

WASHINGTON, D.C. CEMENT MASONS WELFARE FUND

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500 or toll free (888) 490-8800

Dear Participant:

We are pleased to provide you with this updated Summary Plan Description so that you may become familiar with the benefits available to you and your family. Please read it and keep it handy.

The Washington, D.C. Cement Masons Welfare Fund is a self-insured, labor-management trust fund, established pursuant to the Taft-Hartley Act and the Employee Retirement Income Security Act ("ERISA"). The Board of Trustees, half of which is designated by Employer representatives and half by the Union, serves as the Plan Administrator. The Board, in turn, employs the services of a professional administrative firm to carry out the day-to-day functions of the Fund, pursuant to the Board's instructions. The administrative firm is Carday Associates, Inc.

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

In recent years, the cost of health care has risen by leaps and bounds. As a result, everyone must take an active part in controlling health care costs. If we work together to spend our benefit dollars wisely, we anticipate that the Fund will continue to prosper and provide important protection for years to come. In closing, we wish you good health and happiness in the coming months and years. However, if the need for coverage arises, we believe you will share with us the satisfaction of knowing you have the protection of the Fund.

Sincerely,

THE BOARD OF TRUSTEES

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SECTION 1

DEFINITION OF TERMS IN THIS BOOKLET

Collective Bargaining Agreement

The labor agreement(s) between the Cement Masons Local Union No. 891 and participating Employers, which provides for contributions to this Fund.

Contract Administrator

The person or firm retained by the Board of Trustees to administer the Plan on a day-to-day basis. Carday Associates, Inc. serves as the Contract Administrator.

Covered Person

The Participant or the Participant's eligible Dependents.

Dependent

For active Employees, Dependents are defined as:

- your spouse;
- your unmarried children, but for any child, status as a Dependent shall cease no later than December 31 of the year in which such child reaches the age of 18, provided coverage beyond such date is not allowed under another provision of this definition. (For purposes of this definition of Dependent, the term "children" and "child" shall include, in addition to your own unmarried children, such step-children, foster children, adopted children, children placed in your home in anticipation of adoption by you, and other children as are dependent on you for support and maintenance, and are living with you in a regular parent-child relationship and for whom you are entitled to an exemption for income tax purposes.);
- your unmarried children who are primarily dependent upon you for support and maintenance, are enrolled as a full-time student in an accredited school or college, and for whom you are entitled to an exemption for income tax purposes, provided such children have been reported to the Fund Office on a "Student Certification Form" available from the Fund Office, and further provided that for each any such child, status as a Dependent shall cease no later than December 31 of the year in which such child reaches the age of 23; and
- your unmarried children who become disabled prior to December 31 of the year in which any such child reached the age of 18, as long as they remain continuously disabled, unmarried, financially dependent upon you, unemployed, and you remain eligible, provided you submit to the Fund Office a "Disabled Dependent Certification Form" with supporting medical evidence to the Fund Office (the form must be resubmitted by you annually without request from the Fund Office).

The term Dependent does not include a previous spouse from whom you are divorced or a spouse from whom you are legally separated, nor any children who are no longer living with you and are being primarily supported by someone else.

For Retired Employees, your spouse is the only Dependent eligible to receive benefits from the Fund.

Effective Date

The Effective Date of this Summary Plan Description is May 1, 2002.

Employee

A person who: (1) is currently or was recently employed by an Employer; and, (2) has satisfied the Plan's eligibility rules for "Active Employee Medical Coverage" and is currently covered under the Plan.

Employer or Contributing Employer

An Employer who has agreed to make contributions to this Fund in accordance with the terms and conditions of the Collective Bargaining Agreement or other written agreement accepted by the Board of Trustees.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Fund

The Washington, D.C. Cement Masons Welfare Fund.

Hospital

A legally operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under the supervision of a staff of legally qualified Physicians, and with a twenty-four-hour-a-day nursing service, or a place accredited as a Hospital by the Joint Commission on Accreditation of Hospitals. The definition does not include nursing homes or nursing institutions or an institution for convalescence, rest, the aged, or care of drug addicts or alcoholics, or an institution which furnishes primarily domiciliary or custodial care, or an institution operated primarily as a school.

Illness

"Illness" means a medical disorder or sickness resulting in an unsound condition of the mind or body, and which causes a loss that begins while the benefits of the Covered Person are in force.

Incurred Date

The date on which a service or supply is furnished.

Injury

"Injury" means a wound or damage to the body that is sustained accidentally and by external force, which occurs directly and is independent of all other causes, and which causes a loss that begins while the benefits of the Covered Person are in force.

Medical Emergency

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

Participant

An Employee or a Retired Employee who has satisfied the Plan's eligibility rules and is covered for benefits provided by the Fund.

Physician

A duly licensed doctor of medicine (M.D.); a duly licensed doctor of Osteopathy (D.O.); a duly licensed dentist for the purpose of providing dental X-rays in cases of accidental Injury to the teeth; and, a duly licensed Podiatrist (Chiropodist) (DSC) for purposes of treating covered conditions of the feet.

Plan

The plan of benefits and eligibility rules maintained by Washington, D.C. Cement Masons Welfare Fund, and described in this booklet, as amended from time to time.

Retired Employee

A former Employee who has satisfied the Plan's eligibility rules for "Retired Employee Medical Coverage" and is currently covered under the Plan.

Room and Board

Room, board, general duty nursing, and any other services regularly furnished by a Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of a Physician nor intensive nursing by whatever named called.

Union or Local Union

Cement Masons Local Union No. 891.

Usual, Customary and Reasonable Charges or "UCR" Charges

Charges by a service provider which are reasonable and not higher than the usual and customary charges rendered by similar service providers in the geographic area of the Fund.

**SECTION 2
BASIC INFORMATION ABOUT THE PLAN**

- (a) The Plan name is the "Washington, D.C. Cement Masons Welfare Fund."
- (b) This Plan Administrator responsible for maintaining the Plan is the:

Board of Trustees
Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
- (c) The Contract Administrator responsible for the day-to-day administration of the Plan is Carday Associates, Inc.
- (d) The Fund/Plan office is located at:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (410) 872-9500 or toll free (888) 490-8800
- (e) Participants and Dependents may receive from the Fund Office, upon written request, information whether a particular Employer or employee organization is a sponsor of the Plan and, if the Employer or employee organization is a Plan sponsor, the sponsor's address.
- (f) The Fund's Employer Identification Number ("EIN") assigned by the Internal Revenue Service is: 52-6038505. The Plan number assigned by the Board of Trustees is: 501
- (g) This Plan generally provides coverage for hospitalization, Physician's care, disability income, other medical expenses and vision care.
- (h) The name and address of the persons designated as agents for the service of legal process are:

President
Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Service of legal process may also be made upon an individual Trustee of the Fund.
- (i) The name, title and address of the principal place of business of each Trustee of the Fund is as follows:

UNION TRUSTEES	EMPLOYER TRUSTEES
Keith D. Hickman Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Larry Moyer Associated Builders 4903 Baltimore Avenue Hyattsville, MD 20781
Carl Carson Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Joseph H. Smith, Project Manager Clark Construction Group, Inc. 7500 Old Georgetown Road Bethesda, MD 20814
Mary Davis 8300 Laura Lane District Heights, MD 20747	Dennis Carlisle Buch Construction 10945 Johns Hopkins Road Laurel, MD 20723
Steve Stovall Cement Masons Local 891 1517 Kenilworth Avenue, NE Washington, DC 20019	Charles "Chip" Fry John H. Hampshire, Inc. 320 W. 24 th Street Baltimore, MD 21211

- (j) The Plan is maintained pursuant to one or more Collective Bargaining Agreements and a copy of any such agreement may be obtained by Participants or Dependents by making a written request to the Plan Administrator.
- (k) Any Participant or Dependent who makes a request for copies of the Collective Bargaining Agreements, the trust agreement, the latest updated Summary Plan Description, the latest annual report or other instruments under which the Plan is established or operated shall pay the Plan's reasonable costs of furnishing these materials. Information about the cost of copies of the above described materials can be obtained by contacting the Fund Office. The above described materials are also available for examination by Participants and Dependents at all times at the Fund Office and, within ten (10) calendar days after written request to the Plan Administrator, at the principal office of the employee organization:

Cement Masons Local Union No. 891
1517 Kenilworth Avenue, NE
Washington, DC 20019

and at each Employer establishment at which at least 50 Participants covered under the Plan are customarily working.
- (l) The Plan's requirements regarding eligibility and benefits are set forth in the pages that follow.
- (m) The following circumstances may result in disqualification, ineligibility of denial, loss, forfeiture or suspension of benefits:

