Cement Masons' Local 780 Trust Fund

Summary Plan Description
for
Residential Workers

January 1, 2016

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INTRODUCTORY LETTER TO THE PLAN AND SUMMARY PLAN DESCRIPTION

Cement Masons' Local Union No. 780 Trust Fund
76 South Central Avenue Ste. 1C
Valley Stream, New York 11580
P: (516) 775-2280
F: (516) 775-4064

To all Participants:

We are pleased to present you with this updated booklet of the benefits provided by the Cement Masons' Local 780 Trust Fund (the "Trust Fund" or "Fund") under the Cement Masons' Local 780 Trust Plan (the "Plan"). The Plan is funded through a collective bargaining agreement based upon contributions from obligated employers for each hour of covered employment work. You may obtain a copy of the appropriate collective bargaining agreement from the Fund or Union. A list of obligated employers under the collective bargaining agreement is also available from the Fund. The Fund was established by Cement Masons' Local 780 and the Cement League.

This booklet constitutes your Summary Plan Description ("SPD") and plan document for the Plan. The Plan is administered by a Board of Trustees consisting of an equal number of representatives of the Union and of representatives of employers. As you read through this booklet you will learn how you become a Participant, what the benefits are and how to claim them. Be sure to share this booklet with your family since the benefits may affect them as well. We urge you to read this booklet carefully. It summarizes the most important features of the Plan and presents the Plan provisions.

To make this information as clear as possible, this booklet has been written in today's English. Please read this booklet carefully and keep it in a safe place for easy reference. You will notice that some of the terms used in your booklet are capitalized. These terms have a special meaning under the Plan and are defined in this booklet. If you have any questions regarding any of the material presented within, please contact the Fund office at (516) 775-2280 during regular business hours. The Fund office is open Monday through Friday from 8:00 a.m. to 3:30 p.m.

Sincerely,
The Board of Trustees

IMPORTANT ERISA INFORMATION

Cement Masons' Local Union No. 780
Trust Fund
76 South Central Avenue Ste. 1C
Valley Stream, New York 11580
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Important ERISA Information

Pertaining to the Employee Retirement Income Security Act (ERISA).

PLAN NUMBER: 501
E.I.N: 13-1567895
TYPE OF PLAN: Health and Welfare

PLAN ADMINISTRATOR:

Board of Trustees of the
Cement Masons' Local 780 Trust Fund
76 South Central Avenue Ste. 1C
Valley Stream, New York 11580
P: (516) 775-2280

The plan administrator has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process. Service of process upon the Plan may also be made by serving its trustee.

FISCAL YEAR: The Fund's records are kept on a calendar year basis, ending December 31st.

TYPE OF ADMINISTRATION: Trusteed and Self-Administered.

SOURCE OF CONTRIBUTIONS TO THE PLAN: Employer contributions are used to pay the premium costs for the health insurance coverage provided to Participants of the Plan. Funds are held in trust and invested until needed to pay for benefits under the Plan.

ERISA NOTICE

INFORMATION AND ASSISTANCE AVAILABLE TO YOU

Your ERISA Rights

As a Participant in the Cement Masons' Local 780 Trust Plan (the "Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The plan 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, and your covered dependents if there is loss of coverage under the Plan as a result of a Qualifying Event. You or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you

request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Note that certificates of coverage will not be provided after December 31, 2014 in accordance with the Affordable Care Act.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best 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.

Enforce Your Rights

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

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

Assistance with Your Questions

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

IMPORTANT TO REMEMBER

- You are a Participant in this Plan if you are working in covered employment established by the collective bargaining agreement by and between contributing employers and Cement Masons' Union Local 780, and certain Cement Masons' Union Local 780 Fund and Union employees.

- Save this booklet and store it in a safe place. If you have lost your copy, you may ask the Fund office for another, however you may be required to cover reasonable replacement costs. If you do not understand something in this booklet, you can request an explanation in writing from the Trustees. The Trustees will reply to your request.

- Health and Hospital coverage for active and retired members under this Plan is provided by Aetna healthcare. Life and Accidental Dismemberment insurance is provided by Anthem Life. State Mandated Disability Insurance is provided by Shelter Point Life Insurance Co. Vision care is provided by Davis Vision. Dental care is provided by Aetna healthcare and lastly Supplemental Insurance is provided by Colonial Life. These companies are third party providers and the extent of their services are determined by their contract with the Fund office. You are a beneficiary of those contracts and these benefits are provided under this Plan.

- A person must be eligible under this Plan to receive a benefit. If a person is not eligible, including having lost eligibility, no benefits are available under this Plan. To receive benefits for any period, you must be eligible. If requested by a provider or third party provider, you must have submitted a proper application to that provider or third party provider previous to any period for which you are claiming benefits.

- COBRA options are available under this Plan.

- If a change occurs in your marital status or dependent status (i.e.: birth, adoption of a child, unmarried children between age 19 and 26), please notify the Fund office immediately.

- Benefits terminate upon the death of the Participant unless otherwise provided herein under death benefits, loss of active coverage or COBRA.

- Your spouse is your inevitable death benefit beneficiary unless your spouse waives the entitlement on the appropriate forms. Be sure to request these forms from the Fund office and file the appropriate form(s) designating your beneficiary (ies) and file these forms with the Fund office.

- The Fund office at the very least will provide you with a statement annually indicating your total hours worked for the year. You have a period of three months to protest the correctness of this report; otherwise it will be considered your final permanent record of your hours worked for the year. If you have worked hours during the year and do not receive this annual statement, notify the Fund office. You will only receive this statement if the Fund office has received a contribution on your behalf for that year.

- Retirees of age 65 or older and disabled retirees under 65 years of age must submit a copy of their Medicare health insurance card to the Fund office as one condition to secure or maintain retiree eligibility for benefits under this Plan.

- Retirees of age 65 or older and disabled retirees under 65 years of age must possess Medicare A (Hospital) and B (Medical) as one condition to secure or maintain retiree eligibility for coverage under this Plan.

- Benefits provided under this Plan are in no event assignable to another person (although the right to receive payment may in certain cases be assignable to a medical services provider for services provided to the covered person).

- Coordination of Benefits: The rapid growth of group insurance in the past few years has produced a situation whereby an individual might be insured under two or more health plans or programs. In the event of accident or illness this individual could possibly submit claims to each of the different insurance companies or entities underwriting his plan of insurance. To avoid duplication of payment or over insurance, coordination of benefits must occur. Benefits under this Plan will be coordinated with all other types of plans you or your dependents may be insured under so that the total amount payable under all plans will not exceed 100% of medical expenses incurred. For further information, please refer to the procedures described under the heading **"Coordination of Benefits"** on page 56 of this booklet.

- Rights of Recovery: This Plan or third party providers may pay benefits that should be paid by another benefit plan or program or that are later found to be greater than the allowable charge. In such a case, the Board of Trustees (or the plan administrator or any other designee duly authorized by the Board of Trustees) shall have full authority, in their sole and absolute discretion, to recover the amount of any overpayment (plus interest, attorney's fees and costs). Such authority shall include, but not be limited to:

    - The right to seek the overpayment in a lump sum from the other benefit plan or the covered person;

- The right to reduce benefits payable in the future to the person who received the overpayment;
- The right to reduce benefits payable to a beneficiary who is, or may become, entitled to receive payments under the Plan; and
- The right to initiate a lawsuit or take such other legal action as may be necessary to recover any overpayment (plus interest, attorney's fees and costs) against the other benefit plan or the covered person.

➢ Subrogation: If a Participant or his covered dependent suffers an injury or illness that is caused by the negligence or fault of a third party, a reimbursement or subrogation agreement may have to be signed by the Participant or his legal representative before Plan benefits will be paid. In the event of refusal to sign or your failure to notify the Plan of such an occurrence, the Plan is also automatically entitled to these reimbursement or subrogation rights. These reimbursement or subrogation rights allow the Plan to proceed and recover against the third party or hold you the Participant responsible for repayment if you receive payment from the third party.

➢ Claims:

If you are submitting a claim to a third party provider, you must follow the procedures of that provider as has been presented in materials sent to you. If you are presenting a claim to the Fund, the claim must be in writing and on a proper form as provided by the Fund. For further information, please refer to the procedures described under the heading **"Claims and Appeals Procedure"** on page 52 of this booklet.

➢ Denial and Rights of Appeal:

If your claim involving coverage provided by a third party provider is denied, you must submit an appeal to the third party provider in the manner prescribed by the third party provider in the materials you have received from that provider. If your claim relating to your eligibility or a claim involving coverage directly provided by the Fund is denied, you have the right to appeal the denial to the Trustees in strict compliance with the Plan. For further information, please refer to the procedures described under the heading **"Claims and Appeals Procedure"** on page 52 of this booklet.

➢ Participant Fraud:

If a Participant engages in fraud against the Trust Fund, the Trustees have the right to provide further trust benefits and take such other actions which are necessary to protect the assets of the Trust Fund.

- Effective Date:
  This Plan governs the right to the payment of benefits arising after the effective date of this Plan. Previous benefits are governed by the right to the payment of benefits for the plan then in effect. This restatement of the Plan shall become effective on January 1, 2016.

- Gender:
  The masculine pronoun whenever used shall include the feminine gender, the singular number whenever used shall include the plural as well as the plural the singular unless the context clearly indicates a different meaning.

- The Trustees reserve the right to interpret this Plan and to amend, change, modify, eliminate or terminate its provisions from time to time at their discretion. There are no vested benefits under this Plan, and any amendment, change, modification, elimination or termination of its provisions or any provision shall be effective at a time in accordance with such action.

- Be sure to ascertain that any employer for whom you are working as a cement mason is a signed, contributing employer and does not become delinquent in the submission of your benefit contributions.

- This group health Plan believes this Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

  Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (516) 775-2280. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ELIGIBILITY FOR BENEFIT COVERAGE

Who can Obtain Eligibility for Coverage?

