CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL

WELFARE FUND

PLAN

And

SUMMARY PLAN DESCRIPTION

THE EFFECTIVE DATE OF THIS PLAN IS JANUARY 1, 2013

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CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL
WELFARE FUND
35-30 Francis Lewis Blvd., Suite 201
Flushing, New York 11358
(718) 762-6133

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INTRODUCTORY LETTER TO THE PLAN AND SUMMARY PLAN

CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL
WELFARE FUND
35-30 Francis Lewis Blvd., Suite 201
Flushing, New York 11358
(718) 762-6133
Fax (718) 762-5144

To All Participants:

We are pleased to present you with this updated booklet of the Benefits provided by the Cement and Concrete Workers District Council Welfare Fund. The Welfare Fund and Plan is funded through a Collective Bargaining Agreement based upon contributions from obligated employers for per hour of Covered Employment work. You can obtain a copy of the 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 as a Trust by the Cement and Concrete Workers District Council and the Cement League.

The Trustees believe that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the 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 to certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. This plan is in full compliance with the requirements of the Affordable Care Act.

This booklet is the summary plan and plan for the Welfare Fund. 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 many of the Benefits apply to them also.

Your health coverage is not a vested benefit and is subject, in whole in part, to being modified, changed or even eliminated by determination of the Trustees pursuant to law. To make this information as clear as possible, this booklet has been written in everyday, straightforward language. Please read this booklet carefully and keep it in a safe place for easy reference. If you have any questions about any of the material contained in this booklet, please call the Fund Office at (718) 762-6133 during regular business hours. The Funds are open Monday through Friday from 8:00 AM to 3:30 PM.

Sincerely,

THE BOARD OF TRUSTEES

IMPORTANT TO REMEMBER

- Save this booklet. Put it in a safe place. If you lost your copy, you can ask the Fund Office for another (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.

- 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 and also must have, previous to any period for which you are claiming benefits, submitted an application to the Fund claiming that eligibility. There is a sample application form for eligible actives and eligible retirees on page 14. If your benefits are terminated, you must submit a new application. If you retire and are eligible for Eligible Retiree coverage, you must first file an application for this coverage previous to any period for which you claim this coverage. The application form will establish rights to eligibility. Once eligible, claim forms must be submitted for any claim.

- Claim forms in writing must be submitted in writing to the Welfare Fund Office within a reasonable period of time, but not to exceed 90 days from the date of termination of the period of disability or hospital confinement, the date a surgical operation is performed, the date doctor's in hospital, home, or office calls are made, the date of laboratory or diagnostic testing examination, the date expenses are incurred for prescription eyeglasses, prescription drugs, hearing, equipment and expense benefits and not to exceed 180 days from the date a dental expense is incurred (or thirty days after disability has commenced). If the payment forms are not submitted within this specified time, the Fund has the right to refuse and deny payment and you will be fully responsible for the payment.

- Denial, Right of Appeal: If your claim is denied, you must have a written claim and have submitted this claim in writing to the Welfare Fund. Upon the Welfare Funds' denial of a written claim, you have a right to appeal the denial to the Trustees in strict compliance with the Plan. *For further details, please see pg. 81-82.*

- COBRA options are available under this plan.

- If a change occurs in your marital status or dependent status (for example: birth, adoption of child), please notify the Fund Office immediately.

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

- Your spouse is your automatic Death Benefit beneficiary, unless your spouse waives the entitlement on the appropriate forms. Be sure to request from the

Fund Office and file the appropriate form designating your beneficiary and file these forms with the Fund Office.

- At least annually, the Fund Office will provide you with a statement 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.

- 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 and Concrete Worker is a signed, contributing employer and does not become delinquent in the submission of your Benefit contributions.

- Eligible Retirees and eligible dependents of age 65 or older and Eligible Disability Retirees under 65 years of age must submit a copy of their Medicare Health Insurance Card to the Welfare Fund Office in order to be eligible for benefits under this Plan except for those benefits which are additional for Medicare recipients.

- 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).

