulin.
- Diabetic supplies including: insulin syringes (including syringes for pre-filled insulin), test strips, and lancets.
- Prescription oral contraceptives, and contraceptive devices such as diaphragms and cervical caps.
- Prescription smoking cessation drugs for Covered Persons over age 18. A prescription is required. Benefits are provided for Generic Drugs. If a Brand Name Drug is used, Step Therapy applies. There is an annual limit of 2 cycles per treatment.
- Over-the-counter and Generic drugs and supplements when recommended as preventive care by the U.S. Preventive Care Services Task Force under the Affordable Care Act. A prescription is required. Benefits are only provided for over-the-counter or Generic Drugs. Gender, age and quantity limits apply. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. A complete and up-to-date list of preventive care drugs can be found at **www.hhs.gov/healthcare**. This list may be subject to change.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Exclusions
Pharmacy drug benefits are not provided for the following:

- Drugs and medicines which may be lawfully obtained over the counter ("OTC") without a prescription except as described in Covered Prescription Drugs. Examples of non-covered items include, but are not limited to: non-prescription vitamins, food and dietary supplements, herbal or naturopathic medicines, nutritional and dietary supplements.

- Fertility drugs, regardless of their intended use.
- Drugs dispensed for treatment of obesity or to manage weight; anorexiants.
- Drugs to treat sexual dysfunction; impotency medications.
- Drugs which are prescribed or used for cosmetic purposes, including but not limited to hair loss and wrinkles, except Retin A and Renova up to age 26.
- Drugs indicated by labeling to be for experimental or investigative use.
- Professional services including, but not limited to, administration or injection of drugs.
- Prescription refills in excess of the quantity specified by the prescriber, or that exceed FDA quantity limits, or that are dispensed after one year from the date the prescription was written.
- Drugs dispensed for use or administration in a health care facility or take home drugs dispensed and billed by a medical facility.
- Replacement of lost or stolen medication.
- Anabolic steroids.
- Vitamins requiring prescriptions that are other than prenatal.
- Items excluded under General Exclusions and Limitations.

Definitions

Sav-RX means the Prescription Benefits Manager for the Cement Masons Health and Welfare Trust Fund. Sav-RX provides a network consisting of major retail pharmacy chains and many independent retail pharmacies.

Brand Name Drug means a Prescription Drug sold under a trademark name.

Coinsurance means the amount a Covered Person pays for each prescription at a pharmacy or mail order facility as part of the cost sharing arrangement with the Plan. In the case of non-participating pharmacy, co-insurance is the amount the Covered Person pays based on the Plan's contracted rate for each prescription. The patient is responsible for the applicable co-insurance, plus any difference in cost between the non-participating pharmacy's price for the medication and the Plan's contracted rate. Coinsurance must be paid at the time the prescription is filled.

Formulary means a list of preferred medications for the Prescription Benefit Program. This list includes some of the most commonly prescribed, clinically appropriate medications, and serves as a guide for getting excellent values at the pharmacy. The list is routinely reviewed by Sav-RX.

Generic Drug means a drug that contains the same active ingredients, the same strength, and dosage form as the Brand Name counterpart. The U. S. Food and Drug Administration (FDA) regulates the manufacture of all drugs, including Generic Drugs, to assure their strength, quality, and purity. A Covered Person pays the lowest coinsurance for Generic Drugs.

Non-Preferred Brand Name Drug means a Prescription Drug sold under a trademark name that is **not** included on the Sav-RX Formulary.

Preferred Brand Name Drug means a Prescription Drug sold under a trademark name, and included on the Sav-RX Formulary. A copy of the Formulary is available by contacting Sav-RX at (800) 228-3108 or online at www.savrx.com.

Prescription Drug means a drug requiring a prescription and dispensed by a licensed pharmacist.

Specialty Medications means medications that are injectable or infusible, but can also be oral, inhaled or topical, with specific criteria for use and often requiring special storage, handling, dosing and/or monitoring.

AARP Medicare Rx Preferred Prescription Drug Program—Medicare Eligibles

In lieu of the Plan's Prescription Drug Program provided through Sav-RX, Medicare eligible Retirees and Medicare eligible Dependent spouses of Retirees (including Medicare eligible surviving spouses) may enroll in the AARP Medicare Rx Preferred Program, which is a Medicare Part D plan fully insured by United Healthcare and sponsored by the Plan. A Medicare beneficiary who enrolls in the AARP Medicare Rx Preferred Program is provided self-funded supplemental coverage provided by the Plan through Sav-RX when the AARP Medicare Rx Preferred Program pays less than what would otherwise be provided through the Plan's Prescription Drug Program.

Medicare beneficiaries are not required to enroll in the AARP Medicare Rx Preferred Program. However, those who are eligible to enroll and do not enroll will have a higher self-payment for Retiree coverage.

Contact the Administration Office for information regarding the Plan sponsored AARP Medicare RX Preferred Program.

Information About Medicare Part D Prescription Drug Plans for Retirees with Medicare

This notice applies to Covered Persons who are not enrolled in the AARP Medicare Rx Preferred Program.

Individuals who are entitled to Medicare Part A or enrolled in Medicare Part B, are also eligible to enroll in Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage offered by the Plan's self-funded Prescription Drug Program ("Plan") is creditable. This means that the Plan's prescription drug coverage provided to Medicare-eligibles is on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage.

Because this Plan's prescription drug coverage is creditable coverage, Medicare eligible individuals **do NOT need to enroll** in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare.

If a Medicare eligible individual goes 63 days or longer without prescription drug coverage that is creditable coverage, the monthly Medicare premium will go up at least 1% per month for every month they did not have that coverage. For example, if a Medicare eligible individual goes nineteen months without having creditable prescription drug coverage, the premium for Medicare drug coverage may consistently be at least 19% higher than the base Medicare premium. A Medicare eligible individual will have to pay this higher premium as long as they have Medicare prescription drug coverage. In addition, they may have to wait until the next November to enroll.

Medicare eligible individuals may enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. However, if a Medicare eligible individual loses the current creditable prescription drug coverage, through no fault of his own, the individual will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If a Medicare eligible individual enrolls in Medicare Part D, or in a Medicare Part C (Medicare Advantage) Plan that includes prescription drug coverage (other than the AARP Medicare Rx Preferred Program offered by the Plan), that individual will lose the current prescription drug coverage under the Cement Masons and Plasterers Health and Welfare Plan and will not be able to get this coverage back. Further, the Part D premiums will not be reimbursed.

More detailed information about Medicare plans that offer prescription drug coverage will be available in the Medicare and You handbook. All persons enrolled in Medicare (a beneficiary) should receive a copy of the handbook in the mail each year from Medicare. Medicare beneficiaries may also be contacted directly by Medicare approved prescription drug plans. For more information about Medicare prescription drug plans visit: ***www.medicare.gov*** or call 1-800-MEDICARE (1-800-633-4227).

Please contact the Administration Office **before** enrolling in any Part D Plan.

Dental Care Benefits- Active Participants Only

Eligibility
Active Participants and their Dependents are eligible for Dental Care Benefits.

Right to Opt-Out of Dental Care Benefits
In order that the Traditional Dental Care Plan can be considered excepted from the Patient Protection and Affordable Care Act, the Trust offers Covered Persons the right to opt out of all Dental Care Benefits. Electing to opt out of Dental Care Benefits will not change the Dollar Bank deduction rate. If, nonetheless, a Covered Person wants to opt out of all Dental Care Benefits, please send a written request to the Administration Office at the address listed in the Quick Reference Chart at the front of this booklet.

Traditional Dental Care Plan
The following description of coverage and limitations applies to the Traditional Dental Care program which is self-funded by the Plan.

The Traditional Dental Care Plan provides coverage for both Class A and B services, called "Preventive and Routine Services," and Class C services, called "Major Services." When electing coverage through the Traditional Dental Care Plan, Covered Persons may choose any dental Provider.

Preauthorization. Dental treatment which is expected to exceed $400 should be preauthorized to verify eligibility and determine in advance the benefits that will be provided by the Plan. The treating Dentist may submit a preauthorization request to the Administration Office at the following address:

Cement Masons and Plasterers Health and Welfare Plan
P.O. Box 34964
Seattle, WA 98124-1964

The Administration Office will respond to the Covered Person and the Dentist.

Calendar Year Deductible. The dental deductible is the amount of the Allowable Charge dental expenses for Covered Services that a Covered Person must satisfy each calendar year (January 1 through December 31 of the same year) before dental benefits are payable by the Plan. The deductible for dental benefits is separate from the deductible for medical benefits.

The calendar year deductible for dental benefits is $50 per Covered Person and is waived for Preventive Services (Class A). There is no out-of-pocket maximum on dental benefits.

Maximum Benefits Payable. The maximum benefit payable by the Plan during each calendar year on behalf of a Covered Person is **$2,500** for all covered services combined.

Benefits payable for treatment of disorder, disease or dysfunction of the temporomandibular joint (TMJ) are limited to a cumulative lifetime maximum of $750, regardless of the diagnosis or patient age.

Percentage Payable – Preventive and Routine Services - Class A & B. The Plan pays for Preventive and Routine Services performed by a Dentist, as follows:

Consecutive Years of Treatment	Percentage of Allowable Charge Payable
First Year	70%
Second Year	80%
Third Year	90%
Fourth Year and after	100%

A Covered Person must have dental treatment each year in order to move to the next higher percentage level. If a Covered Person does not have dental treatment in any one year, the percentage level drops back 10%, but in no event will it be less than 70%.

Percentage Payable - Major Services - Class C. The Plan pays 50% of the Allowable Charge for Major Services performed by a Dentist.

Covered Preventive and Routine Services - Classes A and B. The following are Covered Services under Classes A and B:

- Oral examinations, but not more than twice in a calendar year.
- Routine prophylaxis (cleaning and scaling of teeth) including periodontal prophylaxis by a Dentist or dental hygienist are covered but only during two dental visits in a calendar year.
- Fluoride treatment by a Dentist or dental hygienist, but not more than once in a calendar year for Covered Persons under the age of 18.
- Dental x-rays to include:
  - Bitewing x-rays.
  - Extra-oral x-rays.
  - Individual periapical x-rays.
  - Occlusal x-rays.
  - Either one complete mouth survey x-ray, seven bite-wings, or one panoramic x-ray during any period of three consecutive calendar years.
- Dental sealants applied to the first and second permanent molars, but only:
  - For Covered Dependents under age 16;
  - When the teeth have not been treated with sealants for at least four years; and
  - When teeth are free of restorations.
- General anesthesia when it is required for complex oral surgical procedures as determined by the Plan.
- Apicoectomy and retrograde filling.
- Biopsy.
- Cast diagnostic.
- Culture, bacteriologic.
- Cyst, removal.
- Extraction, simple.
- Extraction, surgical, including extraction of impacted teeth.
- Hemisection.
- Incision and drainage.
- Injection, therapeutic drug.
- Restorations (unless otherwise provided); except that mesial-lingual, distal-lingual, or dista-buccal restorations on an anterior tooth shall be limited to the cost of a single surface restoration.
- Occlusal adjustment if performed within one year of periodontal surgery.
- Pin retention.
- Provisional splinting.
- Pulpotomy.
- Recement bridges.
- Repair to a full or partial denture or to a bridge only if it is performed more than one year after the initial insertion of the denture or bridge.
- Root canal therapy.
- Root recovery.
- Sedative filling or a palliative treatment to include exam only if no other dental service, other than x-rays, is rendered during that visit.
- Space maintainers.