- Participants

Participants are employees working in covered employment established by the collective bargaining agreement by and between contributing employers and the Cement Masons' Union Local 780 as well as certain Cement Masons' Local 780 Fund and union employees. These Participants, better known as members, may obtain eligibility for Trust Fund benefits, including coverage for Eligible Dependents, however you must be working in covered employment. Covered employment means doing the work covered by these agreements as an employee for whom benefits are received from the signed employer. **To be eligible for a benefit, you must meet eligibility requirements as presented below under the headings "Eligibility Requirements for Working Participants", "Eligibility Requirements for Active Members" and "Eligibility Requirements for Retirees"** (pages 15-17).

- Retirees

In addition, retirees who comply with the specified criteria, which includes work hour requirements and paying required premiums, can obtain Trust Fund benefits including coverage for Eligible Dependents.

- Coverage for Eligible Dependents

If you, the active member or covered retiree, become or are eligible for coverage, this eligibility extends to certain dependents for health and medical benefits, but not for disability or life and accidental dismemberment insurance. These dependents are your lawful spouse and your unmarried children age 19 to 26. To be eligible, your spouse must not be legally separated from you (unless coverage is required by law). Unmarried children of an eligible member or retiree are eligible for medical and dental coverage up to age 26 (end of year age 26). To maintain eligibility, unmarried children over 19 years of age must pre-notify the Trust Fund office. If an Eligible Dependent is on Medicare, the dependent must have both Medicare A (Hospital) and B (Medical) to remain eligible.

An unmarried child whose insurance would otherwise terminate solely due to reaching the age of 19 shall continue to be eligible until the end of year age 26 by law as approved by the Affordable Care Act.
Child includes step-child, adopted children, a proposed adopted child during any waiting period prior to the finalization of the child's adoption and foster children. However,

that child must be dependent upon you for support and maintenance. Child also includes any child for whom the plan administrator determines coverage must be provided under a recognized Qualified Medical Child Support Order that has been accepted by the Plan.

If a newborn dependent child incurs charges (over and above nursery charges) for services because of injury, illness, congenital defects, birth abnormalities or premature birth, coverage will begin at birth.

- Eligibility Requirements for Working Participants

Working Participants are those Participants eligible for basic New York State mandated disability benefits which refers to Participants who incur a non-work related disability or sickness while employed in covered employment or within 4 weeks of termination of that employment.

- Eligibility Requirements for Active Members

You as a Participant will be considered eligible for Trust Fund benefits for a current year as an active member provided that you have sufficient credited work hours in covered employment during the previous year and contributions for those hours were made to the Fund on your behalf as an employee. As presented below under the heading **"Obtaining Eligibility Hours for Benefit Coverage When not Working"** (pg. 19), certain hours may be credited to your account if you were receiving payments on disability or workman's compensation or you were in the military.

The amount of hours required for eligibility is determined by the Trustees and is subject to change for any future year. Active members with 1,000 credited work hours in the prior year will be placed on the Aetna active medical plan provided by the Cement Masons' Union Local 780 Trust Fund for the current year.

Special Rule for Residential Workers in 2016: For year 2016 only, residential workers who have earned at least 1,000 credited work hours during calendar year 2016 will be placed on the active medical plan provided by the Cement Masons' Union Local 780 Trust Fund. Upon working 1,000 credited work hours during 2016, coverage will commence on December 1, 2016 and continue until December 31, 2017. For years beginning after December 31, 2017, coverage will commence on January 1 of that calendar year only for those active members with 1,000 credited work hours in the prior year.

For example, if an active member works at least 1,000 credited work hours in 2016, his coverage for 2017 will commence on December 1, 2016 and continue until December 31, 2017. His coverage for year 2018 will be activated on January 1, 2018, if he works at least 1,000 credited work hours in 2017.

Pension eligible members who retire between the ages of 58 and 62 will have a co-pay of 35% of the premium cost and will be placed on the Aetna active medical plan. Contact the Fund office for the required amount of hours applicable for a given year. **The Fund office will notify you each year of the amount of hours applicable for a given year.**

Suspension of Active Member Medical Coverage

a) Suspension of Active Member Medical Coverage

Effective sixty (60) days after the Summary of Material Reduction notice is mailed to Participants by the Fund office, if a Participant, who otherwise is eligible to receive medical coverage, and is receiving such medical coverage for himself and/or his dependents under the Plan, is engaged in fraud, misrepresentation or misconduct, which means attempting, either directly or indirectly, to undermine the financial integrity and health of the Fund by his actions, including, without limitation:

i) engaging in covered employment for an employer that does not have an obligation to make contributions to the Fund pursuant to a written agreement and/or acknowledgment;
ii) engaging in covered employment for a contributing employer and agreeing to an arrangement by which payment for wages is made in cash, but contributions are not made to the Fund;
iii) submitting false claims to the Fund and/or the insurance provider for the Fund;,
iv) seeking medical coverage for individuals who are not otherwise eligible through deception, fraud or misleading information;

then such medical coverage shall be suspended for such a time deemed reasonable by the Trustees.

b) Notice

The Plan shall inform the Participant of any suspension of his medical coverage by notice given by first class mail ten (10) days prior to the first calendar month in which his coverage is suspended. Such notice shall include a description of the specific reasons for the suspension, copy of the relevant provisions of the Plan, and a statement of the procedure for securing a review of the suspension.

c) Review

A Participant shall be entitled to of a determination suspending his medical coverage by written request filed with the Trustees within 60 days of the notice of suspension. The written request will be reviewed by the Trustees at the next regularly-scheduled

meeting of the Trustees, as long as the written request is received more than 30 days before the next scheduled meeting. If the written request is received within 30 days of the next scheduled meeting, the written request will be reviewed by the Trustees at the subsequent regularly-scheduled meeting.

d) Resumption of Medical Coverage

The Trustees shall have the sole and absolute discretionary authority to determine whether the Participant attempted, engaged in or committed fraud, misrepresentation or misconduct and whether such activity has ceased.

The Participant's medical coverage shall be suspended for such periods of time as set forth below, based on the number of offenses committed by the Participant:

Number of Offenses	Medical Coverage Suspension Period
First offense	One (1) month
Second offense	Three (3) months
Third offense	One (1) year

Any decision of the Trustees will be final, conclusive and binding.

e) Suspension Policies and Procedures

The Trustees shall have the sole and absolute discretionary authority to establish policies and procedures to implement the foregoing.

➢ Eligibility Requirements for Retirees

As a retiree, you and your potential Eligible Dependents shall remain eligible for the Trust Fund health and medical and vision care benefits while on a regular, disability, early retirement or Joint and Survivor Annuity from the Cement Masons' Local 780 Pension Fund **if you were eligible as an active member for Trust Fund benefits on the effective date of your pension.** You must maintain your eligibility and the eligibility for any covered dependents by proper payment of all required premiums. Failure to make such payments will result in termination of your eligibility and the eligibility of covered dependents. **Please note that you may designate your Eligible Dependents for coverage without penalty at any time; however, if those dependents were not eligible for benefits at the time of your retirement, they will not be covered under this Plan.** Retirees of age 65 or older and disabled retirees under 65 years of age must have both A and B Medicare Health Insurance Coverage as one condition to secure or maintain retiree eligibility for coverage under this Plan.

If you retire without medical coverage or lose your retiree medical coverage or the medical coverage of Eligible Dependents because you failed to make proper premium payment for it if required, you may subsequently obtain coverage by returning to employment in the following way: If you return to employment you will be eligible for retiree benefit coverage or to reinstate Eligible Dependent coverage if you withdraw

from employment after 5 consecutive years of having worked in covered employment with the required amount of hours for Trust Fund benefits immediately prior to re-withdrawal. For Participants whose retirement date is before January 1, 2015, to be eligible at such time for retiree medical coverage, you must have 15 years of having worked in covered employment the required amount of hours for receiving Trust Fund benefits. For Participants whose retirement date is on or after January 1, 2015 but before January 1, 2016, to be eligible at such time for retiree medical coverage, you must have 25 years of having worked in covered employment the required amount of hours for receiving Trust Fund benefits. Effective as of January 1, 2016, for Participants whose retirement date is on or after January 1, 2016, to be eligible at such time for retiree medical coverage, you must have 20 years of having worked in covered employment the required amount of hours for receiving Trust Fund benefits.

Suspension of Retiree Medical Coverage

a) Suspension of Retiree Medical Coverage Upon Re-employment

If a retiree, who otherwise is eligible to receive medical coverage, and is receiving such medical coverage for himself and/or his Eligible Dependents under the Plan, is re-employed in "Disqualifying Employment," which means employment in:

i) an industry in which employees covered by the Plan were employed and accrued benefits under the Plan as a result of such employment at the time that the retiree commenced medical coverage, and

ii) a trade or craft in which the employees covered by the Plan were employed at any time under the Plan, and

iii) the geographic area covered by the Plan,

then such medical coverage shall be suspended during the period of such re-employment for each calendar month in which he or she is re-employed in Disqualifying Employment. The retiree shall be deemed as participating in Disqualifying Employment until such time that he or she complies with the notice requirements as set forth in subsections I and I below.

b) Definitions

i) "Industry" means the business activities of the types engaged in by any employees maintaining the Plan.

ii) "Trade or craft" is a skill or skills, learned during a significant period of training or practice, which is applicable in occupations in this Industry and/or supervisory activities relating thereto.

iii) "The geographic area covered by the Plan" shall include the Greater New York Metropolitan Area and any area covered by a Plan which, under a reciprocal agreement in effect when the retiree (then Participant) first commenced benefits under the Plan, had forwarded contributions to this Plan, on the basis of which this Plan accrued benefits to the Participant.

c) **Notice**

i) A retiree whose medical coverage has been suspended shall notify the Plan when Disqualifying Employment has ended.

ii) The Trustees shall have the right to continue the suspension of medical coverage until such notice is filed with the Plan. A retiree may ask the Plan whether a particular employment will be disqualifying. The Plan shall provide the retiree with its determination.

iii) The Plan shall inform a retiree of any suspension of his medical coverage by notice given by first class mail fifteen (15) days prior to the first calendar month in which his coverage is suspended. Such notice shall include a description of the specific reasons for the suspension, copy of the relevant provisions of the Plan, and a statement of the procedure for securing a review of the suspension. In addition, the notice shall describe the procedure for the retiree to notify the Plan when his Disqualifying Employment ends.

d) **Review**

i) A retiree shall be entitled to review of a determination suspending his medical coverage by written request filed with the Trustees within 60 days of the notice of suspension.

ii) The same right of review shall apply, under the same terms, to a determination by or on behalf of the Trustees that the contemplated employment will be disqualifying.

e) **Resumption of Benefit Payments**

Medical coverage shall resume beginning the first day of the month after the notice that Disqualifying Employment has ended has been received and accepted by the Trustees and provided the retiree has complied with the notice requirements set forth above.