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

- 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 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 plans of insurance. To avoid duplication of payment and coordinate who pays first, benefits under the Plan will be coordinated with all other types of plans you or your dependents might be insured under so that the total amount payable under all plans will not exceed 100% of your medical expenses incurred. *For further details, please see pg. 85.*

- Right of Recovery: This Plan 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 this Plan may recover by lawsuit or otherwise the amount paid from the other benefit plan or the Covered Person. *For further details, please see pg. 88.*

- 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 must 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 responsible for repayment if you receive payment from the third party. *For further details, please see pg. 89.*

- Welfare Fund Cost Reduction Providers: The Welfare Fund has a number of coverage programs to reduce the costs of coverage provided. If these programs are applicable to your situation and you benefit from them, effectively you receive greater benefits. *For further details, please see pg. 79-80.*

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

ERISA INFORMATION AND RIGHTS STATEMENT

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

PLAN NUMBER: 501

E.I.N. 13-5542693

TYPE OF PLAN: HEALTH AND WELFARE

PLAN ADMINISTRATOR: BOARD OF TRUSTEES
ADDRESS: 35-30 Francis Lewis Blvd., Suite 201
Flushing, NY 11358
(718) 762-6133

FISCAL YEAR

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

LEGAL PROCESS

CEMENT AND CONCRETE WORKERS DISTRICT COUNCIL WELFARE FUND is authorized to receive legal process, by its trustees listed above, at 35-30 Francis Lewis Blvd., Suite 201, Flushing, NY 11358. The telephone number at this office is (718) 762-6133.

FUND FINANCED

The Fund is financed by Employer Contributions and Contributions made by participants in certain cases (i.e. COBRA continuation coverage).

ERISA NOTICE
INFORMATION AND ASSISTANCE AVAILABLE TO YOU

Your ERISA Rights

As a participant in the Cement and Concrete Workers District Council Welfare Fund's 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:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising you rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of a reason beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 federal court.

The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor:

WASHINGTON, D.C. OFFICE:

U.S. Department of Labor, Pension and Welfare Benefits Administration
200 Constitution Avenue, N.W.
Washington, DC 20210

E-mail Address: Webmaster@dol.gov
Internet Address: http://www.dol.gov

NEW YORK CITY OFFICE:

U.S. Department of Labor, Pension and Welfare Benefits Administration
33 Whitehall Street,
Ste. 1200
New York, NY 10004

Regional Director: Jonathan Kay
(212) 607-8686

APPLICATION FOR WELFARE FUND BENEFIT ELIGIBILITY

Any other provision of the Plan and Summary 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 Application For Welfare Fund Benefits, listing claimed Eligible Dependents, claiming eligibility for coverage. If there are changes in your eligibility or individuals for whom you claim or are entitled to coverage, you must submit a new Application For Welfare Fund Benefits. The Fund will determine if you or your claimed dependents are eligible for coverage. You will not be entitled to payments of any claim incurred at a time previous to your submission of the Application For Welfare Fund Benefits that establishes your coverage. This provision is effective September 1, 2002.

The Application For Welfare Fund Benefits is on following two pages. You can copy these forms or call the Fund office at (718) 762-6133 and request they send the appropriate form to you. The completed application form should be sent to the Fund Office:

Cement and Concrete Workers Welfare Fund
35-30 Francis Lewis Blvd., Suite 201
Flushing, New York 11358

Application for Welfare Fund Benefit Eligibility

In submitting any claim for payment, I agree that claims shall be submitted honestly in accordance with the terms of the plan, including its coordination and subrogation provisions.

Member's signature _____ Date_____

Spouse's signature _____ Date_____

Please provide the following information on self, spouse and each of your dependents and provide the funds with a copy of marriage certificate, birth certificate, legal adoption papers.

Member's name: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

_____

Spouse's information (please submit copy of marriage certificate)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

Dependent information (please submit copy of birth certificate or legal adoption papers)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

Date _____

Dependent information (please submit copy of birth certificate or legal adoption paper)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

Dependent information (please submit copy of birth certificate or legal adoption paper)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

Dependent information (please submit copy of birth certificate or legal adoption paper)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

Dependent information (please submit copy of birth certificate or legal adoption paper)

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other Insurance: _____

ELIGIBILITY AND DEFINITIONS

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INTRODUCTION

Benefits are available only for individuals who fall into one or more of the following categories.