- (1) Failure to satisfy the Plan's eligibility rules -- for example, by reason of insufficient hours of work for which Employer contributions are made to the Fund;
 - (2) Failure to file necessary forms required in support of a claim;
 - (3) Failure to file claims within the time limit specified in the Plan;
 - (4) Filing false claims or false information in support of a claim;
 - (5) Failure of your Employer to make contributions to this Fund on your behalf;
 - (6) Failure of your Employer to comply with its responsibilities under the Fund's Agreement and Declaration of Trust;
 - (7) Failure to repay amounts you owe to the Fund.
- (n) The Fund is financed by contributions made by individual Employers under the provisions of Collective Bargaining Agreements or participation agreements, and by Retired Employees and their spouses. The Fund is also financed by income earned from the investment of contributions. All monies are used exclusively for the purpose of providing benefits to eligible Employees, Retired Employees and/or their Dependents, and the paying of expenses incurred with respect to the operation of the Plan. The assets of the Fund are held in trust by the Board of Trustees. All benefits are provided directly from Fund assets. The Fund has entered into contracts with Spectera for vision care benefits and with OneNet, MAPSI and the Health Care Cost Containment Corporation for pre-admission review, large case management and preferred provider organization ("PPO") services.
- (o) The Plan's annual year-end date is: October 31.
- (p) The Fund will honor Qualified Medical Child Support Orders ("QMCSOs") that satisfy the requirements of ERISA. Generally, a QMCSO is a medical child support order that creates or recognizes a child's right to receive benefits from the Fund and meets certain ERISA requirements. Whenever a child support order is issued by a court, it must be sent to the Fund Office, which will, in turn, determine whether the order is in fact "qualified" under ERISA. When you submit an order to the Fund Office, you will receive a copy of the Fund's procedures for determining whether the court order is qualified.
- (q) The Fund's ability to provide health and welfare benefits is dependent upon a number of factors that may vary from year to year or even month to month. Accordingly, the Trustees specifically reserve the right to change, eliminate, add to or delete from the schedule of benefits provided to Employees, Retired Employees and to their Dependents. The Trustees also reserve the right to terminate, suspend, amend or modify the Plan, in whole or in part at any time, and to adopt new Fund rules and regulations or to modify the existing rules and regulations. **Nothing in this book or elsewhere should be construed to mean the Fund's benefits are guaranteed.** Pursuant to the Fund's Trust Agreement, the Plan may be terminated, suspended, amended or modified by a majority vote of the Trustees. Any of the aforesaid changes in the Plan shall be reflected in the meeting minutes, Summary of Material Modifications or a writing retained in the Fund's file. The Trustees will notify Participants when they make significant changes in the rules, regulations or schedule of benefits.

- (r) Only the full Board of Trustees is authorized to interpret the rules, regulations and plan of benefits set forth herein. Its interpretation will be final and binding on all individuals dealing with or claiming a benefit from the Fund. No representative of any employer or the union has authority to speak on behalf of the Board of Trustees. If you have questions about your eligibility, or you want other information, contact the Contract Administrator. Matters that require interpretation will be referred to the Board of Trustees.

- (s) The Trustees of the Fund have the exclusive power to verify claims for the payment of benefits and to determine whether the conditions for the payment of benefits have been fulfilled. The Trustees also reserve the exclusive discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

SECTION 3 CLAIMS AND APPEALS PROCEDURE

Enrollment Cards

Each eligible Participant must complete and submit to the Fund Office an Enrollment Card, which may be obtained, from the Local Union Business Manager or the Fund Office. Claims cannot be processed until the Enrollment Card is filed with the Fund Office. If you wish to add a Dependent, you must furnish satisfactory documented proof of dependent status.

Notify Fund Office of Important Changes

After a Participant becomes eligible for benefits, he or she must notify the Fund Office of any of the following changes:

- (1) Changes in marital status (proof required);
- (2) Names and birth dates of newborn children (proof required);
- (3) Date that any Dependent child either:
 - (a) Marries, or
 - (b) Reaches his or her 19th birthday; and, or
 - (c) Otherwise loses status as a Dependent.
- (4) Change in address, or the address of your spouse, and/or your Dependent children.

To notify the Fund Office, complete and submit a new enrollment card.

Filing Claims

All Participants and Dependents requesting benefits under the Plan are required to file a written claim for benefits with the Contract Administrator at the Fund Office. The Board of Trustees shall make available prescribed forms for claims applications at the Fund Office and, when possible, at the Local Union office.

Steps to Take

- (1) Get your claim form from your Fund Office or your Local Union Office.
- (2) Have the claim form completed by the Hospital and/or Physician.
- (3) Attach all receipts and bills to the claim form.
- (4) Complete your side of the Attending Physician Statement Form that requires information from you. The form must be signed by the Participant.
- (5) Mail the claim form to the Fund Office as follows:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Filing the prescribed form of claim application shall be considered the normal manner of applying for benefits. However, any form of written claim for benefits filed with the Fund Office and reasonably calculated to notify the Fund Office of the claim and to provide all the necessary information required in order for the Fund Office to determine the eligibility of the applicant to receive benefits shall satisfy the requirements of filing a written claim.

Time Limit For Filing A Claim: One Year

In order for a claim to be considered, it must be received in the Fund Office within one year of the Incurred Date. Failure to make a claim within this one year period shall constitute an absolute waiver of the claim in question and shall be grounds for denial of the claim.

Processing of Claims

The Contract Administrator shall examine all written claims for benefits filed with the Fund Office. The Contract Administrator shall have the right to require submission of all necessary information in addition to that filed with the claim application. No benefit payments will be made under the Plan until an application or written claim is made therefore to the Fund Office and all additional information required by the Contract Administrator to substantiate the claim has been submitted.

A Participant or Dependent may file a claim under this procedure through an attorney or any other authorized representative acting on the Participant's or Dependent's behalf.

If your claim for benefits from the Plan is denied, in whole or in part, you will be notified within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Medical and Vision benefits - Urgent Claims (as medically determined) - Pre-Service Claims - Post-Service Claims - Concurrent Claims (claims for ongoing course of treatment)	72 hours 15 days 30 days Prior to termination of care (if sufficient notice)	None 15 days 15 days None
Weekly accident and sickness benefits	45 days	Two 30 day extensions

If the Contract Administrator needs more information to make a determination on your claim, you will be notified within a reasonable period of time. Extensions are permitted if the Contract Administrator determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Contract Administrator's notification of a claim denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Filing Appeals

Every Participant or Dependent whose application for benefits has been denied in whole or in part shall have the opportunity to appeal the denial to the Board of Trustees. An appeal may be perfected by the Participant or Dependent or through an attorney or any other duly authorized representative acting on the Participant's or Dependent's behalf.

In the event a Participant or Dependent desires to take advantage of the opportunity to appeal, he/she will be required to file a written request for review with the Board of Trustees at the Fund Office.

Time Limit For Filing An Appeal: 180 Days

The written request for review (i.e., the appeal) must be received by the Board of Trustees within 180 days of the Participant's or Dependent's receipt of the Fund Office notification of denial of claim. A request for review shall be considered received by the Board of Trustees at the time it is actually received by the Fund Office.

Failure to request in writing a review of the denial of a claim within the foregoing 180 days shall constitute a waiver of further review of the claim in question and a denial of the claim shall be binding and conclusive on all questions of fact or law, unless further consideration of the claim is permitted at the discretion of the Board of Trustees.

Board Of Trustees Review Of Appeal

The Board of Trustees shall consider all timely filed appeals from denials of claims. In his/her written request for review, a Participant or Dependent shall submit in writing every issue, comment, argument and all other evidence in support of the appeal. The Board may, in its discretion, conduct

an informal hearing on the appeal. The Board may, in its discretion, conduct an informal hearing on the appeal. In such hearings, the formal rules of evidence will not apply. If the Board decides to conduct a hearing, it will provide the Participant or Dependent with notice of the time and place of the hearing. Such notice will also inform the Participant or Dependent of the specific issues to be determined at the hearing and the matter on which findings will be made and a decision rendered. The Board of Trustees shall make its determination with respect to the appeal after examination of the evidence presented by the appealing Participant or Dependent. The decision of the Board shall be final and binding upon all parties.

The Board will determine your appeal within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Medical and vision benefits - Urgent Claims - Pre-Service Claims - Post-Service Claims - Concurrent Claims (claims for ongoing course of treatment)	72 hours 30 days Board meeting (if claim received 30 days prior) Prior to termination of care (if sufficient notice)	None None Next Board Mtg None
Weekly accident and sickness benefits	Board meeting (if claim received 30 days prior)	Next Board Mtg

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible but no later than five days after the determination is made.

If the denial of a claim for medical or vision benefits was based in whole or in part on a medical judgment, the Board will consult with a health care professional who was not consulted in connection with the denial that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment. In making the determination on appeal, the Board will not afford deference to the initial claim denial.