Covered Major Services – Class C. The following are Covered Services under Class C:

- Alveoplasty.
- Bridges fixed.
- Clasps and rests, additional.
- Crown build-up.
- Crowns, gold.
- Crowns, stainless steel.
- Dentures, full.
- Dentures, partial.
- Excision of hyperplastic tissue.
- Frenectomy.
- Gingival curettage.
- Gingivectomy, mucogingival surgery, and osseous surgery shall be limited to one such procedure per area of the mouth per calendar year.
- Gold inlays, onlays, post and core.
- Grafts, pedicle.
- Implants, including surgical placements and attachments.
- Periodontal appliance.
- Relining and adjustment of dentures only if the service is rendered more than six months after initial placement of the denture.
- Removal of exostosis.
- Restorations, gold or porcelain.
- Scaling, root planing, gingival curettage, up to two such services per quadrant per calendar year.
- Surgical exposure of impacted tooth to aid eruption.
- Stomatoplasty.
- Tooth replantation or transplantation.
- Vestibuloplasty.

Dental Exclusions and Limitations
The following services and supplies are not covered or are limited:

- Any treatment services or supply unless it is shown under Covered Services.

- Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth.

- Expense incurred after coverage ends; however, prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date the coverage ends are covered if received within 30 days after eligibility ends.

- Prosthetics, including bridges and crowns, started or under way during a month in which the patient was not covered.

- Replacement of lost or stolen prosthetics.

- Replacement of prosthetics, crowns or inlays less than five years after a previous placement, except if the replacement is made necessary by:
  - An Injury to a Sound Natural Tooth (other than a chewing Injury) if the Injury is sustained in an accident, or
  - The extraction of a Sound Natural Tooth provided that the replacement is completed within 12 months of the date of the Injury or extraction.

- Replacement of a denture, bridgework, crowns or inlay if the existing denture, bridgework, crown or inlay can be made serviceable.

- Orthodontic care, treatment, services and supplies, however, this limitation does not apply to extractions incidental to orthodontic services.

- Local anesthesia and analgesia and their administration.

- Procedures, restorations and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth).

- Facing on a crown or on a plastic or composite restoration when the crown or restoration is on a tooth behind the second bicuspid.

- A crown that is for a tooth that can be restored by other means or is for the purpose of periodontal splinting.

- A temporary full denture.

- The following items and services:
  - An athletic mouthguard.
  - A specialized appliance.
  - A precision or semiprecision attachment.
  - A denture duplication.
  - Oral hygiene instruction.
  - Treatment of fractures.
  - Myofunctional Therapy.
  - Orthognathic surgery.

- Charges a Covered Person is not required to pay, including charges for services furnished by any Hospital or organization which normally makes no charge if the patient has no Hospital, surgical, medical or dental benefits.

- Any expense paid in whole or in part by any other provision of the Plan for expense due to:
  - Treatment of a fractured jaw.
  - Biopsy.
  - Excision of a tumor, cyst or foreign body.
  - Excision of tori.
  - Removal of salivary stones.
  - Orthognathic surgery.
  - Treatment of damage to a Sound Natural Tooth if the damage is sustained in an accident and services incurred within the time frame under Medical Benefits.

- Anything excluded under the General Exclusions and Limitations.

- Expenses for disorder, disease, or dysfunction of the temporomandibular joint regardless of the diagnosis, are limited to a lifetime maximum of $750.

- Expenses for Retirees or dependent(s) of Retirees.

Service Start Dates and Completion Dates
Start Dates. The following are deemed service start dates:

- For root canals, the date the canal is opened.

- For inlays, onlays, laboratory processed labial veneers, crowns, and bridges, the preparation date.
- For partial and complete dentures, the impressions date.

Completion Dates. The following are deemed service completion dates:

- For root canals, the date the canal is filled.
- For inlays, onlays, laboratory processed labial veneers, crowns, and bridges, the seat date.
- For partial and complete dentures, the seat or delivery date.

Temporary Appliance or Crown. A temporary appliance or crown is considered to be permanent unless replaced within one year.

Vision Care Benefits- Active Participants Only

Eligibility
Active Participants and their Dependents are eligible for Vision Care Benefits. The Trust has contracted with Vision Service Plan ("VSP") to administer the Vision Care Benefits.

Right to Opt-Out of Vision Care Benefits
In order that Vision Care Benefits can be considered excepted from the Patient Protection and Affordable Care Act, the Trust offers Covered Persons the right to opt out. Electing to opt out of Vision Care Benefits will not change the Dollar Bank deduction rate. If, nonetheless, a Covered Person wants to opt out of Vision Care Benefits, please send a written request to the Administration Office at the address listed in the Quick Reference Chart at the front of this booklet.

When you go to a VSP member doctor, there are no claim forms for you to file. When you go to a non-VSP provider, you must pay for the vision services at the time you receive them and then file a claim with VSP within 12 months of the date of service. To locate a VSP doctor, contact VSP at www.vsp.com or call (800) 877-7195.

Out-of-Pocket Expenses
There is no deductible for Vision Care Benefits. However, benefits are limited to the scheduled amount in the applicable schedule of allowances. A copayment is also required from Covered Persons for certain services. Copayments and expenses incurred in excess of the scheduled amount are not counted in determining the out-of-pocket maximum for Medical or Prescription Drug Benefits.

Frequency Limitations
Vision Care Benefits are not provided more frequently than described below. The benefit frequency limitations apply regardless of the Provider that is selected.

Examinations. The Plan pays the lesser of the amount incurred or the scheduled amount for a complete examination, but not more frequently than once during any 12 consecutive months.

Lenses. The Plan pays the lesser of the amount incurred or the scheduled amount for each pair of lenses, but not more frequently than once during any 12 consecutive months nor for more than two lenses during any 12 consecutive months. If the vision expense incurred is for just one lens, the amount paid will be 50% of the scheduled amount for a pair of the lenses.

Frames. The Plan pays the lesser of the amount incurred or the scheduled amount for one set of frames, but not more frequently than once during any 24 consecutive months.

Selection of Vision Care Provider
Vision Care Benefits are based upon the scheduled amount shown in the applicable schedule of allowances. There are two different schedules, depending upon whether services are provided by a VSP Provider or by a different Provider.

Although a Covered Person may select any licensed Provider, it may be advantageous to select a VSP Provider because a Covered Person's out-of-pocket expenses for covered services are limited, and the Provider will file the claim on behalf of the Covered Person.

Vision Benefit Summary
If you see a VSP Preferred Provider:

Feature	Copay	Frequency
WellVision Exam • Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses	$25	See Frame and

Feature	Copay	Frequency
		Lenses
Frame • $120 allowance for a wide selection of frames • $140 allowance for featured frame brands • $65 Costco frame allowance	Included in Prescription Glasses	Every 24 months
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements • Standard Progressive lenses • Premium progressive lenses • Custom progressive lenses	$50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses) • $170 allowance for contacts and contact lens exam (fitting and evaluation)	$0	Every 12 months

If you see a non-Preferred Provider:

Feature	Vision Benefit
Exam	Up to $45
Frame	Up to $47
Lenses • Single vision Lenses • Lined Bifocal Lenses • Lined Trifocal Lenses • Progressive Lenses • Contacts	 Up to $45 Up to $65 Up to $85 Up to $85 Up to $170

Vision Care Benefits Limitations and Exclusions
The following services and supplies are not covered under Vision Care Benefits, regardless of the Provider selected:

- Visual field charting.
- Orthoptics or vision training.
- Contact lenses, except as specifically indicated.
- Subnormal vision aids.
- Aniseikonic lenses.
- Tinted lenses, except No.1 and No.2 pink.

- Nonprescription lenses.
- More than the scheduled amount for a standard prescription when multifocal hard resin lenses, coated or no-line bifocals (blended type) are chosen.
- Medical or surgical treatment of the eyes.
- Services and supplies which are related to an Injury or Illness that results from or arises out of any past or present employment or occupation for compensation or profit, including Illness and Injury arising out of or occurring during the course of employment, even if the Covered Person fails to make timely application for or waives the right to those benefits. This includes benefits from occupational insurance purchased by an Employer, benefits provided under state or federal worker's compensation acts, employer liability laws, or other laws providing compensation for work-related Illness or Injury.
- Any expense which results from an act of declared or undeclared war or armed aggression.
- Any expense which is in excess of the Usual, Customary and Reasonable Charge.
- Any expense a Covered Person does not have to pay.
- Any eye examination required as a condition of employment.
- More than one exam for any Covered Person during any 12 consecutive months.
- More than one pair of lenses for any Covered Person during any 12 consecutive months, or more than two lenses for any Covered Person during any 12 consecutive months.
- More than one set of frames for any Covered Person during any 24 consecutive months.
- Any expense paid in whole or in part by any other provision of the Plan.
- Charges for contact lens fitting and testing, except as shown in the VSP Schedule of Allowances.
- Anything excluded under General Exclusions and Limitations.
- Expenses for Retirees or dependent(s) of Retirees.

Weekly Disability Benefits—Active Participants Only

An Active Participant who becomes disabled as a result of a non-occupational Illness or Injury will receive a benefit in the amount of $250 per week, while disabled and under the continual care of a Physician. Benefits begin on the later of the eighth (8th) day of disability, or the day the Active Participant comes under the care of a Physician. Benefits are payable for a maximum of 12 weeks for a disability due to chemical dependency, and for a maximum of 26 weeks for all other disabilities. Disabled means the Active Participant is completely and continuously unable to perform the material and substantial duties of his or her regular occupation. Proof of continued disability may be required.

Withholding
Weekly disability benefits are subject to both FICA (Social Security) and FIT (Federal Income Tax) withholding. The Plan automatically withholds FICA from an Active Participant's benefits.

Restoration of Benefits
Weekly disability benefits will be restored for each new period of disability. A new period of disability begins:

- When an Active Participant becomes disabled after having been back to work full time for at least two consecutive weeks since the previous disability, or

- When an Active Participant becomes disabled due to a cause not related to the previous disability, and the new disability begins after having been back to work full-time for at least one day.

Adjustment of Benefits
Weekly disability benefits are reduced by the daily amount of state disability and federal Social Security disability income benefits, if any. The amount of the reduction will not change just because the Social Security law is changed to increase the level of benefits, or a Social Security cost-of-living increase takes effect. State disability and federal Social Security disability income benefits are any disability income benefits to which the Active Participant is entitled for the covered disability (or could have been entitled if proper application was made) under the federal Social Security Act or a state disability income plan.

Exclusions
Weekly disability benefits are not provided for:

- Any disability for which the Active Participant is not under the regular care and attendance of a Physician.