(a) Active Employees

(b) Eligible Retirees
Falling into 2 categories:
(i) Eligible Retirees age 65 and over
(ii) Eligible Retirees age 64 and under

(c) Eligible Dependents
Falling into 2 categories:
(i) Eligible Dependents age 65 and over
(ii) Eligible Dependents age 64 and under

(d) Participants
This category includes overlapping categories - Active Employees, Eligible Retirees, and 2 additional categories:
(i) Participants Eligible for a Death Benefit
(ii) Participants Eligible for Disability Benefits

(e) COBRA Enrollees

The definition for each benefit classification applicable to individuals establishing the eligibility requirements for benefits is presented hereunder and defined by the definitions that follow, with the exception of COBRA, for which the specifics are included in the section COBRA – RULES GOVERNING VOLUNTARY SELF PAYMENTS, see page 83.

The benefits available for an individual who fulfills the eligibility requirements of a given benefit classification are briefly summarized under each benefit classification in the section BENEFIT HIGHLIGHTS, see pages 27 - 40, and identified and explained in the section BENEFITS, see pages 42 - 76 and DEATH BENEFITS, see page 77 – 78.

"Active Employees"

The term "Active Employee" is used to designate a Participant who is eligible for certain benefits because of satisfying the criteria of "(a)", "(b)" or "(c)" as follows:

(a) If the Employee does not have coverage on the day when the Employee acquires 1,000 Hours of Credit in covered employment within 12 consecutive months or less, coverage shall start immediately on that day and continue until the first day of a month following twelve (12) consecutive months in which he earned at least 1,000 Hours of Credit.

(b) *Either** of the following:

(i) Once an Employee has coverage, the Employee will earn eligibility for a period of six months beginning with the first day of a month following six (6) consecutive months in which he earned at least 500 Hours of Credit; or

(ii) Once an Employee has coverage, the Employee will earn eligibility for a period of twelve months beginning with the first day of a month following twelve (12) consecutive months in which he earned at least 1,000 hours of credit.

***** You may qualify for eligibility under both *(i) and (ii)*, however this <u>would not</u> entitle you to any additional eligibility. In other words, you can in no event acquire eligibility for more than twelve months based upon hours worked within a twelve month period.

(c) As an alternative for those participants who are not eligible under the existing 1,000 hour requirement, applicable to coverage available after January 1, 2011, a participant will be eligible for coverage of claims if that participant received credit for 700 hours to be administered in the same manner and procedure applicable to the previous 1,000 hours provision which it replaces. The Trustees may change the eligibility hour requirements at their discretion.

Effective January 1, 2011, your benefit eligibility will terminate on the first day of the month following such six (6) or twelve (12) month period, if you have not earned either 350 Hours of Credit in the immediately preceding six (6) months or 700 Hours of Credit in the immediately preceding twelve (12) months. In other words, there is a continuing requirement that you meet these Hours of Credit minimums in order to qualify for an additional period of eligibility.

"Benefits"

The term "Benefits" as used herein shall mean welfare benefits as provided by this Welfare Plan.

“COBRA”	An Active Employee, whose benefits are terminated for any reason other than gross misconduct, shall have the right to continue his Benefits Coverage for a period of at least 18 months starting from the date his Benefits Coverage terminates. The Active Employee’s Eligible Dependents will also have this right under certain specified circumstances. These COBRA coverage benefits require the payment of specified continuation premiums by or for the covered person. Certain COBRA benefits are required by federal statute including benefits for Eligible Dependents. For further information about COBRA eligibility, see page 83.
“Collective Bargaining Agreements”	The term "Collective Bargaining Agreements" as used herein or the singular thereof, as the case may be, shall mean any or all Collective Bargaining Agreements now subsisting, or hereafter made, between the Union and either the Association or other Employers, together with any and all amendments, supplements, revisions or renewals thereof or thereto.
“Confinement”	The term "Confinement" means admission to the hospital for at least either (a) a period encompassing an overnight stay, *or* (b) a 24 hour period.
“Contributions”	The term "Contributions" as used herein shall mean the payments required to be made to the Welfare Fund by Employers.
“Covered Employment”	The term “Covered Employment” as used herein shall mean work for which a participating Employer is required to and does make specified contributions to the Cement and Concrete Workers Welfare Trust Fund.