The Board will notify you in writing of the benefit determination on review. In the case of a denial, the notification will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- an internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- a statement of your right to sue under section 502(a) of ERISA.

Notices

Whenever notice is required to be made by these claims and appeals procedures, the notice shall be in writing and signed by the person sending the notice. The notice may be sent by first class mail or hand-delivered, at the option of the sender. Notices to a Participant or Dependent shall be sent to him or her at the last known address, as indicated by the files at the Fund Office.

Notice to the Fund shall be sent to the Fund Office at the following address:

Washington, D.C. Cement Masons Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Penalty for Falsifying Claims or Failing to Refund Overpayment

Any Participant or Dependent who through error, misrepresentation, or otherwise receives an incorrect payment from the Fund must make immediate repayment to the Fund. Failure to comply with the Fund's request for repayment within 30 days will result in imposition of the following penalties.

- (1) Interest will be added to the amount due at the rate of 10% per annum.
- (2) Future benefits payable on the Participant's and his/her Dependents' behalf will be held in and used to offset (i.e. make up) the amount due the Fund plus interest.

In addition, the Participant's and his/her Dependent's eligibility may be terminated by action of the Board of Trustees, and/or the Trustees may choose to file a lawsuit against the Participant and his/her Dependents to recover the money due. In such a case, the Fund will also be entitled to recover its reasonable attorney's fees and costs.

Falsifying a claim for benefits is a serious offense. The Fund may notify legal authorities if a Participant and/or Dependent files a false claim.

SECTION 4

HOW YOU CAN DO YOUR PART TO HELP MAINTAIN THE PLAN

The benefits for medical care described in this booklet have been designed to pay a substantial part of the Usual, Customary and Reasonable Charges for a broad range of necessary medical services, treatments and supplies.

Like any good tool, the Plan must be used properly if it is to endure. In that regard, Plan costs must remain reasonable. And, as you undoubtedly know, the costs of the Plan are governed, in large part, by the claims submitted by Participants and Dependents.

When arranging for Hospital, medical and related services, discuss the charges that your doctor, the Hospital, or others intend to assess. Generally, your doctor or Hospital will be pleased to discuss this matter with you. In fact, most medical societies encourage patients to talk over charges with their doctors in advance of treatment.

Satisfy yourself that the charges will not be more than you would pay if you were paying the entire amount out of your own pocket, nor more than that which is generally charged in your area for similar services. If you are in doubt as to the appropriateness of the charge, consult the Fund Office. ***Remember, charges which are in excess of the Usual, Customary and Reasonable Charges are excluded under the Plan and will be your responsibility.*** Also make sure only necessary services are ordered. In this way, you will be doing your part to help keep the Plan's benefits available for everyone, and at the same time, to hold your own out-of-pocket expenses to a minimum.

SECTION 5 ELIGIBILITY RULES

ELIGIBILITY RULES FOR ACTIVE EMPLOYEE MEDICAL COVERAGE

Initial Eligibility

A cement mason who works under a Collective Bargaining Agreement that: (1) requires an Employer to make contributions on his or her behalf to the Fund, and (2) has been accepted by the Board of Trustees, will become eligible for "Active Employee Medical Coverage" on the first day of the second calendar quarter following a period not to exceed four consecutive calendar quarters during which he or she worked at least 550 hours in no more than three out of the four calendar quarters in this period.

Let's look at some examples to see what this means. As you know, the calendar year has four (4) calendar quarters, like this:

- (1) January, February and March
- (2) April, May and June
- (3) July, August and September
- (4) October, November and December

Eligibility is computed as of the last day of each calendar quarter.

Example #1:

Let's say that you work at least 100 hours in each of the six months of January, February, March, April, May and June, which is two consecutive calendar quarters. You have worked a total of 600 hours in two consecutive quarters so that you become eligible on October 1 which is the first day of the second calendar quarter following a period not to exceed four consecutive calendar quarters during which you worked at least 550 hours in no more than three out of the four calendar quarters.

As you can see, to become eligible you must work a total of at least 550 hours in one, two or three out of four consecutive calendar quarters and then you must wait one calendar quarter before receiving your eligibility. Once you are eligible, you then remain eligible for a complete calendar quarter.

Now, let's look at one more example.

Example #2:

Suppose you work 200 hours in the quarter January, February and March, another 250 hours in the quarter April, May and June, and another 275 hours in the quarter October, November and December. That gives you 725 hours in three out of four consecutive quarters. After waiting the one quarter of January, February and March, you then become eligible on April 1 and you are eligible for April, May and June.

Please note that the Employer's contributions in your behalf must be received by the Fund Office before for your hours will count toward eligibility under the Plan.

Dependent Eligibility

The Dependents of Employees who satisfy the rules for eligibility are also covered for benefits. To determine who is a Dependent, see the Definitions section of this booklet.

Termination of Eligibility

Benefit eligibility for the Employee and his/her Dependents will terminate when the Employee fails to work at least 550 hours in no more than three (3) out of four (4) consecutive calendar quarters. Eligibility will terminate on the last day of the first calendar quarter following such period.

If an Employee dies while eligible, the eligibility of the Employee's Dependents will terminate on the date the Employee's eligibility would have terminated if the Employee had simply stopped working.

Reinstatement of Eligibility

If an Employee's eligibility terminates, and he or she thereafter returns to work in covered employment, eligibility can be reinstated by satisfying the provisions for initial eligibility.

TEMPORARY ELIGIBILITY CREDIT FOR EMPLOYEES OF A DELINQUENT EMPLOYER

If you are an Employee of a Delinquent Employer who is in jeopardy of losing your eligibility due to your Employer's non-payment of contributions, the Fund will provide you with credit for hours actually worked, up to a *maximum* of one quarter (three months), while the Fund pursues collection of the Employer's delinquency. The hours credited will be the oldest hours, in the event of a delinquency spanning several months.

In the event that the Delinquent Employer has also failed to submit the hours worked for its employees, it may be necessary for you to provide proof of your hours worked (pay stubs) in order to provide you with this temporary credit.

ELIGIBILITY RULES FOR NEWLY ORGANIZED GROUPS MEDICAL COVERAGE

If you are an Employee in a Newly Organized Group, you will become eligible for benefits on the first day of the month following the completion of at least 550 hours of contributions being reported to the Fund on your behalf, in the immediately preceding six months.

Initial Eligibility

If you are an Employee in a Newly Organized Group, you will become eligible for benefits on the first day of the month following the completion of at least 550 hours of work in Covered Employment in the immediately preceding six (6) calendar months for which the Fund receives contributions. The names of the new Employees covered under this provision must be received in the Fund Office prior to the first day of the first month of coverage.

Which Employees Qualify For These Special Rules?

The Welfare Fund has established special eligibility rules for “Employees in Newly Organized Groups”. Employees who qualify for these special rules are individuals who are not participants in the Plan and who currently have Employee-provided coverage. They may be current employees of a newly organized company that signs a collective bargaining agreement with the Local Union or newly organized employees represented by the Local Union who are then employed by an Employer already contributing to the Fund. The purpose of these special eligibility rules is to encourage the addition of new participants to the Plan. These special eligibility rules are not available for current employees represented by the Local Union.

To What Period Do These Special Rules Apply?

The summary describes the eligibility requirements and benefits that are applicable to Employees in Newly Organized Groups for a limited period before an Employee establishes eligibility under the regular Initial Eligibility rules of the Plan.

After an Employee in a Newly Organized Group, has maintained eligibility for one year, all of the rules and benefits of the Plan apply as described in this Supplemental and these special rules are no longer applicable. In addition, if an Employee in a Newly Organized Group loses eligibility under the special Continuing Eligibility Rules described in this Supplement, these special rules are no longer applicable. In this circumstance, the Employee can then become eligible for benefits only by meeting the regular Initial Eligibility rules of the Plan as described on page 14 of the Summary Plan Description.

ELIGIBILITY RULES FOR RETIRED EMPLOYEE MEDICAL COVERAGE

Initial Eligibility

A retired cement mason shall be eligible for Retired Employee benefits under the Fund if he or she:

- Elects Retired Employee Medical Coverage within 90 calendar days from the Retiree’s benefit commencement date (such election period shall end 90 days after such benefit commencement date);
- is not eligible for Medicare (e.g., is under the age of 65 and not disabled);
- is retired from active employment;
- met the requirements for retirement status under the Washington, D.C. Cement Masons Welfare Fund prior to 1970, or
- is a pensioner under the Washington, D.C. Cement Masons Pension Fund and was eligible for health benefits under this Fund for five (5) out of the seven (7) years immediately preceding the effective date of his pension benefit from the Washington, D.C. Cement Masons Pension Fund; and
- makes the monthly premium payment in advance to the Fund Office in an amount established from time to time by the Trustees.