- Occupational accidental bodily Injury or Illness.

- Any period of time that the Active Participant is eligible to receive unemployment compensation.

Life Insurance, Dependent Life Insurance, & Accidental Death and Dismemberment—Active Participants Only

Life, accidental death and dismemberment, and Dependent Life Insurance benefits are insured by LifeMap Assurance Company. The following information is only a summary of the benefits provided under the insurance policy between the Trust and LifeMap Assurance Company. A copy of the full policy is available by contacting the Administration Office. LifeMap Assurance Company retains the exclusive right to interpret terms and conditions of the insurance policy.

Life Insurance

Amount Payable. Life insurance is payable upon the death of an Active Participant, or surviving spouse of an Active Participant. The amount payable is as follows:

Covered Person	Life Insurance Benefit Payable
Death of an Active Participant:	$10,000 (*reduced to 65% at age 65 and 50% at age 70)*
Death of a surviving spouse of an Active Participant:	$5,000

Beneficiary. Life insurance is paid to the beneficiary or beneficiaries designated in writing to receive the benefit payable. A beneficiary designation may be changed, provided that any designation must be received by the Administration Office prior to the death of the Participant or surviving spouse making the designation. An enrollment form to designate a beneficiary is available from the Administration Office.

If no beneficiary is named, or if there is no surviving beneficiary, benefits are paid as follows:

- To the surviving spouse; if none, then
- To the surviving natural and/or adopted children; if none, then
- To the surviving parent(s); if none then
- To the surviving brothers and sisters; if none then
- To the estate.

A beneficiary designation of a spouse, or of a person who subsequently becomes a spouse, is automatically revoked if the marriage is subsequently dissolved or invalidated, unless that person is redesignated in writing following the dissolution or invalidation of marriage.

Benefits will be paid in a lump sum, unless another payment option is requested and LifeMap Assurance Company agrees to the alternate mode in writing.

Extension of Life Insurance for Active Participants During Total Disability. If an Active Participant becomes Totally Disabled, life insurance will continue without payment of premium, provided the Participant:

- Was a Covered Participant when the Total Disability first began;
- Was under age 60 on the date Total Disability began;
- Was Totally Disabled for at least six consecutive months;
- Provides written proof of Total Disability to the Administration Office within 12 months after the date the Total Disability began.

To continue life insurance beyond the initial 12 months, a Participant must submit written proof of continuous Total Disability during the last three months of each subsequent 12 month period.

For purposes of extended life insurance, "Total Disability" or "Totally Disabled" means that as the result of illness or injury a Participant is unable to perform the material duties of any occupation for which the Participant is or becomes reasonably suited by education, training or experience, and under the regular care of a Physician.

Extended life insurance ends on the earliest date the Participant is:

- No longer Totally Disabled;
- Fails to give the required proof of continuous disability;
- Refuses to undergo a medical exam at the insurance company's request;
- Attains age 65; or
- Converts to an individual policy.

Dependent Life Insurance

Eligibility for Dependent Life. Dependent Life Insurance is payable upon the death of a Covered Dependent, subject to the following limitations and exceptions:

- The Dependent cannot be a Covered Participant.
- The Dependent cannot be in full-time military service.
- The Dependent cannot reside outside the U.S., Canada or Mexico.
- No person will be considered a Dependent of more than one Covered Participant.
- If a Dependent is confined to a hospital, skilled nursing facility or similar institution on the date eligibility commences, the effective date of Dependent Life Insurance is deferred until the Dependent is no longer confined.
- Life Insurance for a Participant's surviving spouse is paid under the Life Insurance Benefit, rather than Dependent Life Insurance.
- Dependent children must be: at least 14 days of age and under 26 years of age at the time of death; the biological child, adopted child, or step-child of the Participant, or a child placed for adoption by the Participant; a child related by blood or marriage to the Participant for whom the Participant or the Participant's spouse is the legal guardian.

A disabled child can remain insured past age 26, if the child is: unmarried; incapable of self-support because of a physical, mental or developmental disability; either chiefly dependent on the Participant for support or maintenance, or institutionalized due to physical handicap or developmental disability; and the disabling condition existed before attaining age 26. It is the Participant's responsibility to apply for continued coverage for a disabled child prior to the child's attaining age 26. Subsequent proof of continuing disability may also be required.

Amount Payable. The amount of Dependent Life Insurance payable is as follows:

Covered Dependent	Dependent Life Benefit
Death of an Active Participant's Dependent spouse:	$7,500
Death of Participant's Dependent child:	$5,000
Death of surviving spouse's Dependent child:	$5,000

Beneficiary. If a Participant's Dependent dies, Dependent Life Insurance is payable to the Participant. If a surviving spouse's Dependent dies, the Dependent Life Insurance is payable to the surviving spouse.

Continuation of Dependent Life Insurance Following Participant's Death. In the event of the Participant's death, eligible Covered Dependents will remain insured for up to 12 months from the Participant's date of death, but not beyond the earliest of the following dates: the date the Covered Person would cease to be a Dependent if the Participant was living; the date the surviving spouse remarries; and the date group policy terminates.

Extension of Dependent Life Insurance During Participant's Total Disability. If a Participant qualifies for an extension of Life Insurance due to Total Disability, Dependent Life Insurance will also be extended for eligible Covered Dependents.

Conversion.
If life insurance, or any portion of it ends due to loss of Plan eligibility or retirement, a Covered Person or Dependent may request a conversion to an individual life insurance policy provided by the insurance company. A Covered Person or Dependent must submit a written request to convert within 31 days of the date of termination of Plan coverage by contacting the Administration Office or LifeMap. The provisions and benefits under an individual policy will not necessarily be the same as under the Plan.

Accidental Death & Dismemberment (AD&D) Insurance—

For Active Participants ONLY
AD&D insurance is available to Active Participants. Retirees and Dependents are not eligible for AD&D insurance. AD&D insurance becomes payable upon the death or dismemberment of an Active Participant which is the result of Accidental Bodily Injury. The loss must occur while covered under the Plan and within 365 days of the Accidental Bodily Injury.

The amount of the benefit payable is based upon the Principal Sum, which is $10,000. The following amount is payable for a covered loss:

For Accidental Loss of:	AD&D Benefit
Loss of Life:	Principal Sum
Both Hands or Both Feet:	Principal Sum
Sight of Both Eyes:	Principal Sum
One Hand and One Foot	Principal Sum
One Hand or Foot and Sight of One Eye:	Principal Sum
Quadriplegia:	Principal Sum
Paraplegia:	75% of Principal Sum
Hemiplegia:	50% of Principal Sum
One Hand, One Foot or Sight of One Eye:	50% of Principal Sum
Speech or Hearing:	50% of Principal Sum
Thumb and Index finger on either hand:	25% of Principal Sum

No more than the Principal Sum is payable for all covered losses resulting from any one accident, except as may be provided below.

- **Seat Belt Benefit** – an additional 25% of the Principal sum.

- **Air Bag Benefit** –An additional 10% of the AD&D benefit amount is payable, not to exceed $5,000.

- **Exposure and Disappearance Benefit** – Exposure to the elements which results in a covered loss is presumed to be an Accidental Bodily Injury if: it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the Active Participant was an occupant at the time of the accident. A Loss of life is presumed if: the Active Participant's body has not been found within one year after the disappearance of a conveyance in which the Active Participant was an occupant at the time of its disappearance.

- **Repatriation Benefit** –The benefit is the lesser of: the expense incurred for preparation of the body for burial or cremation and transportation of the body to the place of burial or cremation; or $2,000.

Exclusions for AD&D Benefits. Even though a loss results from an Accidental Bodily Injury, no AD&D benefits are paid if either the Accidental Bodily Injury or the loss are caused by, or incurred as a result of, any of the following:

- Suicide, intentionally self-inflected injury, or any attempt to injure oneself, while sane or insane.
- Active participation in a riot. Active participation does not include being at the scene of a riot during the performance of official duties.
- War or any act of war, whether declared or undeclared, or for injury suffered while serving in the military forces of any country.
- Committing or attempting to commit an assault or felony.
- Any sickness, disease or pregnancy existing at the time of the Accidental Bodily Injury, or any medical treatment for such sickness, disease or pregnancy.
- Heart attack (including but not limited to myocardial infarction) or stoke (including but not limited to cerebrovascular accident).
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an Accidental Bodily Injury sustained while covered under the policy.
- Taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for the Active Participant and used and consumed in accordance with the directions of the prescribing Physician or administered by a Physician.

General Exclusions and Limitations

Benefits are not provided under any provision of this Plan for the following conditions, services, or supplies:

- Any treatment, service or supply unless it is included as a Covered Service.

- Any expense in excess of the Allowable Charge, including the Usual, Customary and Reasonable Charge.

- Charges for services and supplies which are:

  - Not Medically Necessary (except as provided under Preventive Care), or
  - Not for treatment of an Illness or Injury (except as specifically provided), or
  - Not provided in accord with generally accepted professional medical standards, or
  - Not recommended by a Physician, or
  - Experimental or Investigational or not proven safe and effective.

- Any service received or ordered or any expense incurred for an individual when not a Covered Person under the Plan, except as specifically provided.

- Any loss, expense or charge which results from:

  - An intentionally self-inflicted Injury or Illness, unless such Injury or Illness is the result of a physical or mental health condition.
  - Suicide or attempted suicide, unless such suicide or attempted suicide is the result of a physical or mental health condition.

- Any loss, expense or charge resulting from the person's participation in a riot or in the commission of a felony.

- Any expense or charge for which the person has no obligation to pay or charges that are made only because the Plan exists.

- Any expense or charge for Custodial Care or rest cures.

- Any loss, expense or charge that results from cosmetic treatment, except:

  - For Injuries or Illness.
  - For repair of congenital defects of newborn children.
  - For repair of defects resulting from Medically Necessary surgery.
  - For the reconstruction of a breast following or coinciding with a mastectomy that is performed as a result of an Illness or Injury, including reconstruction of the breast on which a mastectomy was performed; one surgery on the other breast to produce symmetrical appearance following a mastectomy; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

- Any loss, expense or charge which results from appetite control or any treatment of obesity, including surgery and its complications, inpatient eating disorder programs, services and supplies connected with weight loss or weight control, even if the obesity is affected by psychological factors (except for anorexia nervosa and bulimia which are covered under the mental health benefit and except services covered under Preventive Care). This exclusion applies even if there is an Illness or Injury which may be helped by weight loss.

- Vitamins, minerals, herbs, over the counter food supplements, or prescription food supplements that are not the primary source of caloric intake, except as covered under the Prescription Drug Program.

- Routine foot care, including callus or corn paring or excision, toenail trimming, orthopedic shoes, or other support devices for the feet.

- Non-surgical treatment of the feet.

- Any expense or charge in connection with dental work or dental surgery, unless specifically provided, including:

    - Treatment involving any tooth structure, alveolar process, abscess, or disease of the periodontal or gingival tissue.
    - Surgery or splinting to adjust dental occlusion.