"E.A.P." *or* "Employee Assistance Program"	Employee Assistance Programs are designed to assist employees and their family members in the identification and resolution of personal concerns. EAPs offer professional and confidential assistance with a wide range of issues in the form of support, counseling, and referral. At the time of the publication of this plan, the Welfare Fund uses the following EAP: Care Plus Solutions, Inc. 1-800-765-8263 A more complete description of the program offered by Care Plus Solutions, Inc. can be accessed on this website: www.careplussolutions.com
"Eligible Dependents"	If you are an Active Employee or Eligible Retiree, coverage is extended to the following as being an "Eligible Dependent": (a) your spouse at date of retirement, and (b) Effective January 1, 2011, each of your children during the period from birth and up to the age of 26 years, coverage would cease the month after the birth date, age 26, provided they do not have access to other employer sponsored health coverage. The term "Children" is limited to your lawful children of your blood, and your legally adopted children. Dependents of covered employees will be eligible for the benefits provided under this Plan for dependents on the following dates, whichever is later: 1. The date on which the employee becomes eligible for employee coverage; or 2. The date on which the employee first acquires a dependent. If you are an Eligible Retiree, the term "Eligible Dependent" means your spouse and eligible dependents.

An child whose coverage would otherwise terminate solely due to reaching the age of 26 shall continue to be Eligible provided:

a. the child cannot work due to mental illness, physical handicap, developmental disability or mental retardation, as defined in the Mental Hygiene Law;

b. the child became so incapable before reaching the age of 26;

c. written evidence of such incapacity is sent to the Trust Fund office within 30 days after the child reaches age 26; and

d. proof of the continued existence of such incapacity is sent to the Trust Fund office at its request.

Note: Eligible dependents under age 65 are entitled to different coverage than Eligible Dependents over age 64 – i.e. if your spouse is over age 64.

- **Dependents' Termination of Eligibility**

  Coverage for an Eligible dependent ends:

  (a) on the date of termination of particular type of Coverage on either the Employee or the dependents; or

  (b) on the date a dependent no longer qualifies as a dependent; or

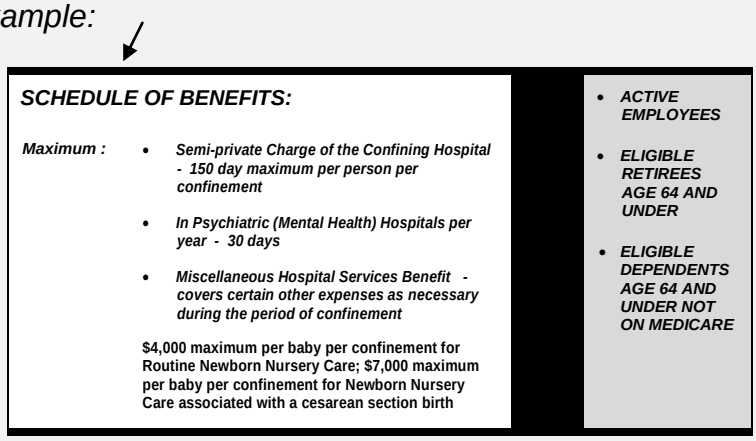
  (c) On the date of the dependents on the date of divorce or legal separation of the dependent from the Employee.

  (d) entrance into military, naval or air service.

  (e) On the date of death of the Active Employee or Eligible Retiree unless otherwise provided by the plan, see page 77-78. If an Active Employee dies with a remaining period of eligibility continuing, the eligible dependents of the deceased Active Employee shall at least be entitled to continuing coverage for the period remaining for the Active Member's coverage.

"Eligible Retiree"	To be covered for Cement and Concrete Workers Welfare Trust Fund benefits, Retirees must have met the minimum service requirement as an Active Employee for twelve months of benefit coverage under the Welfare Plan in each of two (2) calendar years out of the five (5) calendar years immediately preceding the year or date in which he or she applied for a retirement benefit, and: (a) Retire with a Normal or Early Retirement Benefit based on fifteen (15) or more years service credits granted him or her by the Cement and Concrete Workers District Council Pension Fund, *or* (b) Retire and remain retired with a Disability Retirement Benefit based on ten (10) or more years of service credits granted him or her by the Cement and Concrete Workers District Council Pension Fund.
"Employer"	The term "Employer" as used herein shall mean each employer who has presently in force or who hereafter executes a Collective Bargaining Agreement or a supplement thereto with the Union, requiring such employer's participation in and periodic contributions to the Cement and Concrete Workers District Council Welfare Fund for the periods involved. Employers as described in this Section shall, by the making of payments to the Cement and Concrete Workers District Council Welfare Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by this Trust Agreement. Employers may also include the Union, its constituent Locals 6A, 18A and 20, and its affiliated benefit funds.
"Hour(s) of Credit"	"Hour(s) of Credit" means an hour or hours worked by a Participant in covered employment pursuant to an Employer agreement.
"Participants Eligible for a Death Benefit"	"Participants Eligible for a Death Benefit" are certain Participants or certain dependents when the participant has at least five years of credited service under the Cement and Concrete Workers District Council Pension Plan.