IMPORTANT NOTE REGARDING RETIREE COVERAGE: Benefits for retirees and their Eligible Dependents may be modified or terminated at any time and for any reason, in the sole and absolute discretion of the Board of Trustees. Similarly, the required contribution for retiree coverage may change at any time, as determined in the sole and absolute discretion of the Board of Trustees. Retirees and their family members are not vested in, or guaranteed, any level of benefits under the Fund.

➢ <u>Covered Retirees under age 65</u>

To maintain coverage, covered retirees under 65 years of age must make premium payments at rates and at times as established by the Trustees of the Trust Fund on an annual basis. Disabled retirees under 65 years of age must possess both Medicare A

(Hospital) and B (Medical) as one condition to secure or maintain retiree eligibility for coverage under this Plan. **Failure to make the proper premium payments as required will result in termination of coverage and eligibility for coverage for you and your dependents.**

For the year 2015, the Trustees of the Trust Fund have set the following covered retiree under 65 years of age payment rate which can be paid by deduction from your monthly pension check or quarterly in advance by the 15th of each month.

Beginning January 1, 2015 all current retirees between the ages of 58 and 64 will be placed on the Aetna medical benefit plan. The contributions for these members are as follows: All members retiring between the ages of 58 and 62 on or after January 1, 2015 will have a contribution of 35% of the total premium cost for primary subscriber, spouse and Eligible Dependents. This contribution will be required by all eligible members on the active Plan (dependents to age 26 and spouses to age 65).

Retirees between 62 and 64 years of age who retire on or after January 1, 2015 will be required to pay the following contributions:

- $200 for primary subscriber (this may constitute a spouse or Eligible Dependent)
- $100 for spouse
- $100 for Eligible Dependents

➢ Covered Retirees 65 Years of Age and Over

To maintain coverage, covered retirees who are 65 years of age or over must possess both Medicare A (Hospital) and B (Medical) to make premium payments at rates and at times as established by the Trustees of the Trust Fund on an annual basis. Failure to make the premium payments as required will result in termination of coverage and eligibility for coverage for you and your dependents.

Pension eligible members and their spouses who were born prior to 1947 and currently possess both Medicare A and B and are on the Aetna Medicare Advantage PPO plan will be required to pay the following contribution starting January 1, 2015:

- $75 for primary subscriber
- $75 for spouse
- $75 for current disabled pension members

Pension eligible members and their spouses who were born after 1947 and will be receiving both Medicare A and B and will be going on the Aetna Medicare Advantage PPO plan after January 1, 2015 will be required to pay the following contribution starting January 1, 2015:

- $100 for primary subscriber
- $100 for spouse
- $100 for new disabled pension members

➢ Termination of Eligibility for Active Members

Your eligibility for benefits will terminate the first day of January following a calendar year during which you were not in covered employment for the minimum hours required for benefits eligibility. This has been explained under the heading **"Eligibility Requirements for Active Members"** (page 15).

➢ Termination of Eligibility for Active Members

Your eligibility for benefits will terminate if you fail to pay in a timely manner any required premium payment to maintain your coverage. You or your dependents' coverage will not be reinstated unless you comply with eligibility requirements for retirees who do not have coverage or lost coverage as previously stated.

➢ Reinstatement of Active Member Eligibility for Benefits

As an active member, if you lose your eligibility for benefits under the termination rule, you shall again be insured on the first day of January following a calendar year during which you worked the minimum amount of required hours to qualify for benefits.

➢ Obtaining Eligibility Hours for Benefit Coverage When Not Working

- **Disability**- If you are out on disability, you will be granted twenty (20) hours per week towards your hours of eligibility for each week that you receive either weekly disability (which by law provides and is limited to 26 weeks) from the Fund or disability payments from worker's compensation (which by law provides and is limited to 26 weeks).
- **Military Service**- Employees who lose eligibility because of their entrance in the Armed Forces shall be reinstated as eligible for benefits provided they make themselves available for work by a contributing employer within ninety (90) days after release from their active duty or ninety (90) days after recovery from a disability continuing after their release from active duty.

➢ Dependents' Termination of Eligibility

Coverage for your Eligible Dependent ends:

- On the date your own insurance ends.
- On the date a dependent no longer qualifies as a dependent.
- On the date a dependent becomes a member of Cement Masons' Union Local 780.

If termination of your insurance is due to your entrance into the Armed Forces, the insurance of your dependents will continue for a period of six (6) months following the date of actual entrance in the service.

GENERAL BENEFIT INFORMATION

SUMMARY OF BENEFITS AS PROVIDED BY: INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR

Benefits are supplied by the following insurance carriers or third party administrators. A summary of benefits offered by these carriers are available at the Exhibit indicated. For full coverage details and information, refer to the full carrier plans (not included under this general benefit information here but contained in the Exhibits).

IMPORTANT: The actual benefits available are those which the individual insurance carrier or third party administrator specifies in its contract(s) with the Fund and these benefits provided by the contract(s) are the only ones provided. The information provided hereafter is intended as a reference as to the benefits provided in the contract(s). The Fund does not provide any benefits in addition to those which the insurance carriers or third party administrators supply by their contract(s).

Benefit	Insurance Carrier	Exhibit
MAJOR MEDICAL & PRESCRIPTION (Active Members)	Aetna EPO (in-network only)	I
MAJOR MEDICAL & PRESCRIPTION (Retired Members)	Aetna Medicare PPO (in and out of network)	II
DISABILITY BENEFIT Statutory New York State Benefit (Active Members)	Shelter Point Life (26 week benefit)	III
LIFE INSURANCE BENEFIT (Active Members Only)	The Hartford	IV
SUPPLEMENTAL REIMBURSEMENT BENEFIT (Active Members Only)	Colonial Life Voluntary Benefits	Exhibit available upon request

BENEFIT HIGHLIGHTS

IMPORTANT: The actual benefits available are those which the individual insurance carrier or third party administrator specifies in its contract(s) with the Fund and these benefits provided by the contract(s) are what you receive. The Fund office does not

Important Questions	Answers	Why this Matters:

provide actual benefits on its own. The Fund pays for the benefits provided by the contract(s) on your behalf. The information provided hereafter is intended as a summary and reference as to benefits provided in the contract(s). The Fund does not provide any benefits on addition to those which the insurance carrier or third party administrator supplies through their contract(s).

- Working Participant Benefits (Dependents not Covered)★
  - Disability Weekly Benefit ..... 50% of weekly salary up to $410
  - Maximum Benefit ..... 26 weeks

- Active Member Medical Benefits (Dependents Covered)★★
  (Summary for complete coverage from this Carrier see Exhibit I)

Life Insurance and Accidental Death and Dismemberment (Certain rights of Conversion and extended benefits option to accelerate payment).	Members who worked 1000 hours receive $20,000 loss of life plus $20,000 of accidental for having seatbelt in vehicle death accidents.

Note: Your beneficiary will be your spouse (or your estate if you are not married) unless you specifically designate another beneficiary or beneficiaries on a form provided by the Fund.

★ A "Working Participant" eligible for disability benefits is a Participant who, as an employee in covered employment, incurs a non-work related disability or sickness while employed in covered employment or within 4 weeks of termination of that employment. Refer to the heading **"Eligibility Requirements for Working Participants"** (page 15).

★★ An "Active Member" is one who acquires eligibility by working in covered employment with sufficient hours in the prior year to qualify for Trust Fund Benefit Eligibility. Refer to the heading **"Eligibility Requirements for Active Members"** (page 15).

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What is the overall deductible?	For each Calendar Year, In-Network: Individual $1,500 / Family $3,000. Does not apply to office visits emergency care, and preventive care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network: Individual $6,600 / Family $13,200.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *Specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com or call 1-888-982-3862 for a list of network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

Exhibit I

EPO Major Medical & Prescription for Active members

Open Access® Elect Choice®- Low Option **Coverage: 07/01/2016- 12/31/2017**

(Summary of Benefits and Coverage)

⚠ **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.aetna.com/sbcsearch/getpolicydocs?u=070200-050020-151630 or by calling 1-888-982-3862.

★Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
★Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
★The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
★This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Adult visit / $40 Dependent child visit	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician
	Specialist visit	$40 Adult visit / $40 Dependent child visit	Not covered	-----None-----
	Other practitioner office visit	$40 Adult visit / $40 Dependent child visit	Not covered	-----None-----
	Preventive care/screening/immunization	No charge except hearing exams not covered	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$40/ co-pay/ visit	Not covered	-----None-----
	Imaging (CT/PET scans, MRIs)	$75/ co-pay/ visit	Not covered	-----None-----

★ **Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Copay/prescription: $15 (retail), $30 (mail order)	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, oral and injectable fertility drugs. No charge for formulary FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.
	Preferred brand drugs	Copay/prescription: $35 (retail), $70 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: $65 (retail), $130 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs.	Not covered	First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy® networks. Subsequent fills must be through Aetna Specialty Pharmacy®.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit	Not covered	-----None-----
	Physician/surgeon fees	No charge	Not covered	-----None-----
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	0% coinsurance	0% coinsurance	No coverage for non-emergency transport.
	Urgent care	$40 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after $500 copay/stay	Not covered	-----None-----
	Physician/surgeon fee	0% coinsurance	Not covered	-----None-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/visit	Not covered	-----None-----
	Mental/Behavioral health inpatient services	0% coinsurance after $500 copay/stay	Not covered	-----None-----
	Substance use disorder outpatient services	$40 copay/visit	Not covered	-----None-----
	Substance use disorder inpatient services	0% coinsurance after $500 copay/stay	Not covered	-----None-----

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	-----None-----
	Delivery and all inpatient services	$40 copay for physician maternity services; 0% coinsurance after $500 copay/stay for facility services	Not covered	Includes outpatient postnatal care.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 200 visits per calendar year.
	Rehabilitation services	$40 copay/visit	Not covered	Coverage is limited to 60 visits per calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$40 copay/visit	Not covered	Coverage is limited to treatment of Autism.
	Skilled nursing care	0% coinsurance after $500 copay/stay	Not covered	Coverage is limited to 60 days per calendar year.
	Durable medical equipment	0% coinsurance	Not covered	-----None-----
	Hospice service	0% coinsurance after $500 copay/stay for inpatient; not covered for outpatient	Not covered	-----None-----
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 routine eye exam per 24 months.
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Glasses (Child)
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs- Except for required preventative services.

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.

- Chiropractic ca
- Infertility treatr insemination, (
- Private-duty nu
- Routine eye ca
- Bariatric Surge

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage.
Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan.
Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.
For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card.
If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration att 1-866-444-EBSA (3272)
or **www.dol.gov/ebsa/healthreform**. You may also contact the New York State, Department of Financial Services, (212) 709-3500, **www.dfs.ny.gov**.

Additionally, a consumer assistance program can help you file your **appeal**.

Contact: Community Health Advocates, Community Service Society of New York, 105 East 22nd Street,

New York, NY 10010, (888) 614-5400, **http://www.communityhealthadvocates.org**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage".

This plan or policy does provide minimum essential coverage.

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan.

The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-982-3862.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862. Chinese (中文): 如果需要中文的帮助 1-888-982-3862. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862.

★ **Questions:** Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

⚠ **This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

Patient pays: $1,380
Amount owed to providers: $7,540
Plan pays: $6,160

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total:	**$7,540**
Patient pays:	
Deductibles	$1,500
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total:	**$2,200**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
Plan pays: $3,710
Patient pays: $1,690

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total:	**$5,400**
Patient pays:	
Deductibles	$1,500
Copays	$800
Coinsurance	$0
Limits or exclusions	$80
Total:	**$2,380**

★ Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com.
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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples:

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

- For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- No. Treatments shown are justexamples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- No. Coverage Examples are notcost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples.
  When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Exhibit II

Cement Masons Local 780

Aetna Medicare SM Plan (PPO)

Medicare (P01) ESA PPO Plan
Rx $10/$20/$50

Benefits, Value Added Services and Premiums are effective January 1, 2016 through December 31, 2016

National

PLAN DESIGN AND BENEFITS	
PROVIDED BY AETNA LIFE INSURANCE COMPANY	
PLAN FEATURES	**Network & Out-of-Network Providers**
Combined In and Out of Network Deductible (Plan Level/includes Network Deductible)	$0
Member Coinsurance	N/A
Applies to all expenses unless otherwise stated.	
Annual Maximum Out-of-pocket amount (Combined network and out-of-network and the deductible)	$3,400
Annual Maximum Out-of-pocket Limit amount applies to all medical expenses EXCEPT Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.	
Primary Care Physician Selection	Optional

Certification Requirements	
There is not a requirement for member pre-certification. If a member fails to obtain pre-certification they will not be denied services or will any penalty amount be applied. However, pre-certification is requested on certain services including inpatient hospital care, inpatient mental health and substance abuse, skilled nursing facility, home health care and some durable medical equipment.	
Referral Requirement	Not Applicable
PREVENTIVE CARE	
Annual Wellness Exams One exam every 12 months	Covered 100%
Routine Physical Exams One exam every 12 months	Covered 100%
Medicare Covered Immunizations	Covered 100%
Pneumococcal, Flu, Hepatitis B	
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)** One routine GYN visit and pap smear every 24 months	Covered 100%
Routine Mammograms (Breast Cancer Screening)	Covered 100%
One baseline mammogram for members 35-39; and one annual mammogram for members age 40 and over	
Routine Prostate Cancer Screening Exam For covered males age 50 and over every 12 months	Covered 100%
Routine Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Bone Mass Measurement One exam every 24 months	Covered 100%
Additional Medicare Preventive Services* **	Covered 100%
Routine Eye Exams	Covered 100%
One annual exam every 12 months	

Routine Hearing Screening	Covered 100%
One exam every 12 months	
PHYSICIAN SERVICES	
Primary Care Physician Visits	$15 Copay
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$15 copay
Allergy Testing	$15 copay
DIAGNOSTIC PROCEDURES	
Outpatient Diagnostic Laboratory	Covered 100%
Outpatient Diagnostic X-ray	Covered 100%
Outpatient Diagnostic Testing	Covered 100%
Outpatient Complex Imaging	Covered 100%
EMERGENCY MEDICAL CARE	
Urgently Needed Care	$15 copay
Emergency Care; Worldwide (waived if admitted)	$65 copay
Ambulance Services	Covered 100%
HOSPITAL CARE	
Inpatient Hospital Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	Covered 100%
MENTAL HEALTH SERVICES	
Inpatient Mental Health Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$15 copay

ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Substance Abuse (Detox and Rehab)	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay	
Outpatient Substance Abuse (Detox and Rehab)	$15 copay
OTHER SERVICES	
Skilled Nursing Facility (SNF) Care	$0 days 1-10 $25 days 11-20 $50 days 21-100
Limited to 100 days per Medicare benefit period.	
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Home Health Agency Care	Covered 100%
Hospice Care	Covered by Medicare at a Medicare certified hospice
Outpatient Rehabilitation Services	Covered 100%
(speech, physical, and occupational therapy.)	
Cardiac Rehabilitation Services	$15 copay
Chiropractic Services	$15 copay
For manipulation of the spine to the extent covered by Medicare	
Durable Medical Equipment/ Prosthetic Devices	Covered 100%
Podiatry Services	$15 copay
Limited to Medicare covered benefits only	
Diabetic Supplies	Covered 100%
Outpatient Dialysis Treatments	Covered 100%
Medicare Part B Prescription Drugs	Covered 100%
ADDITIONAL NON-MEDICARE COVERED SERVICES	

Healthy Lifestyle Coaching One phone call per week	Included	
PHARMACY - PRESCRIPTION DRUG BENEFITS	**Cost Share**	
Prescription drug calendar year deductible	$0	
Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.		
Pharmacy Network	Group Standard Network	
Formulary	Managed Standard with Select Care (Five Tier)	
Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers. Refer to the "Coverage Tier Chart" below to find which drug types are included in each tier of your plan design.		
Initial Coverage Limit (ICL)	$2,960	Covered Medicare Prescription Drug Expenditure
The Initial Coverage Limit includes the applicable plan deductible. Until covered Medicare Prescription Drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied), cost-sharing is as follows:		
Retail - Member Cost-Sharing up to the Initial Coverage Limit	Member pays $0 Copay for Select Care* Generics Member pays $10 Copay for Tier 1 Generic Member pays $20 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $50 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $50 Copay for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)	
Up to one month (30 day) supply at indicated copay or coinsurance		

Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share.	
Mail Order through Aetna Rx Home Delivery - Member Cost-Sharing up to Initial Coverage Limit	Member pays $0 Copay for Select Care* Generics Member pays $20 Copay for Tier 1 Generic Member pays $40 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $100 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $100 Copay for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)
Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.	
Coverage Gap**	
Once covered Medicare Prescription Drug expenses have reached the Initial Coverage Limit, the Coverage Gap begins. Member cost sharing under the plan between the Initial Coverage Limit and until $4,700 in true out-of-pocket costs for Covered Part D drugs is incurred is as follows:	

Retail - Member Cost-Sharing during Coverage Gap**	Member pays $0 Copay for Select Care* Generics Member pays $10 Copay for Tier 1 Generic Member pays $20 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $50 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $50 Copay for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)
Member cost share of 45% is the member responsibility after the 50% manufacturer discount is applied.	
Up to one month (30 day) supply at indicated copay or coinsurance	
Three month (90 day) supply available at retail. When you obtain a 90 day supply at retail, you pay your Mail Order cost share.	
Mail Order through Aetna Rx Home Delivery - Member Cost Sharing during Coverage Gap**	Member pays $0 Copay for Select Care* Generics Member pays $20 Copay for Tier 1 Generic Member pays $40 Copay for Tier 2 Preferred Brand (includes some high-cost generic and preferred brand drugs) Member pays $100 Copay for Tier 3 Non-Preferred Brand (includes high-cost non-preferred generic and non-preferred brand drugs) Member pays $100 Copay for Tier 4 Specialty (includes high-cost/unique generic and brand drugs)

Member cost share of 45% is the member responsibility after the 50% manufacturer discount is applied.	
Up to a three month (90 day) supply available via our preferred vendor, Aetna Rx Home Delivery.	
Catastrophic Coverage	Greater of $2.65 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of $6.60 or 5% for all other covered drugs.
Catastrophic Coverage benefits start once $4,700 in true out-of-pocket costs is incurred.	
Requirements:	
Precertification	Yes
Step-Therapy	No
Non-Part D Drug Rider	Not Covered
***In your formulary, Select Care drugs are listed as Tier 5 drugs**	
Coverage Tier Chart Tier 1 Generic: includes low-cost generic drugs Tier 2 Preferred Brand: includes some high-cost generic and preferred brand drugs Tier 3 Non-Preferred Brand: includes some high-cost non-preferred generic and non-preferred brand drugs Tier 4 Specialty: includes high-cost/unique brand and generic drugs Tier 5 Select Care Generic: includes select low-cost generic drugs	

** Additional Medicare Preventive Services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease and HIV screening
- Behavioral therapy for HIV screening

Aetna Medicare is a Medicare Advantage organization with a Medicare contract. A Medicare approved Part D sponsor. Enrollment in Aetna Medicare depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B Premium.
Members must be entitled to Medicare Part A and continue to pay the Part B premium and Part A, if applicable.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

This material is for informational purposes only. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage. Plan features and availability may vary by location and are subject to change Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline, or go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare unless otherwise noted in the plan.
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

You may pay more for out-of-network services. Prior approval from Aetna is required for some in- network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

This material is for informational purposes only and is not medical advice. Health information programs provide general health information are not a substitute for diagnosis or treatment by a physician or other health care professional. Contact a health care professional with any questions or concerns about specific health care needs. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna is not a provider of health care services and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Discount programs are offered at discounted prices and are not insured benefits. You are responsible for the full cost of any discounted services.