- Any expense or charge for treatment of craniomandibular or temporomandibular joint (TMJ) disorders, regardless of the origin of the condition that makes the procedure necessary, including any direct or indirect complications and after effects thereof, except as specifically provided under "Dental Care Benefits."

- Any loss, expense or charge for the promotion of fertility including (but not limited to):

    - Fertility tests, drugs, supplies or devices.
    - Reversal of surgical sterilization.
    - Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.

- Pregnancy related charges incurred when acting as a surrogate for another party, or by a person acting as a surrogate for a Covered Person. This exclusion includes services or supplies related to the surrogate mother becoming pregnant, pregnancy, delivery charges and Complications of Pregnancy. Additionally, a child of a surrogate mother will not be considered a Covered Dependent if the child is not the biological child, adopted child or child placed for adoption with a Covered Participant, or if the surrogate mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth and the child is not a Covered Dependent of a Covered Participant. Surrogate mother is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party or who is acting as a gestational carrier for a third party.

- Charges related to pregnancy and Complications of Pregnancy of a Covered Dependent child, except for routine prenatal services listed under the Women's Preventive Care Act.

- Non-prescription contraceptive supplies or devices.

- Any loss or charge for sex transformations except for medically necessary treatment of gender dysphoria.

- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning.

- Any expense or charge for services or supplies which are chiefly for instruction, education or training, except as specifically provided for diabetic self-management.

- Any expense or charge for services or supplies that are provided or paid for by the federal government or its agencies; except for

    - The Veterans Administration, when services are provided to a veteran for a disability that is not service connected.
    - A military Hospital or facility, when services are provided to a Retired Participant (or dependent of a Retired Participant) from the armed services.

- A group health plan established by a government for its own civilian employees and their dependents.

- Any loss, expense or charges that result from an act of declared or undeclared war or armed aggression.

- Any loss, expense, or charge:

  - Which is incurred while on active duty or training in the Armed forces, National Guard or Reserves of any state or county; and
  - For which any governmental body or its agencies are liable.

- Any Injury or Illness that results from or arises out of any past or present employment or occupation for compensation or profit, including Illness and Injury arising out of or occurring during the course of employment, even if the Covered Person fails to make timely application for or waives the right to those benefits. This includes benefits from occupational insurance purchased by an Employer, benefits provided under state or federal worker's compensation acts, employer liability laws, or other laws providing compensation for work-related Illness or Injury.

- Any expense or charge for Injuries or Illness caused by the act or omission of another person (known as a third-party) where there is a potential opportunity for recovery from the third-party, the third-party's insurer or any liability policy. Benefits may be advanced by the Plan pursuant to the "Third Party Recovery—Right to Reimbursement" provisions of this booklet.

- If a Covered Person is entitled to Medicare due to age, disability or as a result of End Stage Renal Disease (ESRD) and the Covered Person fails to enroll in Medicare when eligible, benefits are paid by the Plan as if the Covered Person is enrolled in Medicare. This limitation applies regardless of whether the Covered Person has coverage as an Active or Retired Participant, Dependent, COBRA beneficiary, or self-pays for coverage.

- Acupuncture, massage therapy, or naturopathic services, except as specifically provided in the "Alternative Care."

- Services, supplies and prescription drugs that are contrary to internal guidelines or medical protocols (including guidelines and protocols used for diagnosis, treatment, prescription or billing practices) that are utilized by the Utilization Review Coordinator, prescription drug program, or Board of Trustees in determining coverage for specific services, supplies and prescription drugs.

- Services provided by a person who normally resides with a Covered Person in his home or is part of his family.

- Charges for claims that are not submitted or completed (including submission of supporting documentation that has been requested) within one year from the date(s) of service.

- Charges for services or supplies that are limited or excluded under the specific benefit.

- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.

- Charges for services or supplies billed or charged in breach of or contrary to the Provider's PPO network agreement or in breach of or contrary to Provider guidance or policies established by the PPO network.

Defined Terms

The following are definitions of terms used in this Plan booklet:

Active Participant - any person, who principal residence is in the State of Alaska, on whose behalf an Employer is required, under a collective bargaining agreement, Associate Agreement, or by operation of law, to make contributions into the Trust. For purposes of determining whether an individual is eligible for a category of benefits, an Active Participant shall also include Participants, other than Retirees, who are maintaining coverage for the benefits by making self-payments. Whether a person's principal residence is in Alaska shall be determined by the Plan and may be based on a number of factors including the person's mailing address, where claims are incurred, where the person is working and whether the person is eligible for an Alaska Permanent Fund Dividend. All non-Alaska residents shall be enrolled in the Trust's Plan for Washington Participants.

Allowable Charge(s) –for Covered Services under Medical Benefits (other than outpatient dialysis), the Allowable Charge is as follows:

- For PPO Providers, the Allowable Charge is the rate negotiated by the PPO network; and

- For Non-PPO Providers (other than Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage), the Allowable Charge is the lesser of the Usual, Customary and Reasonable Charge and the actual charge.

- For Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage, the Allowable Charge is the rate of the designated preferred provider hospital or facility or if no rate is established, 50% of the billed charge. This applies to all inpatient admissions, outpatient surgery, diagnostic testing, imagery, rehabilitative and habilitative therapies performed at Non-PPO hospital facilities, surgical centers and outpatient therapy providers in Anchorage.

For Covered Services under Dental Care Benefits, the Allowable Charge is the lesser of the Usual, Customary and Reasonable Charge and the actual charge.

Approved Treatment Facility - an institution providing treatment for substance abuse and operating under the direction and control of the Washington State Department of Social and Health Services or the equivalent department of another state. If the facility does not operate under the direction and control of the Department, then it must provide effective treatment for chemical dependency through a contract with the Department, be included in the Department's current list of approved public and private treatment facilities, and meet all applicable government standards. The facility must also meet the following requirements:

- Have on-site licensed Providers 24 hours per day/7 days a week;
- Provide a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Approve all admissions by a Physician;
- Have access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation;
- Provide living arrangements that are consistent with developmental needs, including appropriate room and board;
- Offer group therapy sessions with at least an RN or Masters-Level Health Professional;
- Provide access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Manage all services by a licensed Provider who needs to (1) meet the appropriate credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed Physician;
- Have individualized active treatment plan directed toward the alleviation of the impairment that caused the admission; and
- Provide a level of skilled intervention consistent with patient risk.

Associate - a person who is not covered by a Collective Bargaining Agreement, but on whose behalf contributions are made to the Trust under an Associate Agreement.

Associate Agreement - a written agreement between an Employer and the Trustees under which the Employer makes contributions to the Trust to provide benefits for the Employer's employees who are not covered by a Collective Bargaining Agreement. The Trustees have discretion to establish the rules for participation of Associates.

Birthing Center - a facility licensed by the state and equipped and operated solely to provide prenatal care and perform uncomplicated, spontaneous deliveries and postpartum care. The facility must:

- Be directed by at least one Physician specializing in obstetrics or gynecology;
- Have a Physician or Nurse Midwife present during each birth;
- Provide skilled nursing in the delivery and recovery rooms under the direction of a registered nurse or Nurse Midwife;
- Have at least two birthing rooms or beds, diagnostic x-ray and lab equipment (or a contract to use that of an area medical facility), and Emergency equipment;
- Admit only patients with low-risk pregnancies (and contracts with an area Hospital for transfer of Emergency cases); and
- Regularly charge patients for services and supplies.

Board of Trustees or Trustees - the Board of Trustees of the Cement Masons and Plasterers Health and Welfare Plan and their successors. The Board of Trustees is the Plan administrator under ERISA.

Collective Bargaining Agreement - a written agreement between an Employer and a labor organization and any supplement, amendment, continuation, or renewal thereof, by the terms of which the Employer is obligated to make contributions to the Trust.

Complications of Pregnancy -

- Any condition resulting in Hospital confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy; or
- A non-elective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, Physician prescribed rest, morning sickness and similar conditions associated with a difficult pregnancy are not Complications of Pregnancy.

Cosmetic - services to improve change or restore physical appearance and/or self-esteem due to deformity or abnormality without materially correcting a functional or medical disorder.

Covered Dependent - a Participant's Dependent who satisfies the eligibility requirements.

Covered Participant - an Active Participant, Associate or Retired Participant who satisfies the eligibility requirements.

Covered Person - Covered Participants and Covered Dependents.

Covered Retiree or Retired Participant - a Participant who retired from active employment with an Employer, no longer qualifies for eligibility as an Active Participant and satisfies the eligibility requirements as a Retired Participant.

Covered Service(s) - a service or supply for which benefits are provided under the Plan.
Custodial Care - services or treatment which, regardless of where it is provided:

- Could be rendered safely by a person without medical skills; and

- Is designed mainly to help the patient with daily living activities, including (but not limited to):
  - Personal care such as help in walking and getting in and out of bed; help with bathing; help with eating, tube or gastrostomy; exercising; dressing; enema and using the toilet.
  - Homemaking such as preparing meals or special diets.
  - Moving the patient.
  - Acting as companion or sitter.
  - Supervising medication that can usually be self-administered.
  - Oral hygiene.
  - Ordinary skin and nail care.

Dental Injury - an Injury to Sound Natural Teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Dentist - a legally qualified Dentist, Physician, or denturist authorized by his license to perform at the time and place involved, the particular dental procedure rendered by him.

Dependent – a Dependent is defined under the section, "Eligibility Provisions – Dependents."

Dollar Bank Account - an account established by the Trustees in the name of each Active Participant consisting of Employer contributions and certain self-payments made to the Trust on behalf of the Active Participant, and from which contributions are deducted to provide eligibility on behalf of the Active Participant.

Elective Abortion - any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

Employer - an employer who is obligated to make contributions to the Trust under either a Collective Bargaining Agreement or Associate Agreement for the purpose of providing welfare benefits to Participants.

Experimental or Investigational – a drug, device or treatment will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan or its designee (based on the information and resources available at the time the treatment was performed or the drug or device was provided, or the drug, device or treatment was considered for preauthorization under the Plan's medical management programs), any of the following conditions were present with respect to one or more essential provisions of the drug, device or treatment:

- The drug, device or treatment cannot be lawfully marketed without the approval of the U. S. Food and Drug Administration and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug device or treatment is furnished; or

- The drug, device or treatment has been determined to be an experimental or investigational procedure by the treating facility's institutional review board, treating practitioner or other body serving a similar function, and the individual has signed an informed consent document acknowledging such experimental status; or

- Federal law classifies the drug, device, or treatment under an investigative program; or

- Reliable evidence shows the drug, device or treatment, or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For the purpose of this definition, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Notwithstanding the foregoing, routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a Covered Service for a Covered Person who is *not* enrolled in the clinical trial. An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Covered Person must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

- The actual clinical trial or the investigational team;

- Items and services solely for data collection that are not directly used in the clinical management of the patient; or

- Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan or its designee has the discretion and authority to determine if a drug, device or treatment is or should be classified as Experimental and/or Investigational. The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Home Health Care Agency - a public or private agency or organization that administers and provides home health care and is either: a Medicare certified Home Health Care Agency or certified as a Home Health Care Agency by the Washington State Department of Social and Health Services or the equivalent department of another state.