Dependent Eligibility

Only the spouses of eligible Retired Employees qualify as Dependents under the "Retired Employee Medical Coverage" provisions of the Plan. Spouses are also required to make monthly premium payments in advance to the Fund Office, in an amount established from time-to-time by the Trustees.

Termination of Eligibility

A Retired Employee loses eligibility if he or she:

- becomes eligible for Medicare (i.e. reaches age 65 or becomes totally or permanently disabled); or,
- fails to make the monthly premium payment in advance to the Fund Office.

The spouse of a Retired Employee loses benefit eligibility by reason of:

- the spouse becomes eligible for Medicare (i.e. reaches age 65 or becomes totally and permanently disabled);
- divorce from the Retired Employee;
- legal separation from the Retired Employee;
- the spouse fails to make the monthly premium payment in advance to the Fund Office.

SECTION 6 CONTINUATION COVERAGE

If coverage (eligibility) under the Fund terminates at the result of a "qualifying event," Covered Persons may purchase a temporary extension of Fund coverage (called "continuation coverage") at a group rate that amounts to 102% of Plan costs. This continuation coverage is sometimes referred to as "COBRA" coverage."

"Qualifying Events" for Continuation Coverage

If you are an *Employee, Dependent spouse or Dependent child* covered by the Fund, you have a right to purchase this continuation coverage for a period up to 18 months, if you lose your coverage because of a reduction in the Employee's hours of employment or the termination of the Employee's employment (for reasons other than gross misconduct).

If you are the *Dependent spouse* of an Employee covered by the Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

- (1) the death of the Employee; or
- (2) divorce or legal separation from the Employee.

If you are a *Dependent child* of an Employee covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

- (1) the death of a parent;
- (2) parents' divorce or legal separation; or
- (3) the Dependent ceases to satisfy the definition of "Dependent" under the rules of the Plan.

If you are the *spouse of a Retired Employee* covered by this Fund, you have the right to purchase continuation coverage for a period up to 36 months, if you lose coverage under the Fund for any of the following reasons:

- (1) the death of the Retired Employee;
- (2) divorce or legal separation from the Retired Employee.

Under certain circumstances a *disabled Covered Person* may qualify for an additional eleven (11) months of continuation coverage if he or she receives a Social Security award showing that he or she was disabled at the time of the initial qualifying event consisting of a termination of employment or reduction in hours. The determination must be filed with the Fund Office within sixty (60) days of the date of the Social Security award and before the end of the date of the first 18 months of continuation coverage. The cost of the additional eleven (11) months of continuation coverage will increase to 150% of Plan costs.

Your Reporting Responsibilities

The Employee or Retired Employee or his or her family members have the initial responsibility to inform the Board of Trustees of a divorce, legal separation, a child losing Dependent status under the Fund or the death of the Retired Employee. The Employee's contributing Employer has the initial responsibility to notify the Board of Trustees of the Employee's death, termination of employment, or reduction in hours.

When the Board of Trustees is notified that one of these events has happened, the Board of Trustees will in turn notify Covered Persons that they have the right to purchase continuation coverage. Covered Persons must inform the Board of Trustees that they want to purchase continuation coverage within sixty (60) days from the date they would lose coverage because of one of the events described above.

The time periods for continuation coverage include all months during which coverage continued after the "qualifying event" occurred, even if the Covered Persons were not required to self-pay for the coverage during those months. For example, if an Employee terminated employment on March 31, but his coverage under the Fund continued until June 30, he or she would be able to purchase fifteen (15) months of continuation coverage (through September of the next year) under these rules. This is a total of eighteen (18) months of continuation coverage.

The premiums for continuation coverage are subject to modification by the Board of Trustees from time to time. Contact the Fund Office for information about continuation coverage premiums. If a Covered Person does not purchase continuation coverage, regular coverage under the Fund will end.

Ways In Which Continuation Coverage May Be Cut Short

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

- (1) the Employee's or Retired Employee's Employer no longer contributes to the Fund for purposes of providing group health coverage to its Employees;
- (2) the Covered Person does not pay the premium for continuation coverage on time;
- (3) the Covered Person becomes covered under another group health plan, whether as an Employee or otherwise, provided that the other group health plan does not contain an exclusion with respect to any pre-existing condition that applies to the Covered Person;
- (4) the Covered Person becomes entitled to benefits under Medicare;
- (5) in the case of eleven (11) month extensions due to certain disabilities, a final determination that the Covered Person is no longer disabled.

A Covered Person does not have to show that he or she is insurable to choose continuation coverage. However, under the law, he or she will have to pay all of the premium for continuation coverage.

Please note that if a Covered Person has changed marital status or addresses, please notify the Board of Trustees immediately.

**SECTION 7
SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEE MEDICAL COVERAGE**

Weekly Accident & Sickness Benefit:	<i>Employee Only</i>
Benefit Paid by Plan	\$200 per week
Maximum Payment Schedule	26 weeks per disability
Comprehensive Major Medical Benefits:	<i>Employee & Dependent</i>
Percentage of Covered Expenses Paid by Plan	90%
Percentage of Covered Expenses Paid by Employee/Dependent	10%
Individual Deductible	\$0
Family Deductible	\$0
Maximum Benefit Paid by Plan (Per Individual)	\$50,000/year
Local Ambulance Allowance Paid by Plan	\$25
Dental Benefit	<i>Employee & Dependent</i>
Percentage of Covered Expenses Paid by Plan	100%
Maximum Benefit Paid by Plan in Calendar Year (Per Family)	\$1,000
Prescription Drug Benefit Program:	<i>Employee & Dependents</i>
Prescription Drug Co-payments (Retail and Mail Order):	
• Generic Drugs	\$5
• Brand Name Drugs	\$10
• Non-Formulary Drugs	\$15
Maximum Benefit Paid by Plan in Calendar Year (Per Family)	\$2,500

**SECTION 7
SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEE COVERAGE
(CONTINUED)**

Prepaid Vision Care Program:

IN-NETWORK BENEFITS

Employee & Dependent

Eye Examination (once every 12 months)	100%
Lenses (once every 12 months <i>only if needed</i>)	100%
Frames (once every 12 months <i>only if needed</i>)	100%
Single Vision Lenses (clear: glass or plastic)	No Charge
Bifocal Lenses (clear: glass or plastic)	No Charge
Multifocal Lenses	No Charge
Contact Lenses (<i>in lieu of lenses and frames</i>)	12 pairs

OUT-OF-NETWORK BENEFITS

Type of Service (Out-of-Network)

Exam (once every 12 months)

Optometrist	\$40.00
Ophthalmologist	\$40.00

Lenses (once every 12 monthly *only if needed*)

Single Vision	\$40.00
Bifocal	\$60.00
Trifocal	\$80.00
Lenticular	\$80.00

Frames (once every 12 months *only if needed*) \$45.00

Contact Lenses (*in lieu of lenses and frames*)

Medically Necessary	\$210.00
Elective	\$105.00

See description in Section 10 of this booklet for details.

SECTION 8
SCHEDULE OF BENEFITS FOR RETIRED EMPLOYEE MEDICAL COVERAGE

(For Retired Employees and their Spouses)

Benefits are based on the Schedule of Benefits provided to Active Employees, except:

1. No prepaid vision care benefits
2. No weekly accident & sickness benefits
3. If the retired Participant or spouse is eligible for Medicare (either by age or disability) the Fund will not provide any benefits.
4. A monthly per person premium payment is required.

SECTION 9 DESCRIPTION OF PLAN BENEFITS

WEEKLY ACCIDENT AND SICKNESS BENEFITS

(Active Employees Only)

General

A weekly indemnity is payable to an Employee while disabled and prevented from working as a result of a non-occupational accident or an Injury or Illness for which benefits are not payable under a Workers' Compensation Law.

It is not necessary for an Employee to be confined to home to collect benefits but he or she must be under the care of a licensed Physician and may not engage in any other work for remuneration or profit during the period of disability.

Once an Employee has begun to receive these benefits, he or she will be required from time to time to have a doctor complete a supplemental form indicating whether or not the Employee is still disabled. This form will be sent to the Employee from the Fund Office and is to be returned to the Fund Office within two weeks.

Period of Coverage

The \$200 weekly benefit to which an Employee is entitled will commence on the first day of disability resulting from an accident or if hospitalized, or on the eighth day of disability if the disability did not result from an accident or did not require hospitalization, and will be payable as long as the disability lasts up to the maximum number of weeks specified in the Schedule of Benefits.

Payment will be made for as many separate and distinct periods of disability as may occur, not to exceed payment for the maximum number of weeks as specified in the Schedule of Benefits. No payments will be made if you are receiving a pension or Social Security disability payments. If a disability ends during a work week, accident and sickness benefits shall be paid at the rate of \$40 per day of disability during that work week with a maximum payment of \$200.