**Your plan sponsor/former employer provides additional coverage during the Coverage Gap phase for covered brand-name drugs. This means that you will generally continue to pay the same amount for covered brand-name drugs throughout the Coverage Gap phase of the plan as you paid in the Initial Coverage phase.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Your plan includes a reduced copay on some generic drugs, called Select Care generics. These generic drugs provide cost-effective options to treat high blood pressure, high cholesterol and diabetes. The list of SelectCare generic drugs can be found in the Medicare formulary guide.
Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offering as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS; we receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Barbiturates (except as identified by Original Medicare for Part D inclusion)
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over the counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

We receive rebates from drug manufacturers that may be considered when determining our Preferred Drug List. Rebates do not reduce the amount you pay the pharmacy for covered prescriptions.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances when a network pharmacy is not available. If you become ill, while traveling in the United States but are outside of your plan's service area, you may need to use an out-of-network pharmacy. An additional cost may be charged for drugs received at an out-of-network pharmacy. Quantity limits and restrictions may apply.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24/7.
- The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778**.
- Your state Medicaid office.

If you qualify, Medicare could pay for up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it.

This information is available for free in other languages. Please call our customer service number at **1-888-982-3862** (TTY/TDD 711) for additional information. Hours of operation: 7 days per week, 8am to 8pm.

Esta información está disponible en otros idiomas de manera gratuita. Si desea más información, comuníquese con Servicios al Cliente al **1-888-982-3862** (TTY/TDD: 711). Horario de atención: los 7 días de la semana, de 8 a.m. a 8 p.m.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to **www.aetna.com**.
2015 Aetna Medicare

*****This is the end of this plan benefit summary*****

SHELTERPOINT
ShelterPoint Life Insurance Company

Exhibit V

State Mandated Disability Insurance

NEW YORK DISABILITY BENEFITS LAW INSURANCE POLICY
This policy is Governed by the Laws of The State of New York

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In return for payment of the state premiums by the policyholder named in the application attached to this policy. Shelter Point Life Insurance Company will pay disability benefits to each employee in a listed class as required under Section 204 of the New York State Disability Benefits Law (New York State Workers' Compensation Law Article 9), subject to the terms and conditions stated in this policy and the statements in the attached application.

This policy provides benefits only

1. for a disability which begins during the term of this policy; or
2. for an employee whose employment with the policyholder terminates during the term of this policy, for a disability that begins within 4 weeks after termination of his employment and prior to the first day employee performs any work for remuneration, profit or benefit received, for an employer other than the Policyholder or a subsidiary or an affiliate of the Policyholder, provided the new employer is a covered employer under the Disability Benefits Law.

See VIII. **Effective Date of Employee's Coverage** for specific information on the date coverage begins.

This policy becomes effective at 12:01 a.m. on the date shown in the master application. Policy anniversaries will be 12:01 a.m. each year after the policy effective date. Policies are continuous; renewal dates are for premium information only.

This policy is signed at the Home Office of the Company in New York on the date of issue.

This policy is subject to all of the terms contained in the following pages. All provisions of the New York State Disability Benefits Law are considered a part of this policy, as if the provisions were contained herein, so far as those provisions apply to the disability benefits provided by the policy.

The policyholder may act for or on behalf of any and all employers, subsidiaries and affiliates named in the master application attached to this policy in all matters pertaining to this policy. Any act taken by the policyholder shall be binding on those employers, subsidiaries and affiliates named in the master application.

This policy, any attached riders and endorsements, and the signed master application are the entire contract of insurance. Any statement made in connection therewith by an applicant, policyholder, or insured, absent fraud, will be deemed a representation and not a warranty. No statement made by an insured will reduce benefits or avoid the insurance, unless that statement is contained in a written document, signed by the policyholder or insured and the policyholder or insured is or has been furnished with a copy of the document.

No change or amendment to the terms of this policy will be valid unless it has been approved by the President, a Vice President or the Secretary of the Company and is shown by an endorsement to this policy or is attached hereto. No agent has the authority to change this policy or waive any of its provisions; to accept any premiums in arrears; to extend the due date of any premium; to waive any notice of claim required by this policy; or to extend the date for submission of a notice of claim.

I. ASSIGNMENT BY POLICYHOLDER

This policy shall not be assigned or transferred without the written consent of the President, a Vice President or the Secretary of the Company.

II. CANCELLATION OF THE POLICY

This policy may be cancelled in whole or for any one or more classes of employees for non-payment of premium. Cancellation for non-payment of premium will be effective 10 days after the date stated in a written notice of cancellation provided by the Company to the policyholder, to each employer whose employees will no longer be covered and to the Chairman of the Workers' Compensation Board.

The policyholder must provide written notice at least 20 days prior to any premium due date of any cancellation of coverage for the employees of any one or more subsidiaries or affiliates, effective on the next premium due date. Confirmation of the cancellation notice and date of cancellation will be sent to the policyholder and to each employer whose employees will no longer be covered, as stated above.

Cancellation for any reason other than non-payment of premium shall be effective 31 days after the date stated in a written notice of cancellation provided by the Company to the policyholder or by the policyholder to the Company and at least 31 days after notice of cancellation is filed in the office of the Chairman of the Workers' Compensation Board of the State of New York. Cancellation due to obtaining insurance from another carrier shall be effective as of the effective date of that new insurance, rather than as of the date stated in the cancellation notice.

The policyholder shall be required to pay all unpaid premiums for insurance on employees of a subsidiary or affiliate to the date of cancellation of insurance. Premiums for cancelled insurance shall be adjusted on a pro-rata basis from the last premium date to the date of cancellation.

Coverage of an insured will end on the earliest of:

1. the date this policy is terminated;
2. 10 days after the date stated in the written notice of cancellation sent to the policyholder for failure to pay the premium due; or
3. the date the employee ceases to be eligible for coverage under this policy.

III. PROVISIONS REQUIRED BY STATUTE

An employee who suffers a disabling injury or illness and gives notice to his employer shall be deemed to have given notice to Shelter Point Life. For the purpose of the Disability Benefits Law and this policy, jurisdiction shall be deemed to be New York State. Shelter Point Life shall be bound in all actions pertaining to this policy by the New York State Disability Benefits Law, and the orders, findings or decisions rendered in connection with the payment of benefits under that law and the New York State Insurance Law and Regulations thereunder.

The Chairman of the Workers' Compensation Board of the State of New York shall have the right to enforce any provision of this policy on behalf of an employee entitled to benefits under this policy. Enforcement shall be by filing of a separate application or by making Shelter Point Life a party to the original application. Payment in whole or in part of any benefits by the

policyholder, the subsidiary or affiliate employer or the Company shall be a bar to recovery against the non-paying policyholder, subsidiary or affiliated employer or the Company.

Bankruptcy or insolvency of the policyholder, subsidiary or affiliated employer shall not relieve the company of any of its obligations under this policy.

In accordance with the requirements of the Disability Benefits Law, when this policy is terminated, any excess of the employee contributions applied to the cost of the insurance but not used to pay premiums to the date of termination shall be used by the policyholder only as set forth in Section 216 of the Disability Benefits Law. Rules governing the distribution of these excess employee contributions are set by the Chairman of the Workers' Compensation Board.

All benefits payable under this policy or under any attached rider or endorsement shall be payable in accordance with the provisions of the Disability Benefits Law. Any provision of this policy which is contrary to the Disability Benefits Law shall be null and void as to that provision only; all other provisions shall remain in effect.

IV. INFORMATION REQUIRED FROM POLICYHOLDER

The policyholder will give to the Company all information which the Company may reasonably require with regard to this policy. All documents, books, and records which pertain to this policy shall be open for inspection by the Company at all reasonable times during the continuance of this policy and for 6 years after the final termination of this policy.

V. CLAIM NOTICES

Written notice of a claim must be given to the policyholder or covered subsidiary or affiliated employer and sent to the Company within 30 days after the start of the disability. The notice must contain all information necessary to identify the policyholder, the subsidiary or affiliated employer. The notice must also specify the employee's name and address, and the time, place, circumstances and nature of the disability. No benefits shall be required to be paid for any period more than 2 weeks prior to the date on which required proof of disability is provided to the Company unless it is shown to the satisfaction of the Chair of the Worker's Compensation Board to be not reasonably possible for the insured to have provided proof sooner and such proof was provided as soon as possible. No benefits shall be paid unless the required proof of disability is provided to the Company within 26 weeks of the start of the period of disability.