Home Health Care Plan - a written plan for continued care and treatment of a Covered Person who is under the care of a Physician, and whose Physician certifies that without the home health care, confinement in a Hospital or skilled nursing care facility would be needed. The Home Health Care Plan must be established within 14 days after home health care begins, and must be reviewed and certified by the Physician every 30 days.

Hospice Care Agency - a public or private agency or organization that administers and provides hospice care and is either: a Medicare-certified hospice agency or certified by the Washington State Department of Social and Health Services, or the equivalent department of another state, as a Hospice Care Agency.

Hospice Care Plan - a plan of continued care of a Terminally Ill Covered Person who is under the care of a Physician. A Physician must establish the Hospice Care Plan within 14 days after hospice care begins, and must be certified every 60 days.

Hospital - an institution that meets fully every one of the following tests:

- It is primarily engaged in providing facilities for the surgical and medical diagnosis, treatment, and care of injured and ill persons under the supervision of a staff of Physicians.

- It continually provides 24-hour registered graduate nursing service.

- It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics or a nursing home.

Illness - a disease, disorder, or condition that requires treatment by a Provider. For a female Covered Participant or Dependent spouse, Illness includes childbirth or pregnancy. It does not include Elective Abortion, but does include complications that are the result of an Elective Abortion. For a Dependent child, Illness does not include Normal Pregnancy or Normal Childbirth, but it does include Complications of Pregnancy.

Injury - an accidental bodily Injury that requires treatment by a Physician.

Medical Emergency or Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in a serious dysfunction of any organ or body part.

Medically Necessary - a procedure, service, or supply that meets the following criteria:

- It is essential and appropriate for the diagnosis and/or treatment of Illness or Injury.

- It is professionally and broadly accepted as the usual, customary and effective means of diagnosing or treating Illness or Injury.

- It is not primarily for the convenience of the patient or Provider.

- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

- A service or supply may be necessary in part only.

The fact that a procedure, service or supply may be furnished, prescribed, recommended, or approved by a Physician does not, of itself, make it Medically Necessary.

Non-PPO Provider – A Provider that is not part of the PPO's network.

Normal Pregnancy or Normal Childbirth - pregnancy or childbirth that is free of Complications of Pregnancy.

Nurse Midwife - a person who is either certified by the American College of Nurse Midwives, or is licensed as a midwife by the state where services are rendered.

Participant - except as otherwise indicated, means an Active Participant, Associate, or Retired Participant. When the context requires, a Participant shall also mean a former Participant.

Physician - a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed and acting within the scope of their license.

Provider - A Physician or other health caregiver who is licensed and acting within the scope of their license, such as a certified mental health counselor, a Master's level certified social worker, acupuncturist, massage therapist, physical therapist, ARNP, Physician's assistant, naturopath, dentist, optometrist, chiropractor, or

psychiatrist. A Provider does not include a person who lives with the Covered Person or is part of the Covered Person's family (spouse, child, brother, sister or parent).

Plan - the Cement Masons and Plasterers Health and Welfare Plan, as stated here and as amended from time to time.

Plan Administrator - the Board of Trustees.

Plan Year - the 12-month period ending March 31.

Preferred Provider Organization (PPO) - the organization(s) the Trust contracts with to provide the network of Preferred Hospitals, Physicians and other Providers and medical management including utilization review. The PPO is currently Aetna and Alaska Regional Medical Center, MatSu Regional Hospital, Surgery Center of Anchorage, New Frontier Anesthesia, Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy.

PPO Provider – a health care Provider that is part of the PPO network.

Sound Natural Teeth - teeth that are:

- Wholly or properly restored, and
- Without impairment or periodontal disease, and
- Not in need of the treatment provided for reasons other than Dental Injury.

Spinal Treatment - a detection or non-surgical correction (by manual or mechanical means) of a condition of the vertebral column, including distortion, misalignment, or subluxation, to relieve the effects of nerve interference which results from or related to such conditions of the vertebral column.

Terminal Illness or **Terminally Ill** - an Illness that a Physician has determined has no reasonable prospect of cure, and that the patient is expected to have less than six months to live.

Total Disability or Totally Disabled - for continuation of Medical Benefits means:

- The Covered Participant is completely and continuously unable to perform the material substantial duties of his regular occupation and is not engaging in any work for profit; and
- The Covered Dependent is unable to perform the normal activities of a person of the same age and sex.

Usual, Customary and Reasonable ("UCR") Charge – means the fees that fall within the customary range charged in a geographic area by most Providers with similar training and experience for performing a similar service or procedure. This provision recognizes there will be differences in charges because of factors such as geographic location, Provider skill and service complexity. For properly billed charges under Medical Benefits and Dental Care Benefits the UCR Charge will not exceed the 90th percentile identified by a national vendor. For properly billed charges under Vision Care Benefits the UCR Charge will not exceed the 95th percentile identified by a national vendor.

When there is, in the Plan's determination, minimal data available from the vendor for a Covered Service, the Plan will determine the UCR Charge by calculating the unit cost for the applicable service category using a national vendor database, and multiplying that by the relative value of the Covered Service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). The Plan will assign a relative value in the event

of a Covered Service that is unusually complex, is a new procedure or does not otherwise have a relative value that is in the Plan's determination applicable.

The UCR Charge is subject to the following:

- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR Charges regardless of the amount billed.

- In no event will the UCR Charge exceed the amount billed or the amount for which the Covered Person is responsible.

- The UCR Charge may not necessarily reflect the actual billed charge.

- The Plan's UCR Charge methodology may vary from one particular claim to the next based on the facts and circumstance of the claim, the services provided and the expected cost-savings.

- The Plan may utilize a third-party reviewer to determine the UCR Charge consistent with this provision.

- Regardless of the Plan's methodology or UCR Charge determination, the Trustees reserve the right to negotiate an acceptable UCR Charge directly with a Provider.

- The Trustees make the final determination as to whether or not the fee is a UCR Charge.

Utilization Review Coordinator – the entity designated by the Trustees to review services and supplies for Medical Necessity and to provide utilization management and case management services.

Coordination of Benefits

Benefits (including medical, vision, and dental benefits) contain non-duplication provisions which are included to coordinate benefits of this Plan with benefits of other plans which provide for payment of medical, dental, vision and hearing aid expenses. The intent is to provide that benefits from all plans will not exceed 100% of total Allowable Expenses.

An "Allowable Expense" is any covered charge of which at least a portion is covered under one of the plans covering an individual for whom a claim is made. However, the difference between the cost of a private room and the cost of a semiprivate room will be an Allowable Expense only when confinement in a private room is Medically Necessary. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

A "plan" for the purposes of Coordination of Benefits will mean a plan that provides medical, vision, dental and/or hearing aid expenses. The plan must be provided by Medicare, Group Insurance, or a Group Hospital or Health Care Service Contractor, or a Health Maintenance Organization Group Contract, or any other coverage arranged through any employer, trustee, union, employee benefit association, or any coverage sponsored by, or provided through, an educational institution. The word plan shall be construed separately with respect to each policy, agreement, or other arrangement that provides for the benefits or services.

The word plan shall not include benefits provided under a student accident policy, the first $200 per day of group hospital indemnity benefits, or benefits provided under a state medical assistance program where eligibility is based on financial need. In addition, a plan will not include individual insurance policies. A plan does not include insurance coverage mandated by state law.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the coordination provision.

When this Plan is the secondary plan and its payment is reduced to consider the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year - to the extent there are Allowable Expenses that would not otherwise be fully paid by this Plan and the other.

Order of Benefits Determination

This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

Rule 1: Non-Dependent or Dependent

1. The plan that covers a person other than as a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

2. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as a retired employee; then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

1. The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

   - the parents are married;

   - the parents are not separated (whether or not they ever have been married); or

   - a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

2. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

3. The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

4. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

5. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

   - The plan of the custodial parent pays first; and

   - The plan of the spouse of the custodial parent pays second; and

   - The plan of the non-custodial parent pays third; and

   - The plan of the spouse of the non-custodial parent pays last; and

   - If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

Rule 3: Active/Laid-Off or Retired Employee

1. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

1. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

1. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

2. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

3. The start of a new plan does not include a change:

    - In the amount or scope of a plan's benefits;

    - In the entity that pays, provides or administers the plan; or

    - From one type of plan to another (such as from a single employer plan to a multiple employer plan).

4. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan has no COB rules

If the other coverage has no COB rules, this Plan will always pay secondary.

Medicare

What is Medicare? Medicare includes:

- Part A (hospital insurance) which helps cover inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Generally, there is no cost for Medicare Part A. Retirees and Dependents should enroll in Medicare Part A when eligible, because the benefits of this Plan are provided as if actually enrolled in Medicare Part A.

- Part B (medical insurance) which helps cover Physician's services and outpatient hospital care. It may also cover some services that Medicare Part A does not cover. A monthly premium is generally required for Medicare Part B. A deductible is also required before Medicare starts to pay. Retirees and Dependents should enroll in Medicare Part B when eligible, because the benefits of this Plan are provided as if actually enrolled in Medicare Part B.

- Part C which is a Medicare Advantage Plan (like an HMO or PPO). Part C includes BOTH Part A (hospital insurance) and Part B (medical insurance) and in some instances, Part D (prescription drug coverage). A Retiree or Dependent who is enrolled in a Medicare Advantage Plan that includes prescription drug coverage is not eligible for the Plan's prescription drug benefits.

- Part D (prescription drug coverage) which helps cover prescription drugs. A monthly premium is generally required for Medicare Part D. A Retiree or Dependent who enrolls in Medicare Part D is not eligible for the Plan's prescription drug benefits, unless the Part D Plan is the AARP Medicare Preferred Rx Preferred Program, with supplemental coverage provided by Sav-RX under the Plan's self-funded Prescription Drug Program).

Medicare Enrollment. Individuals receiving benefits from Social Security or the Railroad Retirement Board should be automatically enrolled in Medicare the first day of the month they turn age 65. Individuals under age 65 and disabled should be automatically enrolled after receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). Individuals who do not want Medicare Part B must follow the instructions that come with the Medicare card**.**

However, if a Retiree or Dependent of a Retiree is eligible for Medicare Part B, benefits under this Plan are provided as if the Retiree or Dependent is enrolled in Medicare Part B, regardless of whether they actually enroll.

Individuals turning age 65 who are not receiving Social Security or Railroad Retirement benefits must apply for Medicare. Even if the Social Security age is older than age 65, eligibility for Medicare enrollment is still age 65.

There is an initial enrollment period for Medicare Part B, which begins three months before the month an individual turns age 65, and ends three months after the month an individual turns age 65. However, the starting date for Medicare Part B will be delayed for individuals who do not sign up before the month they turn age 65.

Individuals who do not sign up for Medicare Part B during the initial enrollment period may sign up during the general enrollment period which runs from January 1, through March 31 of each year. Medicare Part B will start on July 1 of the year of sign up. The cost of Medicare Part B generally increases for each 12-month period that an individual could have taken Medicare Part B, but did not.