"Participants Eligible for Disability Benefits"	"Participants Eligible for Disability Benefits" are those Participants who incur a non-work related disability or sickness while employed or within 4 weeks of termination of employment.
"Participants"	The term "Participant" means any Employee who is within the Cement and Concrete Workers Union collective bargaining unit described in the standard form of collective bargaining agreement with the Union (Local 6A, 18A and 20 of the Laborers' International Union of North America) and/or those Employees who are covered pursuant to a participating Employer making required contributions. As to benefits, see Introduction at page 17.
"Usual, Customary and Reasonable Charges"	"Usual, Customary and Reasonable Charges" are those charges for medical services established by the CPT code. The CPT code is a procedure code associated with a schedule of usual, customary and reasonable medical charges in a specific locality published by MAG Mutual Healthcare Solutions, Inc.
"Retiree"	"Retiree" means an individual who has applied for and received a pension from the Cement and Concrete Workers District Council Pension Fund. A Retiree is entitled to benefits under this plan if the Retiree is an Eligible Retiree or satisfied some other eligibility requirement.

"Schedule of Benefits"	The "Schedule of Benefits" identifies the only services and payments and the maximum payments available as benefits under the plan for the benefit category. *Example:*  ***SCHEDULE OF BENEFITS:*** ***Maximum :*** • ***Semi-private Charge of the Confining Hospital - 150 day maximum per person per confinement*** • ***In Psychiatric (Mental Health) Hospitals per year - 30 days*** • ***Miscellaneous Hospital Services Benefit - covers certain other expenses as necessary during the period of confinement*** **$4,000 maximum per baby per confinement for Routine Newborn Nursery Care; $7,000 maximum per baby per confinement for Newborn Nursery Care associated with a cesarean section birth** • ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***
"Trust Agreement"	The term "Trust Agreement" as used herein shall mean this Agreement and Declaration of Trust and any amendments, supplements, modifications or restatements hereafter duly made and adopted pursuant to which this plan is issued.
"Welfare Fund"	The term "Welfare Fund" as used herein shall mean all employer contributions, monies or other things of value which come into the hands of the Trustees and comprise the corpus and additions to the Cement and Concrete Workers District Council Welfare Fund of which this is the plan.
"Welfare Plan"	The term "Welfare Plan" as used herein is this plan and shall mean the Welfare Plan adopted by the Trustees, specifying the detailed basis upon which payments are to be made from the Welfare Fund.
"Union"	The term "Union" as used herein shall mean the Cement and Concrete Workers District Council, comprised of Locals 6A, 18A and 20, all affiliated with the Laborers International Union of North America.
"Year"	The term "Year" as used in this plan shall in all cases mean calendar year, except where a provision specifically provides otherwise.

EXCLUSIONS AND LIMITATIONS OF COVERAGE

None of the benefits of this Plan are payable for loss or expense caused by accidental bodily injury incurred during the course of employment; or, by injuries or sicknesses covered by any Workers Compensation Law or similar legislation; or, for care or treatment provided by the laws of the United States or any state or province or any political subdivision of them. Certain benefits which are payable under Medicare shall not be paid under this Plan for persons eligible to receive benefits under "Medicare," whether or not so enrolled, except this provision will not apply to benefits payable under the Plan for certain services which are not payable by Medicare.

Coverage is also not provided for the following types of medical services and procedures:

- Medical services or procedures for which a covered individual is not under the direct and continuing care of a physician.
- Medical services which are not recommended and approved by a physician.
- Medical services or procedures which are covered or payable under any Automobile No-Fault law or similar legislation, under any other insurance plan or policy, by any Government agency or unit directly or indirectly or for which there would be no liability in the absence of insurance.
- Medical services or procedures which are covered or payable under any other insurance plan or policy.
- Medical services or procedures which are covered or payable by any Government agency or unit, either directly or indirectly (*i.e. a person eligible for coverage loses eligibility on entry into military service*).
- Medical services or procedures for which there would be no liability in the absence of insurance.
- Elective or cosmetic services or procedures.