Successive Periods of Disability

Unrelated Causes: If an Employee returns to work following an absence for which weekly accident and sickness benefits have been paid and again becomes disabled, both periods of absence will be considered as one disability unless the subsequent disability is due to an injury or illness entirely unrelated to the cause(s) of the previous disability and commences after the employee returns to full active employment with an Employer.

The Same or Related Causes: In the event of a subsequent disability for the same or a related cause, the Employee must have recovered completely and completed at least two weeks of full time active employment with an Employer after the first disability in order for the second absence to be considered a second disability for which weekly accident and sickness benefits are payable. In this instance, the Employee's Physician must confirm that the Employee recovered completely and returned to work with the Physician's permission.

In all cases, the Trustees, in their discretion, may request that the Employee who is claiming entitlement to benefits be examined by a Physician selected by the Trustees.

MEDICAL BENEFITS

Preferred Provider Organization (PPO)

The Trustees have retained the services of the "OneNet" and "MAPSI" Preferred Provider Organizations (PPO) -- groups of Physicians, specialists, and Hospitals, which have agreed to provide their services to Fund Participants at discounted rates. The OneNet PPO can be used for medical problems or emergency medical problems. The MAPSI PPO is a special network designated to provide services for the treatment of mental and nervous disorders.

It is not mandatory to use either PPO group. However, by using the PPO, there is considerable savings to both you and the Fund. Remember, under this Plan, you are responsible for paying 10% of the charges after the deductible. The higher the charges, the more you have to pay.

The OneNet and MAPSI PPO Directory lists the participating Physicians and Hospitals. It is a guide to assist you in identifying providers and is organized by specialty and geographical location. Please contact the Fund Office for a copy of the Directory.

As you might expect, the list of health care providers participating in the PPO does change, periodically. The list in the Directory is as complete as our procedures allow at the time of issue. However, because of the possibility that some listed providers may no longer participate in the PPO, you must check with your provider each time you request health care services. This will ensure that your provider is still participating so that you and the Fund will be afforded the appropriate discounts.

Pre-Admission Hospital Review Requirements

When a Covered Person needs to be hospitalized, the Plan will cover many of the Hospital charges. However, all Covered Persons must follow these pre-admission review procedures to help insure that the charges for the Hospital stay are necessary and appropriate:

- (1) At least 7 to 10 days before a scheduled Hospital stay, you or your doctor must call OneNet (the Fund's Pre-Admission Review and PPO provider) at 1-800-962-0643. (If the Hospital admission is an emergency, the call must be made within 48 hours of your admission).
- (2) The doctors and nurses at OneNet will discuss the proposed length of stay with your doctor. They will either approve it or recommend an alternative, such as outpatient treatment. You and your doctor will receive confirmation of the decision.
- (3) OneNet will monitor the Hospital stay and, if necessary, approve additional days for benefit coverage.
- (4) As the Pre-Admission Review provider, OneNet acts as an advisor to the Fund for the purpose of recommending the number of Hospital days that the Fund should pay for under your Schedule of Benefits.

Medical Case Management

If a Hospital confinement is expected to be unusually long and costly, a "case manager" at OneNet may be assigned to help determine the most appropriate and cost effective way to provide the necessary care. For example, instead of remaining in the Hospital, the patient might be referred to receive convalescent care at home, with visits from a nurse. The Fund will cover its share of the charges for such alternative care recommended by the case manager.

The case manager will work with your doctor to develop a treatment plan and make the necessary arrangements. He or she will continue to monitor the case until specialized treatment is no longer necessary.

Description of Covered Medical Expense Benefits

As shown on the Schedule of Benefits, the Fund provides coverage pursuant to a "comprehensive major medical plan," whereby covered medical charges are paid 90% by the Fund and 10% by you. This coverage is designed to reimburse you, to a large extent, for expenses incurred as a result of non-occupational Injuries or Illnesses. The Fund has a maximum payment obligation of \$50,000 per year per covered individual.

The amount of the maximum medical benefit available for all covered expenses is shown on the Schedule of Benefits. This maximum applies separately to each Participant and Dependent per year. When the maximum medical expense benefit has become payable to a Participant or Dependent, medical expense benefits for that year will terminate. Termination of an individual's medical expense benefits by reason of payment of the maximum benefit will not require termination for other eligible family members.

Covered medical expenses under this part of the Plan are the charges you are required to pay for the following services and supplies, less the 10% co-payment charge:

- (a) Hospital and Surgical Expenses -- including Room and Board and any other charges which are made by the Hospital as a condition of occupancy on a regular or weekly basis. However, if a private Hospital room is used, any excess of daily Room and Board charges over the Hospital's average, semi-private room charge will not be counted as a covered medical expense. The Definitions section of this booklet contains the definition of a "Hospital."
- (b) Other Medical Expenses, Services and Supplies including:
 - (1) The services of a legally qualified Physician.
 - (2) The services of a registered, graduate nurse (R.N. -- other than a nurse who ordinarily resides in your home or who is a member of you or your spouse's family).
 - (3) Drugs and medicines attainable only upon a prescription of a Physician, unless listed under the exclusions set out in Section 11 of this booklet.
 - (4) Diagnostic laboratory and x-ray examinations.
 - (5) X-ray, radium and radioactive isotope therapy.

- (6) Anesthetics and oxygen, including administration.
- (7) Rental of an iron lung and other durable, medical or surgical equipment.
- (8) Artificial limbs, larynx and artificial eyes, but not hearing aids, eye examinations or eyeglasses (except as provided under the vision care program).
- (9) Local ambulance service when used to transport the individual from the place where he is injured by an accident or stricken by a illness to the first Hospital where treatment is given -- up to a maximum payment of \$25.00. However, no other charges in connection with ambulance travel are included.
- (10) Hospital and medical expenses incurred in connection with dental work or oral surgery when performed to repair damage to natural teeth or other bodily tissues resulting from a non-occupational, accidental Injury occurring while the individual is eligible, provided the services are received within twelve (12) months of the accident.
- (11) Cosmetic surgery is covered only when necessary for the prompt repair of a non-occupational, accidental Injury occurring while the individual is eligible. No other expenses for cosmetic surgery are covered.
- (12) Casts, splints, trusses, leg braces and crutches.
- (13) Electronic heart pacemaker.
- (14) For excess expenses which are for treatment of a mental or nervous disorder while not confined in a hospital as an inpatient, the plan pays 50% of allowable expenses up to a maximum payment of \$50,000.
- (15) In vitro fertilization benefits are available, to eligible Participants and spouses (but not to other Dependents) if the following guidelines for outpatient and out-of-hospital expenses are followed:
 - (a) The patient's eggs are fertilized with the sperm of the patient's spouse;
 - (b) The patient and the patient's spouse have a history of infertility of at least five (5) years duration or the infertility is associated with one or more of the following medical conditions:
 - i. endometriosis;
 - ii. exposure in utero to diethylstilbestrol (DES); or
 - iii. blockage of, or surgical removal of, one or both fallopian tubes.

- (c) The patient has been unable to attain a successful pregnancy through any less costly, applicable infertility treatments for which coverage is available under the Plan.
 - (d) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society's minimal standards for programs of in vitro fertilization.
- (16) Benefits are provided for Diabetes Self Management Education Programs offered through local hospitals to assist with helping you learn the skills and knowledge that can lead to better diabetes control. Benefits are limited to \$350 per lifetime. Please carefully read and follow the instructions provided below:

How to use the program

- Contact a local hospital to determine if they offer diabetes-self management education programs.
- Your local hospital that provides the program can bill the Fund for the program fee when diabetes education is ordered by a physician.
- A physician referral is required. You will be required to bring this to the first class or ask your doctor to fax it to the facility prior to attending the class.
- Prior to attending the class, your doctor should fax the result of your latest Hemoglobin A1C and blood cholesterol levels to the facility.

If you have not had these drawn, please request them from your physician as soon as possible.

- Please complete all necessary forms and have ready for your first class.

- (17) Preventive medical care is provided as followed:

- (a) Physical Exam - Coverage for one physical exam per year and related diagnostic testing for the member and dependent, ages 2 and over, at 90% of the Usual, Customary and Reasonable charge.
- (b) Mammograms - Coverage for mammogram for members and dependents at the following ages, frequency and coverage levels:

<u>Age</u>	<u>Frequency</u>	<u>Coverage Level</u>
25 to 39	One Exam	100% up to \$100
40 to 49	One every 2 years	100% up to \$100
50+	Once a year	100% up to \$100

- (c) Pap Smears - For women over age 18, coverage will be provided for one pap smear test per year, at 100% up to \$100.
- (d) Well Baby Care - Six (6) well-baby routine visits during the first 24 months of life. These six visits will be covered at 90% of the Usual, Customary and Reasonable charge.