There is a special enrollment period for those who waited to enroll in Medicare Part B because they or a spouse was working and had other group health plan coverage based upon that employment. The special enrollment period is anytime the individual is still covered in the group health plan, or during the eight months following the earlier of the month that group health plan ends or employment ends.

Individuals with end-stage renal disease should also enroll in Medicare. Different enrollment rules may apply. Contact Social Security for information.

In order to receive full Plan benefits, Retirees and Dependents of Retirees MUST enroll in Medicare Parts A and B when eligible for that coverage. Even if COBRA is elected in lieu of Retiree coverage, Retirees and Dependents are expected to enroll in Medicare when eligible. This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A or Part B if a Retiree or Dependent fails to enroll.

Covered Persons with End-Stage Renal Disease should also enroll in Medicare when eligible.

A Retiree or Dependent who enrolls in Medicare Part C coverage that includes prescription drug coverage is not eligible for the Plan's prescription drug benefits.

Coordination of Benefits with Medicare. If the total amount of benefits provided by the Plan together with the amount of like benefits a Covered Person or Dependent receives or is entitled to receive from Medicare exceeds the actual expenses incurred for such benefits, the benefits provided by the Plan will be reduced so that the combined benefits do not exceed the actual expenses for such benefits.

Like benefits refers to reimbursement for the cost of services and supplies for which benefits would otherwise be payable under the Plan.

Active Participants and their Dependent spouses will normally have benefits paid first by this Plan, then by Medicare. The law allows Active Employees and their Dependent spouses to choose Medicare as the primary coverage. However, if Medicare is elected as the primary coverage, benefits cannot be received from this Plan.

COBRA Beneficiaries with Medicare. If a Participant or Dependent is covered under COBRA and also entitled to Medicare based on age or disability and no longer has current employment status, Medicare will pay first and the Plan will only pay secondary and coordinate with Medicare.

Retirees and their Dependent spouses who are eligible for Medicare have benefits paid first by Medicare, then by the Plan. **The Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A or Part B even if a Retiree or Dependent fails to enroll.**

Retirees and their spouses who are eligible to enroll in Medicare and enter into a private contracting arrangement with a Provider, will have benefits for Covered Services paid as if they are enrolled in Medicare. This will result in substantial out-of-pocket expenses.

Coverage Under Medicare and This Plan for End-Stage Renal Disease. If, while actively employed, a Covered Person becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan generally pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Entitlement to Medicaid
Benefits will be provided under this Plan without taking into account entitlement to Medicaid benefits. Benefits will be made in accordance with any assignment of rights by or on an individual's behalf as required by a State Medicaid Plan. If benefits have been provided under a State Medicaid Plan, and the Plan has liability to make payment, benefits will be paid by the Plan in accordance with any applicable State law which provides that the State acquired the rights with respect to such payment.

Coordination with Tricare/Champus or Veterans Affairs Facility Services
Under federal law, Tricare/CHAMPUS is always the secondary plan. If a Covered Person is covered by both this Plan and Tricare/CHAMPUS, this Plan pays first and Tricare/CHAMPUS pays second.

If services are received in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by this Plan.

If services are received in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related Illness or Injury, benefits are payable by this Plan to the extent those services are Covered Services. If a Covered Person is also eligible for Medicare, benefits under this Plan are paid secondary to Medicare.

Motor Vehicle Accidents
Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payment insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.

The Plan will not pay benefits for health care costs to the extent that the Participant is able to, or is entitled to, recover from motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent a Covered Person has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The Plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the Plan's "Third-Party Recovery-Right to Reimbursement" provisions.

If the Plan pays benefits before motor vehicle insurance payments are made, the Plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the Covered Person and, when applicable, the Plan may recover benefits directly from the motor vehicle insurer or out of any settlement or judgment which the Covered Person obtains in accordance with the Plan's "Third-Party Recovery-Right to Reimbursement" provisions. The Plan may also recover benefits under the Plan's provisions for "Recovery of Overpayments."

Disputed Workers' Compensation Claims

The Plan does not provide benefits for any condition for which benefits of any nature are recovered, or are found to be recoverable through adjudication or settlement, under workers' compensation laws, occupational disease laws, or similar laws, even though the Covered Person fails to claim such right to benefits. If a dispute arises concerning whether an Injury or Illness is work-related, the Plan may advance payment of benefits pending resolution of the dispute, provided the Covered Person submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the Covered Person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the Covered Person. The Covered Person shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers' compensation claim, no further benefits will be provided related to the Injury or Illness.

Third Party Recovery-Right to Reimbursement

The Plan excludes medical, prescription drug, and dental for any Injury or Illness caused by the act or omission of another person (known as the third party), where a potential opportunity for recovery exists from the third party, including, but not limited to, an Injury or Illness potentially covered by a third party or coverage available under an automobile insurance policy (including coverage for underinsured or uninsured motorist), homeowners policy or commercial premises policy. If a Covered Person has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the Covered Person, may advance benefits pending the resolution of the claim. However, the Plan's payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery. By this agreement, the Plan will have an equitable lien in the Covered Person's recovery.

If the Plan provides benefits, the Plan is entitled to reimbursement of all benefits paid, regardless of whether the Covered Person is made whole by the recovery (the make whole doctrine is expressly rejected) and regardless of the characterization of the recovery, except that if the Covered Person complies with the terms of the Plan and any agreement to reimburse, the Plan will deduct a pro rata share of attorney fees (not to exceed the contingency fee percentage the Covered Person's agreed at the commencement of representation) and costs from the reimbursement amount.

Prior to advancing funds on the Covered Person's behalf, the Plan can require that a Covered Person and the Covered Person's attorney execute an agreement acknowledging this Plan's reimbursement right, including the obligation to hold an amount sufficient to satisfy the Plan's reimbursement amount in a trust account or escrow until the Plan's claims are resolved by mutual agreement or court order. Also, prior to advancing funds on the Covered Person's behalf, the Plan can require that the Covered Person provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved and a factual description of the accident and/or Injury or Illness and any other information requested by the Plan to secure its reimbursement interest.

When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into a trust account or escrow and held there until the Plan's claims are resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the Covered Person, or the individual who receives or distributes the recovery funds shall be liable for any loss the Plan suffers as a result.

The Plan may cease advancing benefits if there is a reasonable basis to determine that the Covered Person or the Covered Person's attorney will not honor the terms of the Plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable, or the Trustees modify this provision related to advancing benefits. The Plan may also deny coverage for expenses incurred after recovery on the third party claim, if such expenses are related to the third party recovery and known or reasonably expected at the time of settlement.

If the Plan is not reimbursed upon recovery on a third party claim, it may bring an action against the Covered Person to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits, including those of family members, or by recovery from the source to which benefits were paid. If the Plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

In any legal action under this provision, venue may be laid in King County Superior Court or in the United States District Court for the Western District of Washington at Seattle, at the option of the Trustees.

After recovery from a third party or insurer, the Plan is relieved from any obligation to pay further benefits for the Injury or Illness that were reasonably expected or identifiable at the time of recovery up to the amount of the balance of the recovery.

How to File a Claim

Time Period for Filing a Claim

An enrollment form, with all supporting documentation, must be on file at the Administration Office before claims will be processed. An enrollment form may be obtained on the Plan's website or by contacting the Administration Office. A claim will be denied if the enrollment form is not on file.

Claim forms should be submitted within 90 days after services are rendered or a period of disability commences, or as soon as reasonably possible. All claims, supporting documentation, and additional information that is requested to process the claims must be submitted within one year of the date services are rendered. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered Covered Services and are excluded from coverage.

Method of Funding Benefits

Medical, prescription drug, the Traditional Dental Care option, vision, and weekly disability benefits provided by the Plan are self-funded and paid through Trust assets. The Plan also maintains a stop-loss policy for medical benefits.

The life insurance, accidental death and dismemberment insurance and Dependent life insurance benefits are insured under a policy issued to the Trustees by an insurance carrier.

Neither the Board of Trustees nor any individual or entity has liability to provide payments over and beyond the amount in the Trust that has been collected and made available for such purpose. No Participant, Dependent or other beneficiary has any vested rights to benefits under this Plan.

How to File a Medical Claim

PPO Providers. PPO Providers bill Aetna directly. Aetna reprices the claim based on the network provider discounts and then forwards the repriced claim to the Administration Office. The Administration Office processes the claim and provides an Explanation of Benefits (EOB) to the Covered Person which describes what the plan paid, the network discount(s) and what is owed by the patient as part of the annual deductible, copayment, coinsurance, and noncovered expenses.

Non-PPO Providers. A Non-PPO Provider may submit claims on a Covered Person's behalf if the Provider has all of the needed information.

If a Non-PPO Provider does not submit a claim, a Covered Person may obtain a claim form from the Administration Office or the Plan's website. The instructions on the claim form must be followed when submitting a claim. A completed claim form, including the itemized bill(s), should be sent to:

Aetna Life Insurance Company
PO Box 981106
El Paso, TX 79998-1106

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Non-PPO Provider payments will be made, at the Trust's option, to the Covered Person, to the Covered Person's estate, to the Provider or as required under federal law, such as for a Qualified Medical Child Support Order. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Non-PPO Providers that claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Plan, notwithstanding any internal rules the Provider may have to the contrary. In the event a Non-

PPO Provider refuses or delays a reasonable audit request by the Plan, the Plan shall have the right to withhold payment on the claim in question and on other pending or future claims from the Non-PPO Provider.

Claims for Medicare eligible Retirees and Medicare Eligible dependent(s) of Retirees should be sent by providers who accept Medicare assignment electronically through Medicare Cross Over to payer ID 91136. Paper claims should be submitted along with a completed claim form, itemized billing and Explanation of Medicare Benefits to:

Cement Masons and Plasterers Health and Welfare Plan
P.O. Box 34964
Seattle WA 98124-1964

How to File a Prescription Drug Claim
Claims for prescription drugs purchased at a participating retail pharmacy will be filed electronically with Sav-Rx by the pharmacy. No claim form is required when using a Sav-Rx pharmacy.

Claims for prescription drugs that are not purchased at a Sav-Rx pharmacy must be filed with Sav-Rx by mailing to:

Sav-Rx Prescription Services
PO BOX 8
Fremont, NE 68026

Claim forms may be obtained from the Administration Office or online at www.cementmasonstrust.com.

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

How to File a Dental or Vision Claim
A dental or vision care Provider may submit claims on behalf of a Covered Person. If a Provider does not submit a claim, a Covered Person may obtain a claim form from the Administration Office or online at www.cementmasonstrust.com. The instructions on the claim form must be followed when submitting a claim. A completed claim form, including the itemized bill(s), should be sent to:

Cement Masons and Plasterers Health and Welfare Plan
P.O. Box 34964
Seattle, WA 98124-1964

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Provider payments will be made, at the Trust's option, to the Covered Person, to the Covered Person's estate, to the Provider or as required under federal law, such as for a qualified medical child support order. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Providers that claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Plan, notwithstanding any internal rules the Provider may have to the contrary. In the event a Provider refuses or delays a reasonable audit request by the Plan, the Plan shall have the right to withhold payment on the claim in question and on other pending or future claims from the Provider.