The foregoing list is not complete or exhaustive. Coverage maximums are provided separately. Certain other exclusions and limitations, applicable to specific benefits, are included in the descriptions of the following pages. Please see “BENEFITS”, beginning at pg. 41, under specific benefit categories for more complete information on exclusions and non-covered risks.

Claim forms must be submitted in writing to the Welfare Fund Office within a reasonable period of time, but not to exceed 90 days from the date of termination of the period of disability or hospital confinement, the date a surgical operation is performed, the date doctor's in hospital, home, or office calls are made, the date of laboratory or diagnostic testing examination, the date expenses are incurred for prescription eyeglasses, and prescription drugs, and not to exceed 180 days from the date a dental expense is incurred (or thirty days after disability has commenced). To be eligible for coverage, you must have previously claimed coverage and submitted an Application for Welfare Fund Benefits.

BENEFIT HIGHLIGHTS

IMPORTANT: The information provided under this "BENEFIT HIGHLIGHTS" section is intended as a summary and reference as to Benefits provided. For details please refer to pgs. 26-40.

The information provided under this "BENEFIT HIGHLIGHTS" section is intended as a summary and reference as to Benefits provided and those eligible for the benefits. This section (pages 27-40) should be used as a general reference, and to familiarize you and your family with the types of benefits to which they are entitled. For greater detail regarding each individual benefit and those eligible for coverage, please refer to the "BENEFITS" section, pages 42-78, under the appropriate heading as follows:

THOSE ELIGIBLE:	BENEFITS:
For Participants Eligible for a Disability Benefit (pg.23)	DISABILITY BENEFITS……....43
For Participants Eligible for a Death Benefit (pg.22)	DEATH BENEFITS……77
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BENEFIT FOR:

- **For Participants Eligible for a Disability Benefit (pg. 23)**

• DISABILITY BENEFIT (pg. 43)	$400 per week, for up to 26 Weeks, for non-work related disability or sickness incurred while employed or within 4 weeks of termination of employment.

BENEFIT FOR:

- **For Participants Eligible for a Death Benefit (pg. 22)**

• DEATH BENEFIT (pg. 77-78)	Paid to your beneficiary as designated by you to Fund Office or to you if your spouse dies, pg. 77. (amount varies according to years of credited service under the pension plan).

BENEFIT FOR:

- **Active Employees *(pg. 18)***

• Workers' Compensation Benefits Extension of Benefit Coverage (pg. 42)	Benefit Coverage extended for up to twelve (12) consecutive months from termination of active benefits if you have received a Notice of Decision that you cannot return to work during this period and you do not return to work.

BENEFITS FOR:

- **Eligible Retirees age 65 before January 1, 2004 or otherwise on Medicare starting before January 1, 2004.**
- **Eligible Dependents age 65 before January 1, 2004 or otherwise on Medicare starting before January 1, 2004.**

• 50% OF THE MEDICARE QUARTERLY PREMIUM AND DEDUCTIBLE AMOUNT REIMBURSEMENT (pg. 44-46)	Effective January 1, 2004 These amounts will be reimbursed to you by your Welfare Fund provided your Medicare Health Insurance Card is first submitted to the Welfare Fund Office: Part A – Fund Reimburses Part B - Fund Reimburses No co-insurance is paid.
• ADDITIONAL BENEFITS NOT PROVIDED BY MEDICARE (pg. 39)	Some benefits relating to Medical Equipment, Dental, Eyeglasses, Prescription drugs and Hearing Aids, not provided by "Medicare" but covered under the Welfare Fund Program will also be provided for persons eligible to receive "Medicare." See Summary of Benefits pg. 39 and pgs. 67 - 75.

BENEFITS FOR:

- **Eligible Retirees *who became* age 65 after December 31, 2003 or otherwise on Medicare starting after December 31, 2003.**
- **Eligible Dependents *who became* age 65 after December 31, 2003 or otherwise on Medicare starting after December 31, 2003.**

• DEDUCTIBLE AMOUNT REIMBURSEMENT FOR PART B MEDICAL BENEFITS COVERAGE (pg. 44-46)	Effective January 1, 2004 These amounts will be reimbursed to you by your Welfare Fund <u>provided</u> your Medicare Health Insurance Card is first submitted to the Welfare Fund Office: Part B - Fund Reimburses No co-insurance is paid.
• ADDITIONAL BENEFITS NOT PROVIDED BY MEDICARE (See pg. 39)	Some benefits relating to Medical Equipment, Dental, Eyeglasses, Prescription drugs and Hearing Aids, not provided by "Medicare" but covered under the Welfare Fund Program will also be provided for persons eligible to receive "Medicare." See Summary of Benefits pg. 39 and pgs. 67 - 76.