Be sure to check the Exclusions and Limitations Section of this booklet (Section 11) before you seek any medical treatment.

Women’s Health and Cancer Rights Act

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

Newborns’ and Mothers’ Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth or the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For more information on precertification, contact the Plan Administrator, Carday Associates, Inc.

Medicare Benefits For Actively Working Employees

The Fund serves as the primary payor of benefits for *actively working* Employees and their spouses, age 65 and over. Medicare coverage, if available, will be secondary. This means your benefits will first be paid under this Fund. If there are any medical expenses not paid by the Fund, Medicare may reimburse you if those expenses are covered by Medicare. In order to obtain reimbursement from Medicare, you must enroll for Medicare. Also, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium. Enrollment periods for Medicare coverage are during the month of your birthday, or during the three months before and after the month of your birthday. Contact your local Social Security Administrative Office for information about enrollment procedures. Employees and their spouses are urged to enroll with Medicare so this coverage is available when needed.

SECTION 10 PRESCRIPTION DRUG BENEFIT PROGRAM

You and your eligible Dependents will be covered by the Fund's Prescription Drug Benefit Program. The Program is administered by Caremark.

When your doctor prescribes drugs and medicines, present your Identification Card and the prescription to a participating pharmacy, and you will receive your prescription for a \$5.00 co-pay for generic drugs, a \$10.00 co-pay for brand name formulary drugs, and a \$15.00 co-pay for brand name non-formulary drugs. You are generally limited to a 30-day supply of any prescription drug under this Program. The maximum benefit payable under the Prescription Drug Benefit Program is \$2,500 per family, per calendar year.

Mail order service is mandatory for maintenance drugs. Maintenance drugs will be dispensed in supplies of up to 90 days through the mail order program. Co-pays of \$5.00, \$10.00 and \$15.00 will also apply to mail order service. **There is a considerable savings to both you and the Fund when you use the mail order service; you only pay one co-pay for a 90-day supply.** Also, there is the added convenience of home delivery.

The Prescription Drug Benefit Program provides payment for covered prescription drug charges. This benefit is payable in excess of a deductible (or co-pay) per prescription of \$5.00 for generic drugs, \$10.00 for brand name formulary drugs, and \$15.00 for brand name non-formulary drugs.

Prescription benefits will be processed through Caremark. Caremark will issue an Identification Card with no effective date or termination date. This Identification Card will only be accepted by those pharmacies that are able to check member eligibility via computer while the Participant is in the store. If there is a change in your eligibility status, that change will be communicated directly to the pharmacy via the computer.

If you or your Dependent has a prescription filled or refilled at a pharmacy that participates with Caremark, the Plan pays for the total cost of the prescription or refill (minus the deductible or co-pay).

All of the major chain stores and most of the independent stores have on-line pharmacies. This means that they have a direct computer link with the eligibility files maintained by Caremark. You should ask the pharmacist before purchasing the prescription, whether the pharmacy is on-line with Caremark. If you require direct reimbursement, contact the Fund Office for a Caremark Prescription Drug Claim Form.

When your doctor prescribes drugs and medicines, present your Identification Card and the prescription to a participating pharmacy and you will receive your prescription for a \$5.00 co-pay for generic drugs, \$10.00 for brand name formulary drugs and \$15.00 for brand name non-formulary drugs.

Some important features and limits of the Prescription Drug Benefit Program are:

Participating Pharmacy

You must obtain your prescriptions from a pharmacy that participates in the Prescription Drug Benefit Program through Caremark and pay the appropriate co-pay. The Fund will pay the balance of the cost for FDA-approved medications prescribed by a licensed Physician. This means that the

Federal Drug Administration (FDA) has approved the drug as safe and effective treatment for certain illnesses or conditions.

Co-Pays

Your co-pay will be \$5.00, \$10.00 or \$15.00 depending on whether you choose to obtain a **generic (\$5.00 co-pay), brand name (\$10.00 co-pay) or non-formulary (\$15.00 co-pay)** prescription. A **generic** drug is one that is chemically similar to the brand name drug and becomes available once the patent for the brand name drug has expired. It is typically less expensive. A **brand name** drug is a drug protected by a patent and other companies cannot manufacture the drug until the patent expires (unless they obtain permission from the patent holder). A **non-formulary** or **non-preferred** drug is one that is found to be either inferior in curing a particular illness or condition or less cost effective than the **formulary** or **preferred** drug.

Preferred Drug Formulary

When you get a prescription for a brand name medication that does not have a generic equivalent and that medication appears on the list of prescription drugs or formulary developed by Caremark, the Fund will be entitled to a rebate from those companies that manufacture those drugs. This rebate will be used to offset the costs to the Fund for the prescription drug program. Your co-payment for **brand name drugs** that appear on the formulary list will be \$10.00. If you obtain a brand name drug that *is not* on the formulary (**non-formulary**) your co-payment will be \$15.00.

Non-Participating Pharmacy

You must fill your prescription at a pharmacy that participates in the Prescription Drug Benefit Program. If you obtain a prescription at a non-participating pharmacy, the Fund will not reimburse you for any portion of the cost of the prescription.

Calendar Year Maximum

The Fund will limit its total Prescription Drug Benefit to \$2,500 per calendar year maximum per family, whichever comes first. For example, a three person family may have one member who uses \$1,000 of the benefit while the others use \$1,500 which, when combined, will exhaust the \$2,500 benefit for the calendar year. **Once the \$2,500 calendar year maximum is reached by you or your Dependents, no further prescription benefits will be paid by the Fund for the remainder of the calendar year.**

Covered Prescription Drug Expenses

Benefits are payable for any *medically necessary* FDA-approved generic drug, or any brand name drug, provided it required compounding (mixing of two or more compounds - one or more being a prescription item - examples are eye drops, ointments, and creams) or is a legend-type drug. A legend-type drug is one that requires a prescription in order to be dispensed. Medication that you buy "over-the-counter" such as aspirin or antacids are *not* legend-type drugs and are not covered under the Prescription Drug Benefit Program. *Medically necessary* means that the drug must be prescribed in order to treat an illness, disease or condition.

Limitations on Quantity

The maximum amount of prescription drugs in accordance with the direction of the prescriber that will be considered as eligible charges cannot exceed a 30-day supply, except maintenance drugs ordered through the mail order program. A maintenance drug is a medication needed for the control or treatment of a chronic illness or condition over an extended period of time. Contact Caremark at 866-282-8503 to determine if your prescription is defined as a maintenance drug.

Mail Order Service

You have the option of having your prescription filled through a special mail order program. Contact Caremark at the phone number noted above, or contact the Fund Office for mail order forms.

Charges That Are Not Covered

Prescription Drug Benefits are not paid for:

- Non-legend, patient or proprietary medicine or medication not requiring a prescription;
- Canes, crutches, wheelchairs or any other similar medical aid;
- Braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items;
- Abdominal supports, trusses, hypodermic syringes and/or needles (except for diabetes), oxygen;
- Vitamins, minerals, dietary supplements, cosmetics, health or beauty aids;
- Medication which is to be taken or administered, in whole or in part, to the individual while a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital nursing home or similar institution;
- Any delivery charges for any drugs or medicines or any charges for administering any drugs or medicines to the eligible individual by the prescriber;
- Any charges payable under any of the other Benefits of the Plan to the extent of the portion of such charges so paid. (Please note the items listed under the Major Medical portion of the Plan).
- Any drug that does not bear the label, "Caution, Federal Law Prohibits Dispensing Without a Prescription";
- Any drug labeled "Caution-Limited by Federal Law to Investigational Use" or experimental drugs whether or not a charge is made to the patient;
- Drugs or medicines that are available to you or your Dependent under a Workers' Compensation Law, occupational disease law, or similar legislation;
- A refill that exceeds the number of refills specified by your Physician;
- Any prescription in excess of \$1,000 without prior authorization;
- Refills that are filled more than one year after the original prescription;
- Prescriptions that exceed a 30-day supply filled at a pharmacy or 90-day supply through mail order service;
- Drugs that are dispensed from a Physician's office or from a location other than an outpatient pharmacy or a licensed pharmacy.

SECTION 11 PREPAID VISION CARE PROGRAM

(Active Employees and Dependents Only)

General Information

The purpose of the Prepaid Vision Care Program ("Program") is to provide Employees and their Dependents with general vision care services, so as to maintain visual efficiency, prevent the development of conditions that might result in serious loss of sight and maintain each Employee's ability to see safely on and off the job.

Vision care benefits are provided through the Spectera Vision Care Plan.

How to Use the Program

Before you use the Program, if you would like to identify a network provider, call Spectera's Provider Locator Service at 1-800-839-3242 and follow the voice prompts as indicated.