How to File a Weekly Disability Claim
Weekly disability claims must be filed at the Administration Office by the Participant. A claim form may be obtained from the Administration Office or online at www.cementmasonstrust.com. The instructions on the claim form must be followed when submitting a claim. A completed claim form, including any requested documentation, should be sent to:

Cement Masons and Plasterers Health and Welfare Plan
P.O. Box 34964
Seattle, WA 98124-1964

Claims should be submitted within 90 days from commencement of the disability. If a claim, or information that has been requested to process a claim, is received more than one year after commencement of the disability, the claim will be denied.

How to File a Life Insurance, Accidental Death and Dismemberment, or Dependent Life Insurance Claim
A properly completed claim form for life insurance, accidental death and dismemberment, or Dependent life insurance must be filed with LifeMap Assurance Company within 90 days after the date of loss. Failure to file the form within 90 days will not invalidate or reduce the claim if it is not reasonably possible to complete the claim form within that time period, provided the form is furnished as soon as reasonably possible. However, in no event, except in the absence of legal capacity, may the properly completed claim form and all required documentation be submitted later than one year from the time proof is otherwise required. Claim forms are available from the Administration Office, or online at www.cementmasonstrust.com, or by contacting LifeMap Assurance Company at:

LifeMap Assurance Company
P.O. Box 1271, MS E3A
Portland, Oregon 97207-1271
(800) 794-5390

Claim Procedures—Medical, Prescription Drug, Vision, Dental, Weekly Disability

What is a Claim
A claim for benefits is a request for benefits from the Plan made in accordance with the Plan's claim procedures.

What is NOT a Claim
A request for a determination regarding the Plan's coverage of a medical treatment or service that a Provider recommended is not a claim under these procedures if the treatment or service has not yet been provided and the treatment or service does not require prior authorization. In this circumstance, a determination may be requested from the Administration Office regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment, because such a request is not a claim as described in this section and therefore will not be subject to the requirements and timelines described in this section.

When presenting a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if a request for prescription benefits is denied at the pharmacy, in whole or in part, a claim and appeal may be filed regarding the denial by using these procedures.

Processing of Claims.
Claims that are properly filed will be processed in accordance with the following guidelines:

Post-Service Medical, Prescription Drug, Dental, and Vision Claims. A post-service claim is any properly filed claim for medical, prescription drug, dental, or vision benefits that is not a pre-service claim. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Pre-Service Claims. A pre-service claim is a properly filed medical claim which must be preauthorized to receive full benefits from the Plan. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

Pre-Service Urgent Care Medical Claims. Pre-service urgent care claims are claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the claimant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

This Plan does not require preauthorization of urgent care claims as established by the DOL. If a Covered Person needs medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

Further, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "pre-service claim." The Covered Person simply follows the Plan's procedures for filing the claim as a post-service claim.

Concurrent Claims. A "concurrent claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either: the Plan determines that the course of treatment should be reduced or terminated; or the Covered Person requests an extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures for filing a post-service claim.

Weekly Disability Claims. Claimants will be notified of a determination on a claim for weekly disability benefits within 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (to a total of 105) days.

If an extension is necessary due to the claimant's failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Notification of Claim Denial
If a claim is denied or partly denied, the claimant will be notified in writing and given an opportunity for review. The written denial will give:

- The specific reasons for the denial.

- Specific reference to pertinent Plan provisions on which the denial is based.

- 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.

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

- If the denial is based on medical necessity or experimental treatment or a 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, or a statement that such an explanation will be provided free of charge upon request.

- An explanation of the Plan's claim review procedure, including a statement of the claimant's right to external review and the right to bring a civil action under ERISA § 502(a).

Remedies Available If a Claim is Denied—Appeal Procedures

Internal Appeal Process to Board of Trustees

Notification of Appeal. Any Participant or beneficiary (hereafter "claimant") who applies for benefits and is ruled ineligible by the Trustees (or by the administrator acting for the Trustees), or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees, will have the right to appeal to and request review of the matter by the Board of Trustees, provided that he makes such a request, in writing, within 180 days after the Board's action or within 180 days after receipt of the notification or decision.

Requests for appeal should be sent to the Trust Administration Office at the following address:

Appeals Department
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

The appeal will be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees, which has been allocated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal. Except for claims involving pre-service and urgent care, the Trustees will review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within 30 days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination will be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan will notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

The Trustees will review a properly filed appeal of a pre-service claim within 30 days after receipt of the appeal.

Appeal Procedures. A claimant is generally entitled to present the claimant's position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal may be held telephonically by the Trustees. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

A claimant may be represented by an attorney or by any other representative of his choosing at his own expense.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision after Appeal Hearing. The Trustees will issue a written decision on review of a claim (other than a pre-service claim) as soon as possible, but not later than 5 business days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim will be made within 30 days after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- 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.
- A statement of the claimant's right to an external review and the right to bring a civil action under ERISA § 502(a).

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

Review of Trustees' Decision. A claimant who remains dissatisfied after exhausting the appeal procedures may: request external review by an Independent Review Organization (IRO) (provided the claim is a medical claim involving medical judgment or rescission of health coverage); or bring a civil action under ERISA § 502(a). A claimant must exhaust the Internal Appeals Process prior to bringing a civil action or requesting external review by an IRO.

External Review
External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage. There is no external review for dental, vision, weekly disability, life insurance, accidental death and dismemberment, or Dependent life insurance.

A request for external review must be filed with Plan within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Appeals Department
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Expedited External Review. A claimant may request an expedited external review if the claimant received an adverse decision on appeal to the Trustees which involved a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or the decision concerns an admission, availability of care,

continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from the facility.

Preliminary Review of External Review Request. Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization (IRO). If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review. If a claim satisfies the requirements for an expedited external review, the IRO will provide a response to the claimant within 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a).

Judicial Review
If a claimant remains dissatisfied after issuance of the Trustees' decision on appeal, or issuance of the IRO's decision, the claimant may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on appeal. A failure to file a civil action within the one-year period will operate as a waiver of and bar the right to further review, and the decision of the Trustees will be final and binding.

The question on review of the Trustees' determination will be whether the Trustees' decision was an abuse of their discretion.

Sole and Exclusive Procedures
The Plan's appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. A claimant must exhaust all remedies under the appeal procedures as a condition precedent to the commencement of a lawsuit.

Claim Procedures—Life, Accidental Death and Dismemberment, and Dependent Life Insurance
A properly completed claim for life, accidental death and dismemberment, and Dependent life insurance will generally be processed within 30 days after receipt. If a claim is denied, the claimant has the right to request review of the denial by LifeMap Assurance Company. A request for review of life and accidental death claims must be submitted within 60 days after receipt of the notification of the denial. A request for review of accidental dismemberment claims must be submitted within 180 days after receipt of notification of the denial. The request for review must be submitted in writing to LifeMap Assurance Company at the address listed in the Quick Reference Chart at the front of this booklet. The claimant may submit written comments or additional documents with the request for review.

Decision on Appeal
A decision on review of life and accidental death claims will be made by LifeMap within 60 days, or within 120 days if special circumstances require an extension. A decision on review of accidental dismemberment claims will be made within 45 days, or within 90 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to specific policy provisions.

A claimant may not commence a legal action until 60 days after the properly completed claim was given, or more than three years after the time the properly completed claim was required to be given.

In making benefit determinations, LifeMap has discretionary authority to determine: a person's eligibility for insurance; a person's entitlement for benefits; the amount of benefits payable; and the adequacy and amount of information LifeMap may reasonably require to make the above determinations. LifeMap also retains authority to construe the terms of the policy, including but not limited to, the authority to administer claims, interpret policy provisions, and render a decision in case of a request for review.

Important Information

Protection of Trust, Contributions, and Benefits
No part of the Trust (including the contributions) or the benefits payable under the Plan shall be subject in any manner by a Participant or Dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from a Covered Person to a PPO Provider that has treated or cared for, or provided services or goods to the Covered Person, and provided further that the Trustees shall recognize the assignment of benefits under a State Medicaid Plan, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order. No part of the Trust (including contributions, or the benefits payable under the Plan) shall be liable for the debts of a Participant or Dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against a Participant or Dependent or other beneficiary and any attempt shall be null and void.

In the event the Trust determines that an individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event an individual has not provided the Trust with an address at which he can be located for payment, the Trust may during the lifetime of the individual, pay any amount otherwise payable to the individual to the husband or wife or relative by blood or to any other person or institution determined by the Trust to be equitably entitled thereto; or in the case of the death of the individual before all amounts payable under the Plan have been paid, the Trust may pay any such amount to any person or institution determined by the Trust to be equitably entitled thereto. Any payment in accordance with this provision shall discharge the obligation of the Trust hereunder.

Availability of Trust Resources
Benefits provided by the Plan can be paid only to the extent that the Trust has available adequate resources for such payments. No Employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments, nothing in the Plan shall be construed as obligating any Employer to make payments in order to provide Plan benefits.

A portion of the benefits available under the Plan are paid directly from the assets of the Trust. There is no liability on the Trustees, individually or collectively, or upon any Employer, the Union, an employer association or other person or entity to provide benefits if the Trust does not have sufficient assets to make benefit payments due or to pay premiums.

Authority to Make Changes
In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend either the amount or conditions with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
- To alter or postpone the method or payment of any benefit; and
- To amend or rescind any other provisions of the Plan.

The benefits of this Plan are provided on a month-to-month basis to the extent that Employer contributions and self-payments continue to be sufficient for such purpose. There is no long-range funding or reserve program. The Trustees reserve the right to change the eligibility rules, reduce the benefits, increase the required self-payments, amend or eliminate Retiree coverages, or eliminate the Plan entirely, as may be required by future circumstances.

No Waiver of Claim Paid in Error—Recovery of Overpayments
In the event that through mistake or inadvertence or any other circumstance, a Covered Person or other individual has been paid or credited with more than the individual is entitled to under the Plan or under the law, the payment or credit will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Trust may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the Covered Person or other individual, or from the service Provider, or it may offset future benefit payments due to the Covered Person or the Covered Person's family members by the amount paid in error. The Trust may also take such further action as the Board shall determine.

Right to Receive and Release Necessary Information
As a condition to receiving benefits under this Plan, an individual agrees to:

- Authorize any Provider of services or other party having knowledge to disclose to the Plan any medical information it requests.

- Authorize the Plan to examine any medical records of the patient at the offices of any Provider of services for the purpose of verifying services or supplies.

- Authorize the Plan, in the exercise of its right to reimbursement, and individuals acting on behalf of the Plan to release any information about the patient's illness or injury and the benefits and medical services received by the patient to any individual who may be liable to the patient or to the Plan, and to such patient's insurer.

- Waive any claim of privilege or confidentiality that might be asserted in any action by or against the Plan or the party furnishing such information.