VI. PREMIUM & PREMIUM RATES

Premiums will be calculated and must be paid on the basis specified in the attached application. The Company will bill for each premium after the initial premium. The policy anniversary date shall be 12 months following the first day of the calendar quarter coinciding with or next following the effective date of this policy. There is a grace period of 31 days from the premium due date for all payments except the initial payment. The policy remains in effect during the

grace period. All premiums due under this policy are to be remitted to the Company by the policyholder.

The Company may establish new premium rates as of the effective date of any amendment to the Disability Benefits Law which affects or alters the Company's obligation under this policy. Any such change will be set forth in a rider to be attached to this policy. The Company reserves the right to change the premium rates after this policy has been in effect for 12 calendar months, or on any premium due date thereafter, by notifying the policyholder in writing at least 31 days in advance of the date the rate change becomes effective. If the policyholder does not pay the new premium, this policy will automatically terminate for non-payment 31 days after the due date of the first premium payment reflecting the rate change.

VII. STATUTORY ASSESSMENTS

The Company will pay any assessments levied on the total payrolls of employees covered under this policy pursuant to Sections 214-2, 214-3 and 228 of the Disability Benefits Law of New York.

VIII. EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Each employee eligible for insurance under this policy shall become insured as of the date of his eligibility to be placed in a class of employees. An employee who returns to work for the same employer/Policyholder after an agreed and specified leave of absence or unpaid vacation shall become eligible for benefits immediately upon return to work.

Richard White
Chief Executive Officer

ENRICHED BENEFITS RIDER
Additional Excess Disability Benefits Coverage Only

Effective 10/01/2006, Policy Number DBL260818, to which this Rider is attached, is hereby amended by adding the following:

Enriched Benefits: Increased benefits are provided to all covered employees upon proof of disability pursuant to policy provisions as follows:

50% of the employee's current salary up to a maximum benefits of 1.50 times the statutory disability benefits law weekly benefit for a maximum of $410 per week for the earlier of duration of the disability or 26 weeks. The enriched benefit includes the statutory benefit

available to the insured employee pursuant to the requirements of the New York State Disability Benefits Law.

All other terms and conditions of the policy remain the same.

Richard White
Chief Executive Officer

THE HARTFORD

Exhibit VI

Group Life Insurance

Basic Employee Life and AD&D

Class Description(s):
Class 2: All Full-time Active Employees who are Active Members working 1,000- 1,399 hours or more in the previous calendar year
Full Time Eligibility: 30 hours per week

Feature	Description
BENEFIT SCHEDULE	Class 2 - Flat $20,000
GUARANTEED ISSUE	Equal to Benefit Amount
BENEFIT REDUCTION SCHEDULE	Class 2 - 50% @ 70
CONTINUITY OF COVERAGE	None
LIFE DISABILITY PROVISION	Class 2 - Premium Waiver to Normal Retirement Age if Disabled Prior to 60
PREMIUM WAIVER ELIMINATION PERIOD	Class 2 - 9 Months
LIVING BENEFIT OPTION (ACCELERATED BENEFIT)	Class 2 - 12 Months Life Expectancy, 80% of Benefit (Total Basic and/or Supplemental Acceleration may never

	exceed $500,000)
LIFE PORTABILITY OPTION	Not Included
CONVERSION	Included
MILITARY LEAVE OF ABSENCE CONTINUATION	Class 2 - 12 Weeks
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Class 2 - Matches Basic Life Benefit
EMPLOYEE CONTRIBUTION	Non-Contributory
PARTICIPATION REQUIREMENT	100% of Eligible Employees
INITIAL RATE GUARANTEE PERIOD	2 Years

CLAIMS AND APPEALS PROCEDURE

As previously stated, various welfare coverage is provided to you by the Trust Fund through third party providers. For claims relating to services of these third party providers of which they have advised you, the third party providers are required by ERISA to advise you of these procedures. If you require further information, please contact the Fund office or your certificate of coverage provided to you by Aetna.

For purposes of the Plan and services undertaken directly by the Plan, a claim for a benefit is a written application, submitted on an appropriate Fund form, for benefit filed with the Plan. This written application must be made to the Trust Fund even though the original claim, which was denied, for the benefit was not in writing. You can appoint an authorized representative to act on your behalf in filing a claim. You must, however, notify the Fund office in advance in writing of the name, address, and phone number of the authorized representative.

- In the event that any Participant or other person claims to be entitled to services provided directly by the Plan, and the Plan determines that such claim should be denied in whole or in part, the Plan shall, in writing, notify such claimant within 60 days of receipt of such claim that his claim has been denied in whole or in part, setting forth the specific reasons for such denial. Expedited review is required by ERISA, subject to different regulations, for urgent care claims and pre-service claims.

Such notification shall provide:

- The specific reason for denial.
- The Plan provision(s) upon which the decision is based.
- What additional material or information you need to provide to process your application and an explanation of why the material or information is needed.
- What procedures you need to follow to get your application reviewed and any applicable time frames.
- A statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Upon request and free of charge, you or your duly authorized representative will be allowed to review relevant documents and submit issues and comments to the Fund office in writing. A document, record or other information is "relevant" and is required to be made available to you only if:

- It was relied upon by the plan administrator in making the benefit determination.
- It was submitted, considered or generated in the course of making the benefit determination.
- It demonstrates compliance with the Plan's administrative processes and safeguards required under federal law.

You can appoint an authorized representative to act on your behalf in appealing a claim. You must, however, notify the Fund office in advance in writing of the name, address and phone number of the authorized representative.

Within 180 days after the mailing or delivery by the Plan of a notice denying a claim, such claimant may request, by mailing or delivery of a written notice to the Trustees, a review by the Trustees. If the claimant fails to request such a review within a 180 day period, it shall be conclusively determined for all purposes of this Plan that the denial of such a claim by the Plan is correct, binding and conclusive. If a review is requested, the Participant or other person shall have 30 days after filing a request for review to submit additional written material in support of the claim. After such review, the Trustees shall determine whether such denial of the claim was correct and shall notify such claimant in writing of its determination.

Such notification shall provide:

- The specific reason for the denial.
- The Plan provision(s) upon which the decision is based.
- A statement that upon request and free of charge, you or your duly authorized representative will be allowed to review relevant documents.
- A statement of your right to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If such determination is favorable to the claimant, it shall be binding and conclusive. If such determination is adverse to the claimant, it shall be binding and conclusive unless the claimant notifies the Trustees within 90 days after the mailing or delivery to him/her by the Trustees of its determination that he/she intends to institute legal proceedings challenging the determination of the Trustees, and actually institutes such legal proceedings within 180 days after such mailing or delivery.

No interest shall be payable with respect to any favorable determination or reward regarding a claim for benefit under the Plan.

COBRA RULES GOVERNING VOLUNTARY SELF PAYMENTS

(Consolidated Omnibus Budget Reconciliation Act of 1986)

Under the federal law known as "COBRA", you are eligible to continue Trust (Health and Vision) coverage for you and your family dependents at your own expense (direct pay) after you cease to be otherwise eligible for welfare coverage. The number of months for which you are eligible for COBRA coverage can vary between 18 and 36 months, depending on the Qualifying Event.

Qualifying Event	Entitlement
If the Participant was terminated or merely worked too few hours to otherwise qualify for welfare coverage	18 months
If the Participant is disabled at the time welfare coverage would otherwise have ended	18 months with an 11 month extension available
If the Participant dies, becomes divorced, legally separated, eligible for Medicare while on COBRA, or a child ceases to be a dependent due to age or student status★	36 months

★ **NOTE:** It is the responsibility of the Participant or another family member to inform the Fund office of a divorce, legal separation or a child losing dependent status under this Plan NOT MORE THAN 30 DAYS after this Qualifying Event in order for the Participant and/or his/her family to be eligible for continued coverage.

Notification and Filings:

- In the event the employee coverage is scheduled to be terminated for any reason other than gross misconduct, he will be notified as to his right to make direct payment to continue his benefits of coverage. In all other cases, he or a family member are responsible for giving notice to the plan administrator of any divorce, legal separation or change in a dependent child status (attainment of maximum age, change in student classification, etc.) which results in a loss of benefit coverage. Under the law, the employee or one of his family members have up to 60 days to file an election with the plan administrator for continuation of benefits of coverage on a direct payment basis and another 45 days to pay the required premium.

Termination of Benefits:

- The benefits coverage will automatically cease if:
  - Self-payments are not received when due.
  - The employee or any of his dependents become covered under another Group Health Plan (including Medicare)
  - A divorced spouse or widow remarries and becomes covered under another Group Health Plan.

Benefit Coverage:

- There will be no continuation of the Employee Weekly Disability Benefits or Life Insurance and Accidental Dismemberment benefits under COBRA. COBRA must be retroactive to the date that coverage would otherwise have terminated.

- The amount of the direct payment will be based on the group rate as determined by the Fund's actuary. These costs may change from time to time, based on the actual claim experience of the group. In any event, the amount of the monthly direct payment required to maintain the health benefits will be furnished upon request. Annually, the Fund office establishes the COBRA rates pursuant to statue, which rates are directly related to the actual cost of your coverage.

COORDINATION OF BENEFITS

This Coordination of Benefits section sets out rules for the order of payment of covered charges when two or more plans including Medicare are paying. When a covered person is covered by this Plan and another plan, or the covered person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plans involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula. The total reimbursement will never be more than the secondary (or subsequent) plan's formula, 50% or 80% or 100%, whatever it may be. The balance due, if any, is the responsibility of the covered person.