Prior to using your benefits at a network provider, please call the provider and make an appointment. Inform the provider that you are a Spectera participant. This system will allow you to find providers in your area prior to using the Spectera Vision Care Plan.

Plan Services Generally

Spectera has established a provider network that has agreed to accept reduced fees for the service and materials provided. If you choose to buy more expensive materials than those provided under the Plan (such as fashion frames, self-tinting lenses, blended lenses, contact lenses, etc.) you will be responsible for paying the excess of the cost of the materials you have selected over the Plan allowances.

IN-NETWORK BENEFITS

When using a Spectera network provider, enrolled participants and eligible dependents are eligible for the following:

Frequency of Services

Vision Examination -- Every twelve (12) months
Lenses -- Every 12 months, *only if needed*
Frames -- Every 12 months, *only if needed*
Contact Lenses – Every 12 months (*in place of lenses and frames*)

Benefits

Vision Care Benefits for covered services are shown in the Schedule of Benefits for Active Employees and Dependents on page 21 and as follows:

Type of Service (In-Network)

Fund Pays

Eye Examination (once every 12 months)	100%
Lenses (once every 12 months <i>only if needed</i>)	100%
Frames (once every 12 months <i>only if needed</i>).....	100%
Single Vision Lenses (clear: glass or plastic).....	No charge

Bifocal Lenses (clear: glass or plastic).....	No charge
Multifocal Lenses	No charge
Contact Lenses (<i>in lieu of lenses and frames</i>).....	12 pairs

OUT-OF-NETWORK BENEFITS

If you choose to obtain vision services from a non-participating provider, the Fund will pay up to the following for the services noted below:

Type of Service (Out-of-Network) Fund Pays Up To

Exam (once every 12 months)

Optometrist	\$40.00
Ophthalmologist.....	\$40.00

Lenses (once every 12 months *only if needed*)

Single Vision	\$40.00
Bifocal	\$60.00
Trifocal	\$80.00
Lenticular	\$80.00

Frames (once every 12 months *only if needed*) \$45.00

Contact Lenses (*in lieu of lenses and frames*)

Medically Necessary	\$210.00
Elective	\$105.00

If you choose a non-network provider, you will need to send your itemized receipts, with the Plan Participant’s Social Security Number and the Patient’s date of birth to:

Spectera
 2811 Lord Baltimore Drive
 Baltimore, MD 21244-2644
Attention: Claims Department

Extra Charges (In-Network and Out-of-Network)

You will be responsible for the additional cost over and above the allowed amount for:

- Progressive lenses
- Scratch(es)
- U.V. treated, Polaroid or Anti-Reflective Coatings

Vision Care Benefit Exclusions

Services and materials listed below are not covered under the Prepaid Vision Care Program. The following, if desired, must be paid for by the patient directly to the participating optometrist.

- (a) Examinations, lenses, frames or contacts obtained more frequently than as stated previously;

- (b) Non-prescription glasses or sunglasses, or the fitting thereof;
- (c) Examinations required by an employer in connection with the occupation of a Covered Person;
- (d) Surgical or medical care of eye disease or injury, other than a vision examination;
- (e) Visual training, orthoptics, aniseikonia or reading rate and comprehension studies;
- (f) Replacement of lenses or frames lost, or stolen, if benefits have already been provided during the time limitations shown previously;
- (g) Expenses incurred prior to your date of eligibility or after termination of your eligibility;
- (h) Services or supplies for which benefits are provided under any other provision of the benefit plan;
- (i) Services covered under a Workers' Compensation Law or plan;
- (j) Expenses for which benefits are not payable under the Plan;
- (k) Medical or surgical treatment of the eyes - these procedures are already covered under the Plan's existing medical benefits.

SECTION 12 DENTAL BENEFITS

General

You may visit the dentist of your choice, and a claim form must be completed in all instances in order to receive benefits. The annual deductible is not applied to this benefit.

Benefits

The Fund will pay 100% of the dentist's charges, up to a \$1,000 combined maximum, per family, per calendar year.

SECTION 13 GENERAL PLAN EXCLUSIONS AND LIMITATIONS

No benefits are available under this Plan for the charges listed below, and the amount of any such charges will be deducted from the Covered Person's expenses before the benefits of this Plan are determined.

- (1) Charges that would not have been made if no eligibility existed or charges that a Covered Person is not required to pay.
- (2) Charges for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government.
- (3) Charges for services or supplies which are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
- (4) Charges for services or supplies received as a result of an act of war occurring while covered.
- (5) Charges for services and supplies which are not medically necessary for treatment of the Injury or Illness or are not recommended and approved by the attending Physician.
- (6) Charges incurred in connection with an occupational Injury or Illness, including (a) Injury arising out of, or in the course of, any employment for wage or profit or (b) Illness covered, with respect to such employment, by any Workers' Compensation Law, occupational Illness law or similar legislation.
- (7) Charges for treatment of alcoholism or substance abuse.
- (8) Charge in excess of the Usual, Customary and Reasonable Charge.
- (9) Charges for Physician's services in connection with eye refractions or hearing problems or any other examinations to determine the need for, or the proper adjustment of eye glasses or hearing aids; except as provided pursuant to the Prepaid Vision Care Program.
- (10) Charges for the fitting or cost of hearing aids;
- (11) Charges for X-Ray examinations made without film.
- (12) Charges for treatment of periodontal or periapical Illness or any condition involving teeth, surrounding tissue or structure, except as described above for dental treatment due to accident.
- (13) Charges for dental work, dental x-rays and/or treatment, except as described above for dental treatment due to accident;
- (14) Charges for treatment of: (a) weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and, (b) corns, calluses or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating metabolic or peripheral-vascular Illness.

- (15) Charges for nursing, speech therapy, or physiotherapy rendered by yourself, spouse, or a child, brother, sister or parent of yourself or spouse.
- (16) Charges incurred as the result of self-inflicted injuries;
- (17) Charges incurred for services in connection with the pregnancy, child birth, miscarriage, abortion or related event incurred by a Dependent other than a spouse;
- (18) Charges by a hospital or a physician that does not satisfy the definition of hospital or physician in this booklet;
- (19) Charges made by a nursing home or any institution or part of one, used principally as a facility for convalescence, nursing, rest or for the aged;
- (20) Charges for transportation or travel other than local use of ambulance service;
- (21) Charges for doctors' services in connection with mental illness or functional nervous disorders will be covered at 90% of the Usual, Customary and Reasonable charge and up to fifty (50) visits per calendar year.
- (22) Charges for cosmetic surgery or treatment, except when necessitated by an accidental bodily Injury;
- (23) Charges for vision care services, except as provided in this booklet;
- (24) Charges incurred in connection with treatment of voluntary surgically induced infertility;
- (25) Charges incurred in connection with transsexual operations or any care or services associated with this type of operation;
- (26) Charges for medical services or supplies used primarily for dietary control;
- (27) The purchase or rental of air conditioners, humidifiers, dehumidifiers, vaporizers or similar devices;
- (28) Charges for services or supplies which are experimental or investigational, including:
 - Any treatment, drug or supply which is not recognized as acceptable medical practice in the United States;
 - Any items requiring governmental approval which was not granted at the time the services were rendered;
 - Any service or supply that is available only upon approval of an Institutional Review Board (as required by federal statute, including ones that require completion of an Informed Consent For Experimentation on Human Subjects) as required by federal regulations;
 - Any treatment that involves drugs which are not approved by the FDA, including dosages, combinations and uses that are not approved;

- Any new drug or device for which investigational application has been filed with the FDA;
 - Any treatment that is available only through participation in FDA Phase I or II Clinical Trials, or through FDA Phase III Experimental or Research Clinical Trials sponsored by the National Cancer Institute; and/or
 - Any service or supply that has protocols or consent documents describing it as an alternative to more conventional therapies.
- (29) Charges for vitamins, minerals, dietary supplements, dietary drugs, medications which can be legally purchased over-the-counter without a prescription (even if prescribed by a Physician), medications whose primary purpose is cosmetic in nature, nicorette and other anti-smoking drugs or devices, fertility medications, serums or vaccines, and medications to promote hair growth.

SECTION 14 OTHER PLAN RULES AND REGULATIONS

Coordination of Benefits

The purpose of the "coordination of benefits" rules is to permit Covered Persons to receive benefits from one or more group plans, but in no event, to receive more than 100% of covered incurred expenses.

Since most of the insurance industry has some form of "coordination of benefits" if this Plan did not include such a provision it would always be considered the "primary" plan, and therefore, would always pay benefits first. If such were the case, other plans would experience great savings at the expense of this Plan.