Misrepresentation
An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the Plan on account of such misrepresentation, as well as potential criminal liability.

HIPAA Privacy Disclosures and Certification

Protected Health Information

For purposes of this section, "Protected Health Information" ("PHI") shall have the same meaning as in 45 CFR 160.103.This section shall be administered in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Parts 160 and 164.

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following administration functions:

- To make or obtain payment for care received by Covered Persons.
- To facilitate treatment that involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Covered Persons.
- In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To advise Covered Persons of treatment options or alternatives.
- To provide information to Covered Persons on health-related benefits and services.
- To review claim appeals, solicit bids for services, or modify, amend or terminate the Plan.
- For authorized activities by health oversight agencies, including audits, civil, and administrative or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to a Covered Person's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Parts 160 and 164.

Trustee Certification

The Plan agrees that it will disclose Protected Health Information to the Board of Trustees only upon receipt of a certification that this Amendment has been adopted and the Board of Trustees, as Plan sponsor, agreed to abide by the following conditions:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or required by law.
- The Trustees will require each of their subcontractors or agents to whom they may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect the use and disclosure of PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any unrelated benefit or other employee benefit plan.
- The Trustees will report to the Plan and its Privacy Officer any known impermissible or improper use or disclosure of PHI not authorized by this Amendment of which it becomes aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI available to the Plan and to the Department of Health and Human Services ("DSHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees will, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests
The Trustees will use their best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Access to Protected Health Information by Participants
The Trustees will make PHI available to the Plan to permit Participants to inspect and copy their PHI contained in a designated record set.

Amendment of Protected Health Information
The Trustees will make a Participant's PHI available to the Plan to permit Participants to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate amendments provided by the Plan.

Accounting of Protected Health Information
The Trustees will make a Participant's Protected PHI available to permit the Plan to provide an accounting of disclosures.

Adequate Separation
The Trustees represent that adequate separation exists between the Plan and the Board of Trustees so that PHI will be used only for Plan administration purposes. Each Trustee certifies that no employees or other persons under their control will have access to a Participant's Protected PHI.

Effective Mechanism for Resolving Issues of Noncompliance
The Trustees certify that any individual or entity described who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Office at Welfare & Pension Administration Service, Inc., 7525 SE 24th Street, Suite 200, Mercer Island, Washington 98040.

Notice of Privacy Practices

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

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes PHI as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

Protected Health Information
PHI generally means information that: (1) is created or received by a Provider, health plan, employer, or health care clearing house; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information
Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment: The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or Providers, for the care you receive, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication of reimbursement of your health claims.

To Facilitate Treatment: The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

To Conduct Health Care Operations: The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants.

Health care operations include: making eligibility determinations; contacting Providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning-related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees: The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans.

Summary Health Information is information which summarizes Participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative: When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the "Right to Request Restrictions" section below.

Disclosure Where Required By Law: In addition, the Trust will disclose your health information where applicable law requires. This includes:

1. *In Connection With Judicial and Administrative Proceedings.* The Trust may disclose your health information to a health oversight agency for authorized activities (including audits; civil; administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which health information is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

2. *When Legally Required and For Law Enforcement Purposes.* The Trust will disclose your protected health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law.

   The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. *In the Event of a Serious Threat to Health or Safety.* The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

5. *For Specified Government Functions.* In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

6. *For Workers' Compensation.* The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

7. *To Business Associates.* The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

Authorization to Use or Disclose Health Information
Other than as stated above, the Trust will not disclose your health information without your written authorization.

Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Additionally, your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

Your Rights with Respect to Your Health Information
You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your Provider has been paid by you out-of-pocket and in full. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.

Right to Inspect and Copy Your Health Information: You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable,

associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Trust's labor costs in responding to the request.

Right to Receive Confidential Communications: You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information: If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting: You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for treatment, payment or health care operations; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, www.cementmasonstrust.com.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Contact Person
Assistant Manager – Employee Benefits - Claims
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official
Manager – Employee Benefits - Claims
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Toll Free: 800-331-6158
Fax No: 206-441-9110

Duties of the Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

Summary Plan Description

Name of Plan
This Plan is known as the Cement Masons and Plasterers Health and Welfare Plan.

Board of Trustees - Plan Administrator
The Plan is sponsored and administered by a joint labor-management Board of Trustees, with the assistance of a contract administrative agent. The name, address and telephone number for the Board of Trustees is:

Board of Trustees
Cement Masons and Plasterers Health and Welfare Plan
c/o Welfare & Pension Administration Service, Inc.
7525 SE 24th Street, Suite 200
Mercer Island, WA 98040

The name, address and telephone number of the contract administrative agent is:

Welfare & Pension Administration Service, Inc.
7525 SE 24th Street, Suite 200
Mercer Island, WA 98040

P.O. Box 34203
Seattle, Washington 98124-1203

(206) 441-7574
(800) 331-6158

Identification Number
The Employer Identification Number assigned to the Plan by the Internal Revenue Service is EIN 91-1106482. The Plan Number is 501.

Type of Plan
The Plan can be described as a welfare plan which provides medical, prescription drug, dental, vision, life and dependent life insurance, accidental death and dismemberment insurance, and weekly disability benefits.

Authority to Interpret and Change the Plan
The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for and entitlement to Plan benefits and to amend the Plan. Any construction or determination by the Trustees made in good faith which is not contrary to law is conclusive on all persons affected.

The Board of Trustees has delegated to its third-party administrator and other designated entities the authority to provide certain administrative services to the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions. In administering the Plan, the Administration Office and any medical review organization or other entity used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. The Administration Office does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Administration Office is subject to review by the Board of Trustees. No individual Trustee, Employer, employer association, labor organization, or any individual employed by an Employer or labor organization, has any authority to interpret or change the terms of the Plan.

The Trustees reserve the right to make any changes they deem necessary to promote efficiency, economy and better service for the Participants and their Covered Dependents. The Trustees have no obligation to furnish benefits beyond those that can be provided by the Trust Fund. The Plan, including Retiree benefits, is provided to the extent that money is currently available to pay the cost of such programs.

Legal Process
The Board of Trustees has designated its contract administrative agent, as the agent for purposes of accepting legal process on behalf of the Trust at the address indicated above. Legal process may also be served on any of the Trustees. The names and addresses of the individuals currently serving on the joint Board of Trustees are:

Employer Trustees	**Union Trustees**
Garrett Condel (Secretary) Sellen Construction 227 Westlake Ave. N. Seattle, WA 98109	Eric Coffelt (Chairman) Cement Masons Local 528 6362 6th Ave. S. Seattle, WA 98108
Andrew Ledbetter AGC of Washington 1200 Westlake Ave. N., Ste 301 Seattle, WA 98109	Edward Case 1817 Oakes Ave. Everett, WA 98201
Patrick McQueen Lease Crutcher Lewis 2200 Western Ave., Ste 500 Seattle, WA 98121	Frank Benish P.O. Box 103 Nine Mile Falls, WA 99026
John Salinas Salinas Construction, Inc. 7804 40th Ave. W. Mukilteo, WA 98275	Justin Palachuk Cement Masons Local 528 6362 6th Ave. S. Seattle, WA 98108
Larry White Applied Restoration, Inc. 617 Industry Dr. Tukwila, WA 98188	Thomas Parsons Cement Masons Local 528 6362 6th Ave. S. Seattle, WA 98108

Plan Year
The Plan is on an April 1 to March 31 fiscal year.

Description of Collective Bargaining Agreements
This Plan is maintained under numerous collective bargaining agreements. A copy of the pertinent agreements may be obtained by Participants and beneficiaries upon written request to the Board of Trustees. Such agreements are also available for examination by Participants and beneficiaries at the Administration Office, and at the local union offices, upon ten days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing an agreement. Participants and beneficiaries may wish to inquire as to the amount of the charge before requesting copies.

Upon written request, Participants and beneficiaries may receive from the Administration Office information as to whether a particular Employer or employee organization maintains this Plan, and, if so, the address of that Employer or employee organization.

Eligibility and Benefits
The eligibility rules which determine when Participants and beneficiaries are entitled to benefits are shown on pages 4-9 of this booklet.

Termination of Eligibility
The rules which determine when eligibility for benefits terminates are shown on pages 4-9.

Funding Medium
The Plan is funded through Employer contributions and Participant and dependent self-payments and interest. The amount and method of calculating the contributions is specified in the Collective Bargaining Agreements or Associate Agreements. The Board of Trustees holds contributions to the Plan in trust pending payment of benefits, insurance premiums, and administrative expenses. Medical, prescription drug, dental, vision, and weekly disability benefits are self-funded by the Plan. The Plan offers an insured dental option which may be selected instead of the self-funded dental benefits. The Plan also maintains stop-loss insurance to cover medical and prescription drug claims that exceed the insurance policy's attachment point. Life, dependent life, and accidental death and dismemberment benefits are insured by LifeMap Assurance Company.

Availability of Information
All pertinent documents required to be made available under ERISA are available for inspection at the Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Administration Office will state the charge for specific documents on request so that you can find out the cost before ordering.

This Program Is Not Guaranteed
The Board of Trustees is providing these programs of benefits, including Retiree benefits, to the extent monies are currently available to pay the cost of this program. The Board of Trustees reserves full and exclusive authority, in its discretion, to determine the extent to which monies are available for this program and to determine the expenditure of such monies for the program. The program is not guaranteed to continue indefinitely. The Board of Trustees reserves the right to terminate or modify the Plan. In the event of termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans until such monies and assets are exhausted.

Claims and Appeal Procedures
The Plan's claim and appeal procedures are described on pages 77-86 of this booklet.

Statement of Rights under Employee Retirement Income Security Act of 1974
As a Participant in the Cement Masons and Plasterers Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits
- Examine, without charge, at the Administration Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon request to the Administration Office, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Administration Office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administration Office is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself and dependents(s) if there is a loss of coverage under the Plan as result of a qualifying event. You or your dependent(s) may have to pay for such coverage. Refer to the "Continuation of Coverage by Self-Payment of COBRA" section of this booklet.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons 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 your interest and the interest of other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a 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 thirty (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 request a hearing before Trustees. You also have the right to be represented by an attorney or any other representative of your choosing. If you are dissatisfied with the Trustees' determination you may file suit in state or Federal court.

- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- 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 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. The Seattle regional office of the Employee Benefits Security Administration is located at 300 Fifth Avenue, Suite 1110, Seattle, WA 98104, telephone number 206-757-6781

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and

issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires group health plans to notify health plan members of their rights under this law.

What benefits does the law guarantee?

Under this law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain Reconstructive Surgery. This includes:

- Reconstruction of the breast on which a mastectomy has been performed.

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

- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The law also states that "the services will be considered in a manner determined in consultation with the attending Physician and the patient." In other words, you and your Physician will determine the most appropriate treatment for your individual situation.

Coverage of these services is subject to the terms and conditions of the Plan, including the Plan's annual deductibles and coinsurance provisions.

For more information regarding your benefits, visit the Trust website:

cementmasonstrust.com

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