Benefit Plan:

- The provision will coordinate the medical and dental benefits of a benefit plan. The term "benefit plan" means this Plan or any one of the following plans:
    1. Group or blanket benefit plans.
    2. Group practice and other group repayment plans.
    3. Federal government plans or programs, including Medicare.
    4. Other plans required or provided by law. This does not include Medicaid or any benefit plan similar to it, by its terms, does not allow coordination.
    5. No fault auto insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge:

- For a charge to be allowable, it must be a usual and reasonable charge and at least part of it must be covered under this Plan.
- In the case of Extended Provider Organization ("EPO") plans, this Plan will not consider any charges in excess of what an EPO provider has agreed to accept as payment in full. Also, when an EPO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the EPO had the covered person used the service of an EPO provider.
- In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations:

- This Plan shall always be considered the secondary carrier regardless of the individual's election under Personal Injury Protection ("PIP") coverage with the auto carrier.

Benefit Plan Payment Order:

- When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:
    1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits by these rules up to the allowable charge:
    A. The benefit plan that covers the patient as an employee or member will be considered before a benefit plan that covers the patient as a dependent.
    B. The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as laid off or an eligible retiree. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule does not apply.

- <u>Dependent children of parents not separated or divorced:</u>
    1. Birthday: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered the parent longer pays first. The plan that covered the other parent for a shorter time pays second. A person's year of birth is not relevant in applying this rule.
    2. The Transition Rule: This provides that if one coordinating plan uses the birthday rule and the other uses the male/female rule, both plans will follow the birthday rule.

- <u>Dependent children of parents who are divorced or separated:</u>
    1. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody. This rule applies when the parent with custody of the child has not remarried.
    2. The benefit plan of the parent with custody will be considered first. The benefit plan of the step parent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last. This rule applies when the parent with custody of the child has been remarried.
    3. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent. This rule will be in place of items (1) and (2) above when it applies.
    4. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated.

- If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

- Medicare will pay last to the extent stated in federal law. When Medicare pays first, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

- Claims Determination Period:
  Benefits will be coordinated on a calendar year basis. This is called the "claims determination period."

- Right to Receive or Release Necessary Information:
  To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A covered person will give this Plan the information it asks for about other plans and their payment of allowable charges.

- Facility of Payment:
  This Plan may repay other plans for benefits paid that the plan administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

- Use and Disclosure of PHI:
  The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. As relates to the Trust Fund, the term "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

- "Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to the following:
  1. Determination of eligibility, coverage and cost sharing amounts (e.g. cost of a benefit, Plan maximums and co-payments as determined for an individual's claim).
  2. Coordination of benefits.
  3. Adjudication of health benefit claims (including appeals and other payment disputes).
  4. Subrogation of health benefit claims.
  5. Establishing employee contributions or partial payments.
  6. Risk adjusting amounts due based on enrollee health status and demographic characteristics.
  7. Billing, collection activities and related health care data processing.
  8. Claims management and related health care data processing, including accounting auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments.
  9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
  10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges.
  11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review.
  12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, SSN, payment history, account number and name and address of the provider and or health plan).
  13. Reimbursement to the Plan.

Health care operations include but are not limited to, the following activities:

1. Quality assessment.
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of

health care providers and patients with information about treatment alternatives and related functions.

3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities.
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).
5. Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs.
6. Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.
7. Business management and general administrative activities of the entity, including but not limited to:
    A. Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification.
    B. Customer service, including the provision of data analyses for policy holders, plan sponsors or other customers.
    C. Resolution of internal grievances.
    D. Due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest is a covered entity or, following completion of the sale or transfer will become a covered entity.
8. Compliance with and preparation of all documents as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to other plans to which information may be disclosed, including pension plan, disability plan, reciprocal benefit plans, worker's compensation insurers, etc. for purposes related to administration of these plans.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to other plans to which information may be disclosed, including any pension plan, disability plan, reciprocal benefit plan, worker's compensation insurers, etc. for purposes related to administration of these plans.

With respect to PHI, the Trust plan sponsor and representative Board of Trustees agree to:

1. Not use or further disclose the information other than as permitted or required by the Plan document or as required by law.
2. Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information.
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual.
4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by the individual.
5. Make PHI available to the individual in accordance with the access requirements of HIPAA.

6. Make PHI available for amendment and incorporate any amendments to PHI, but only to the extent as legally required.
7. Make available the information required to provide an accounting of disclosures.
8. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the secretary of HHS for the purposes of determining compliance by the Plan with HIPAA.
9. If feasible, return or destroy all PHI received from the Plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the plan sponsor and representative Board of Trustees must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The plan administrator
- Staff designated by the plan administrator who are designated in the course of their everyday activities to conduct the work and affairs and business of the Trust Fund. As well, the consultants and business associates are designated who in the ordinary course of their business regarding the function of the Trust Fund are required to render assistance relating to health care treatment, payment for health care and health care operations.

The persons described above may only have access to and use and disclose PHI for plan administration functions that the plan sponsor and representative Board of Trustees perform for the Plan.

If the persons described above do not comply with terms set forth in this booklet, the plan sponsor and representative Board of Trustees shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

We are pleased to state that this Plan is in compliance with the Woman's Health and Cancer Rights Act of 1998, which amends existing federal law (ERISA and the Public Health Service Act). The act requires health insurance carriers of group and individual policies that cover mastectomies to also cover reconstructive surgery or related services following a mastectomy.

Essentially, the act guarantees coverage to any Plan member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy. The health insurance company that issues the policy is now required to provide coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed.
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
C. Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The law specifically states that these services may be subject to annual deductibles and coinsurance under the Plan's normal terms. Such coverage must be provided in a manner determined in consultation with the attending physician and the patient.

A patient may not be denied eligibility (or continued eligibility) to enroll or to renew coverage under the terms of the Plan solely for the purpose of avoiding the requirements of this section. Further, a provider may not be given incentives or penalized to induce such provider to provide care inconsistent with this section.

NOTE: This law requires that Participants be notified of this coverage in the next available communication, but no later than January 1, 1999, and annually thereafter. However, for those plans that already meet the requirements of this act and offer the benefits it mandates, the notice requirement is relaxed.

FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")

You may be entitled to health coverage required by the FMLA if you take family or medical leave.

The FMLA requires that unpaid leave from work must be granted for up to twelve (12) weeks for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care.
- To care for the employee's spouse, son or daughter, or parent who has a serious health condition.
- For a serious health condition that makes the employee unable to perform the employee's job.

Pursuant to the FMLA, an employer must maintain group health benefits that an employee was receiving at the time leave begins during periods of FMLA leave, at the same level and in the same manner as if the employee had continued to work. Under most circumstances, an employee may elect, or the employer may require the use of any accrued paid leave (vacation, sick, personal, etc.) for periods of unpaid FMLA leave. FMLA leave may be taken in blocks of time less than the full twelve (12) weeks on an intermitted or reduced leave basis. Taking of intermitted leave for the birth, placement or adoption or foster care of a child must be approved by the employer.

You may be liable for the employee share of group health premiums during leave.

Please inquire with the Fund office regarding your continuing Plan coverage during this twelve (12) week period.

FEDERAL MENTAL HEALTH PARITY ACT

The Federal Mental Health Parity Act went into effect on January 1998. Under the new law, a health plan cannot impose an annual or lifetime dollar limit on mental health benefits if dollar limits do not exist for medical and surgical benefits.

For example, the law does not allow a health plan to limit a member's mental health benefits to $1,000 per year if the plan does not place a dollar limit on medical or surgical benefits. A health plan may continue, however, to limit the number of mental health visits per year.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

HIPAA defines permissible pre-existing condition limitations for employees and their dependents when an employee changes employers and that new employer is not an employer under this Plan.

To this end, HIPAA mandates that a new health plan must credit coverage provided under the old health plan toward any pre-existing condition requirements. Therefore, the law requires that employers provide qualified beneficiaries with HIPAA certificates. These certificates verify the individual's most recent period of coverage with the employer/carrier. Not all plans have a pre-existing condition limitation. Please refer to your Certificate of Coverage for details.

HIPAA certificates must be provided to all qualified beneficiaries at the following times:

- When coverage is terminated, whether or not there is COBRA continuation.
- When coverage ends under COBRA (or similar state continuation provisions).
- At an individual's request within twenty-four (24) months of his or her loss of coverage.

ADDITIONAL PROVISIONS OF THE PLAN

A. Incorporation of all Previous Substantive Provisions

- All of the previous substantive provisions are incorporated into and are part of the Plan.

B. Administration of the Plan

- Responsibility of Trustees: The Trustees shall have the authority and responsibility for the management and administration of the Plan and shall be considered the "named fiduciary" for the Plan within the meaning of Section 402(a) of ERISA.

- Maintenance of Records: The Trustees shall keep a record of the hours worked of each employee (as reported by, or otherwise obtained from, an employer) and shall maintain accounts showing the fiscal transactions of the Plan.

- Reliance by Trustees: The Trustees may rely upon all certificates and reports made by an accountant designated or otherwise authorized by the Trustees, upon all opinions given by legal counsel and investment consultants selected by the Trustees, upon all tables, valuations, certificates and reports furnished by an actuary engaged by or otherwise authorized by the Trustees; upon medical opinion submitted by a doctor acceptable to the Trustees and shall be fully protected in respect of any action taken or suffered by them in good faith in reliance upon any accountant, counsel, actuary or doctor and such action shall be conclusive upon employees, employers, Participants and others having anything to do with the Trustees, the Plan or the Fund.

- Indemnification: Except as otherwise provided by applicable law, the Plan shall identify and save harmless each member of the Board of Trustees against any cost or expense (including attorney's fees and disbursements) or liability arising out of any act or omission to act as a Trustee except for any liability arising out of a Trustee's own gross and wanton negligence or willful misconduct.

- Powers and Duties of Trustees: In addition to the foregoing and the powers granted in the Trust Agreement, the Trustees shall have the following additional powers and duties:
    1. To establish a welfare benefit policy and method as well as specific benefits and to meet as necessary to review such funding for the policy and method and specific benefits.
    2. To authorize specifically by a resolution in writing the allocation of their collective responsibilities for the operation and administration of the Plan to one or more Trustees acting as a committee, provided that the resolution creating such committee shall specify its powers and purposes. If the Trustees have allocated specific responsibilities, obligations or duties among the Trustees, a Trustee to whom certain responsibilities, obligations or duties have not been allocated shall not be liable wither individually or as a Trustee for any loss resulting to the Plan arising from the acts or omissions on the part of

another Trustee to whom such responsibilities, obligations or duties have been allocated.