For purposes of this Plan's coordination of benefits rule, an "allowable expense" is any necessary, Usual, Customary and Reasonable Charge covered, at least in part, by one of the plans. "Plans" mean medical or welfare benefit coverage provided: (a) under a governmental plan established specifically for the government's own civilian employees and their dependents, or (b) under a group insurance policy or group plan or other coverage for a group of individuals, including student coverage obtained through an educational institution.

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

- (1) A plan covering a person as an employee will pay benefits first. A plan covering a person as a dependent will pay second.
- (2) If a dependent child is covered by both parents' plans, the benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined as primary. The benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined as secondary.

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

- (3) When the parents are divorced or separated the order is:
 - (a) The plan of the parent with custody pays first. The plan of the parent without custody pays second.
 - (b) If the parent with custody has remarried, the order is:
 - (1) the plan of the parent with custody,
 - (ii) the plan of the step-parent,

(iii) the plan of the parent without custody.

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

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

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

If this Fund is secondary under the above-stated rules, this Fund will pay the amount it would have paid if it had been primary, minus whatever the primary plan paid.

Third Party Recovery (Subrogation, Reimbursement and Offset)

This Fund has subrogation, reimbursement and offset rules that apply when a Covered Person is injured or becomes ill and someone else is potentially responsible for the Injury or Illness. Under such a circumstance, the Fund will advance the payment of benefits to cover the Covered Person's qualified claims, however, the Fund will retain a right to subrogation, reimbursement, and/or offset with respect to any such payment as further described below.

The Fund's subrogation, reimbursement, and offset rights are three distinct rights. The Fund may elect to pursue one or more of the rights in a particular matter. Moreover, the Fund's failure to pursue a given right does not constitute a waiver by the Fund with respect to any other right, nor shall such failure diminish or otherwise alter the extent of the Fund's remaining rights. For example, if the Fund chooses not to assert its subrogation interests in a particular case, the Fund will still have the right to full reimbursement and/or offset as further described below.

The subrogation, reimbursement, and offset rules are in place to assist Covered Persons B by paying qualified claims while they proceed against the responsible third party. The rules also prevent a situation where a Covered Person is compensated twice for the same Injury or Illness B once by the Fund when it pays the medical bills and a second time by the third party when it pays damages for the loss. The bottom line is that the rules help to ensure that assets are available for all of the Fund's Participant's and beneficiaries.

The Fund's rights of subrogation, reimbursement, and offset arise and will be exercised when any benefits are paid by the Fund to or on behalf of the Covered Person due to a loss, injury or illness for which another person or entity is or may be legally responsible. This would include, but is not limited to, a loss, injury or illness compensable under Social Security, the workers' compensation system, and/or due to medical malpractice, negligence, tortuous and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's payment of benefits in this context, the Covered Person is subject to the Fund's rights of subrogation reimbursement and offset, as follows:

- The Covered Person must sign and return the Fund's subrogation and reimbursement agreement as well as any other paperwork deemed necessary by

the Fund or its agents to protect the Fund's subrogation, reimbursement, and/or offset interests. Benefits will not be paid unless the Fund Office receives a copy of all required documentation, including the subrogation and reimbursement agreement, signed by the Covered Person or, in the case of incapacitation, the Covered Person's authorized guardian. Notwithstanding anything to the contrary in the immediately preceding sentence, the Fund's rights to subrogation, reimbursement, and/or offset apply regardless of whether the required documentation, including the subrogation and reimbursement agreement, is actually signed by the Covered Person and received by the Fund Office. Thus, the payment of benefits by the Fund on behalf of a Covered Person absent the receipt of the required documentation, including the signed subrogation and reimbursement agreement, by the Fund Office does not constitute a waiver of the Fund's subrogation, reimbursement, and/or offset rights with respect to such payment.

- The Covered Person will do nothing to impair or negate the Fund's right of subrogation and will fully cooperate with the Fund. To this end, no settlement shall be made with or release given to a third party for claims arising out of the Covered Person's loss, injury or illness for which benefits have been paid under the Fund without prior written consent of the Fund. If the Covered Person performs any act or fails to act, or otherwise compromises the Fund's right, the Fund may immediately seek recovery of all benefit amounts paid by any available means, including legal action.
- The Fund shall be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Fund. The Fund shall receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the Covered Person, payment of attorneys' fees and/or expenses. The Fund's right in first priority to full reimbursement shall not be subject to reduction for reasons including but not limited to the Covered Person's failure to recover the perceived full or actual value of his claim for whatever reason, attorneys' fees, expenses or other costs, and/or the Fund's failure to actively participate in the claim and/or recovery. **Further, the Fund expressly rejects and otherwise prohibits application of the "make-whole" and "common fund" doctrines or any similar doctrines or common law rules with respect to its subrogation, reimbursement, and offset rights.**
- The Fund shall be fully reimbursed from and/or granted a lien in any recovery that occurs or is available from any source, including but not limited to the person or entity that is or may, be responsible for such loss, injury or illness, the insurer of such person or entity, the Covered Person's insurer including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance, Social Security, the workers' compensation system, or any other source. Such recovery includes but is not limited to court judgments, administrative or agency orders, private settlements, or any other payments.
- This repayment obligation applies to any recovery from a third party, regardless of whether the recovery is characterized as compensation for pain and suffering or something else.

- By way of example, if the Fund pays out \$15,000 in medical claims on your behalf and you later recover \$25,000 from a third party, you must reimburse the Fund for the \$15,000 of medical benefits paid on your behalf.
- If a Covered Person recovers money, but refuses to repay the Fund, future health and welfare benefits will not be paid on the Covered Person's behalf until such time as the Fund offsets the full amount due to be reimbursed under these rules plus 10% per annum. These offset benefits shall be permanently forfeited by the Covered Person and the Covered Person shall be legally responsible to any provider for any unpaid claims.

The Fund may also choose to bring legal action against a Covered Person to collect monies due under these subrogation rules. If the Fund prevails, a Covered Person must also pay interest at the rate of 10% per annum and the Fund's reasonable attorney's fees.

Selection of Service Providers

Use of the services of any Hospital, clinic, Physician or other provider rendering health care is the voluntary act of the Participant or Dependent. Nothing in this booklet or elsewhere is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on the factors you deem appropriate. All providers are independent contractors, not employees of the Fund. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission by any provider in connection with Fund coverage. The provider is solely responsible for services and treatments rendered.

SECTION 15 PRIVACY OF HEALTH INFORMATION

Effective April 14, 2003, the receipt, use and disclosure of protected health information ("PHI") by the Fund is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Board of Trustees and the Fund's business associates may receive, use and disclose PHI in order to carry out payment, treatment and health care operations under the Fund. These entities and individuals may use PHI for such purposes without your consent or written authorization. In the normal course, if your PHI is used or disclosed for any purpose, your written authorization for such use or disclosure will be required. All Fund Participants will receive a Notice of Privacy Practices on or before April 14, 2003, that explains the Fund's obligation to protect your PHI and also describes certain rights you will have with regard to your PHI.

Under this new law, the Fund (or health insurance issuer or HMO with the Fund's permission) may disclose PHI, as defined in HIPAA, to the Board of Trustees to carry out its administrative functions related to the Fund. The Board's administrative functions include the responsibility to control and manage the operation and administration of the Fund, in accordance with ERISA. Such administrative functions include, but are not limited to, the responsibility to determine appeals of benefit claims. The Board may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for these purposes.

The Board of Trustees are subject to the following limitations and requirements related to its use and disclosure of PHI received from the Fund:

- The Board shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA.
- The Board shall require any agents, including subcontractors, to whom it provides PHI received from the Fund to agree to the same restrictions and conditions that apply to the Board with respect to such information.
- The Board shall not use PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan.

The Board shall report to the Fund any improper use or disclosure of PHI of which it becomes aware.

- The Board will:

- make available PHI for access purposes in accordance with 45 C.F.R. ' 164.524;
 - make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. ' 164.526; and
 - make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. ' 164.528.
-
- The Board shall make its books, records, and internal practices relating to the use and disclosure of PHI received by the Fund available to the Secretary of the Department of Health and Human Services for audit purposes.
 - If feasible, the Board shall return or destroy all PHI received from the Fund that the Board retains in any form when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Board shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
 - To the extent the Board hires any employees, the Board will provide for adequate separation between it and the Fund. At this time, the Board has no employees.

The Fund will disclose PHI to the Board of Trustees only upon receipt of a certification by the Board that the Plan documents have been amended in accordance with 45 C.F.R. ' 164.504(f), and that the Board shall protect the PHI as described herein.

SECTION 16

STATEMENT OF ERISA RIGHTS

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

As a Participant in the Washington, D.C. Cement Masons Welfare Fund you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Fund office and at other specified locations, such as worksites and Union halls, all Plan documents, including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. 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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.