3. To amend, modify, terminate and interpret in their discretion the Plan, benefits as provided by the Plan and governing rules and regulations.
4. To withdraw monies from the Trust Fund by means of checks, drafts, vouchers or other withdrawals signed by designated Trustees. The Trustees may be reimbursed or receive advances for all reasonable and necessary expense of any suit or proceeding brought by or against the Trustees (including attorney's fees and disbursements) shall be paid from the Trust Fund as incurred to the extent then permitted by applicable law.
5. To authorize any person or group of persons to serve in more than one capacity (fiduciary or otherwise) with respect to the Plan (including service both as Trustee and plan administrator).
6. To allocate fiduciary responsibilities, other than Trustee responsibilities, among Trustees.
7. To designate persons other than Trustees to carry out responsibilities, fiduciary or otherwise (other than Trustee responsibilities) under the Plan.
8. To employ one or more persons to render advice with regard to any responsibility such Trustee has under the Plan, including legal, accounting and actuarial advice and services.
9. To appoint one or more investment managers (as defined in Section 3(38) of ERISA) who shall be responsible for the management, acquisition, disposition, investing and reinvesting of such of the assets of Fund as the Trustees may specify. If an investment manager or managers or investment service provider have been appointed by the Trustees, no Trustee shall be liable for the acts or omissions of such manager or managers, or be under any obligation to invest or otherwise manage any asset of the Plan which is subject to the management of such investment manager.
10. To purchase insurance out of Trust Fund assets for the Trustees and the Plan, which insurance shall cover liability or losses occurring by reasons of the act or an omission of a Trustee, to the fullest extent permitted by applicable law.

- Requirement to File Coverage Application Form: Any other provision of the Plan notwithstanding, those eligible for coverage, other than disability benefit or death benefit coverage, will only receive coverage for those eligibility periods subsequent to the submission of the eligible active or eligible retiree application form, listing claimed Eligible Dependents, claiming eligibility for coverage.

- Action of Trustees: The Trustees shall be the sole judges of the standard of proof required in any matter relating to the Plan, or any case or appeal relating to the Plan and the application and interpretation of this Plan and the decisions of the Trustees shall be determined by their discretionary powers and shall be final and binding on all parties. Benefits or services under this Plan will be paid or provided only if the plan administrator decides in his discretion that the applicant is entitled to them. In keeping

with their position as sole judge, but not being arbitrary or capricious, wherever in the plan the Trustees are given discretionary powers, they shall exercise such powers in a uniform and non-discriminatory manner. The Plan shall process a claim for benefits as speedily as is feasible, consistent with the need for adequate information and proof necessary to establish the claimant's benefit rights and to commence the payment of benefits.

C. Merger, Amendment and Termination

- Merger, Amendment: The Trustees in their sole discretion shall have the right to merge, amend, alter or modify the Plan at any time, or from time to time, in whole or in part. Any such amendment shall become effective under its terms upon adoption by the Trustees. However, no amendment shall be made to the Plan which shall:
    1. Make it possible for any part of the corpus or income of the Fund (other than such part as may be required to pay taxes and administrative expenses) to be used for or diverted to purposes other than the exclusive benefit of the Participants or their beneficiaries.
    2. Notwithstanding any provision of this section or any other provisions of the Plan, any amendment or modification of the Plan may be made and applied retroactively if necessary or appropriate to conform to or to satisfy the condition of any law, government regulation, or ruling and to meet the requirements of ERISA, as it may be amended.

- Termination of the Plan:
  The Trustees reserve the right at any time and in their sole discretion to discontinue payments under the Plan and to terminate the Plan in accordance with applicable provisions of law.

  In the event of termination of the Plan, the assets of the Plan will be used towards payment of obligations of the Plan and any remaining surplus will be distributed in the manner determined by the plan administrator to best effectuate the purposes of the Plan in accordance with the applicable regulations under ERISA.

  Upon proper termination of the Fund, the Trustees shall be discharged from all obligations under the Plan and no Participant or beneficiary shall have any further right or claim therein.

D. Miscellaneous

- Uniform Administration: Whenever in the administration of the Plan, any action is required by the Trustees or other persons administering the Plan, including but not by way of limitation, action with respect to eligibility or classification of employees, Participants or benefits, such action shall be uniform in nature as applied to all persons similarly situated.

- Payment due an Incompetent or Incapacitated Person: If the Trustees determine that any person to whom a payment is due under the Plan is incompetent or incapacitated

by reason of physical or mental disability, the Trustees shall have the power to cause the payments becoming due to such person to be made to the person or institution maintaining or having custody of such person, without responsibility of the Trustees to see to the application of such payment. Payments made pursuant to such power shall operate as a complete discharge of any and all liability on the part of the Trustees and the Plan.

- Identity of Payee: The determination of the Trustees as to the identity of the proper payee of any benefit under the Plan and the amount of such benefit properly payable shall be conclusive and payment in accordance with such determination shall constitute a complete discharge of all obligations on account of such benefit.

- Source of Payment, Plan does not Affect Employment: All liabilities under this Plan shall be satisfied, if at all, only out of the Fund held by the Trustees. All benefits shall be paid or provided solely from the Fund and the Trustees do not assume any liability or responsibility therefore, except to the extent required by applicable law. Participation in the Plan shall not give any Participant any right to be retained in the employ of the employer.

- Non-alienation of Benefits: No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge the same shall be void; nor shall any such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefits; except as specifically provided in the Plan. Notwithstanding the foregoing, the creation, assignment or recognition of a right to any benefit payable with respect to a Participant pursuant to a "qualified domestic relations order" shall not be treated as an assignment or alienation prohibited by this section.

- No Reversion of Fund Assets: In no event shall any of the corpus or assets of the Fund revert to any employer or be subject to any claims of any kind or nature by the employers except for return of an erroneous contribution within the time limits prescribed by law.

- Location of Participant or Beneficiary Unknown: In the event that all or any portion of the distribution payable to a Participant or to a Participant's beneficiary hereunder shall, at the expiration of three (3) years after it shall become payable, remain unpaid solely by reason of the inability of the Trustees to ascertain the whereabouts of such Participant or beneficiary, after sending a registered letter, return receipt requested, to the last known address, and after further diligent effort, the amount so distributable shall be used to pay Plan expenses. A Participant or beneficiary shall be entitled to no interest or accretion beyond the previous benefit amount.

- Participant Fraud: If a Participant engages in fraud against the Trust Fund, the Trustees have the right to provide further trust benefits and take such other actions which are necessary to protect the assets of the Trust Fund.

- Effective Date, Governing Documents - Restated Plan: This restatement of the Plan governs the right to the payment of benefits arising after the effective date of this Plan. A Participant's rights shall be determined under the terms of the Plan as in effect as of the date the Participant first became entitled to receive the benefits. This restatement of the Plan shall become effective on January 1, 2016.

- Headings: The article headings and section numbers or other headings are included solely for ease of reference. If there is any conflict between such headings or numbers and the text of the Plan, the text shall control.

- Applicable Law: Except to the extent governed by federal law, the Plan shall be administered and interpreted in accordance with the law of the State of New York.

- Counterparts: This Plan may be executed in any number of counterparts, each of which shall be deemed an original; said counterparts shall constitute but one and the same instrument, which may be sufficiently evidenced by any one counterpart.

DEFINITIONS

These definitions apply when the following terms are used in this booklet.

Affordable Care Act
The term "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

COBRA
The term "COBRA" means Title X of the Consolidated Omnibus Reconciliation Act of 1985, as amended.

Eligible Dependent
The term "Eligible Dependent" means an individual described under the heading **"Coverage for Eligible Dependents"** on page 14 of this booklet.

Joint and Survivor Annuity
The term "Joint and Survivor Annuity" means a lifetime pension described under Article V of the Cement Masons' Local 780 Pension Plan, as amended and restated.

Medicaid
The term "Medicaid" means the Medical Assistant program under Title XIX of the Social Security Act.

Medicare
The term "Medicare" means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Participant
The term "Participant" means an individual described under the heading **"Participants"** on page 14 of this booklet.

Qualified Medical Child Support Order
The term "Qualified Medical Child Support Order" ("QMCSO") means a medical child support order as defined in clause (B) of 29 U.S. Code §1169(a)(2) that meets the requirements of clause (A) of that provision, i.e., §1169(a)(2).

Upon receipt of a medical child support order, the plan administrator shall follow these procedures:

(a) The plan administrator shall promptly notify in writing the Participant, each alternative recipient covered by the order, and each representative for these parties of the receipt of the medical child support order. Such notice shall include a copy of the order and these QMSCO procedures for determining whether such order is a QMSCO.

(b) The plan administrator shall permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order.

(c) The plan administrator shall, within a reasonable period after receiving a medical child support order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.

(d) The plan administrator shall ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the SPD and any subsequent Plan amendments.

Qualifying Event

The term "Qualifying Event" means an event described under the heading **"COBRA Rules Governing Voluntary Self Payments"** on page 54 of this booklet.

Summary Plan Description

The term "Summary Plan Description" ("SPD") means a summary of the Plan provisions and how the Plan operates.

Trust Agreement

The term "Trust Agreement" means the Agreement and Declaration of Trust establishing the Cement Masons' Local 780 Trust Fund, as amended.

Trustees/Board of Trustees

The term "Employer Trustees" means the Trustees appointed by the employers. The term "Union Trustees" means the Trustees appointed by the executive board of the Union. The term "Trustees" or "Board of Trustees" means the Employer Trustees and Union Trustees collectively and includes their successors when acting as Trustees.