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• HOSPITAL EXPENSE BENEFITS (pg. 47) Daily Benefits	Room and board benefits for up to 150 days per person during any one period of hospital confinement including Mental Health • $4,000 maximum per baby per confinement for Routine Newborn Nursery Care; $7,000 maximum per confinement for newborn nursery care associated with cesarean section birth
• HOSPITAL MISCELLANEOUS SERVICE BENEFITS (pg. 48)	Non-surgical care while admitted to hospital: • ambulance transportation to or from a hospital • diagnostic testing and laboratory services certain other expenses as necessary while admitted to hospital
• HOSPITAL OUT-PATIENT BENEFITS (pg. 49)	Up to $10,000.00 maximum per person per occurrence
• SURGICAL EXPENSE BENEFITS (pg. 50)	Effective 1/1/2012 $30,000.00 maximum per person per surgical operation according to the usual and customary standard of reimbursement. $300 maximum for ancillary services out-of-hospital

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• SECOND SURGICAL OPINION (pg. 50)	given by a qualified specialist per required conditions, $250.00 Maximum per operation
• ANESTHESIA BENEFITS (pg. 52)	Usual, Customary and Reasonable amount for anesthesia in connection with medical procedures (in addition to other benefits)
• CATASTROPHIC EXPENSE BENEFIT (pg. 53)	For Treatment of Malignancies, Cardiac Problems, Kidney Failure and Lupus, Hepatitis C, Pulmonary Disease and Multiple Sclerosis (an additional $150,000.00 maximum per person over a consecutive annual period of two years with a maximum total payment of $500,000.
• PRIVATE DUTY NURSES (pg. 54)	$2,400.00 maximum per hospital confinement ($120.00 per 8-hour shift, up to 20 shifts)

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• HOME HEALTH CARE EXPENSE BENEFITS (Nursing Care, Etc.) (pg. 55)	While under the continuing care of a physician: • Deductible of $50.00 per person per year. • Coinsurance - 75% of Usual, Customary and Reasonable Maximum of forty (40) Visits per person per year

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• MEDICAL EXPENSE BENEFITS (Home and Office Calls) (pg. 56) • Maximum $5,000 per person. Out-patient alcohol and substance abuse including detoxification and rehabilitation $60.00 - $130.00 **All eligible individuals requesting this coverage will be referred to the Plan E.A.P. ("Employee Assistance Program"), Care Plus Solutions, Inc. Please contact the Fund offices for further information*	Overall $5,000 maximum per family for treatment rendered out of hospital. • Home - $160.00 per day per treatment per provider • Office - Initial visit, new patient, $130 Established patient, $90 Established Low Complexity, $70.00 Basic Office Visit, $60.00 • Not more than one treatment per day per provider
• CHIROPRACTIC/PHYSICAL THERAPY BENEFIT (pg. 56-57)	Overall maximum of $1,800 per family per year or 30 visits per family per year. Maximum of $60.00 per visit. If exhausted, coverage can continue as an above medical expense benefits.
• IN-HOSPITAL MEDICAL EXPENSE BENEFITS (pg. 56) • Includes In-Patient alcohol and substance abuse benefits including detoxification and rehabilitation.	For professional services rendered personally by licensed physician during period of confinement: $60.00 - $130.00 based on the complexity of the visit, per day per treatment per Provider • Overall maximum during hospital confinement - $2,500.00 per person

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• WELL BABY CARE (pg. 58)	In addition to other Plan Benefit: Home & Office (per visit) - $50.00 Maximum office visits during first two (2) years of life - Twelve Visits per child
• IMMUNIZATION (pg. 59)	For eligible dependent children, immunization inoculation - $50.00 per inoculation (this benefit is additional to other Plan Benefits). Eligible dependents ages 9-26 maximum of 3 HPV injections - $500 maximum benefit.
• PREGNANCY EXPENSE BENEFITS (Delivery Physician Services in lieu of and replacing other physician or surgeon benefits otherwise provided by the Plan) (pg. 60)	Normal Delivery - $3,500.00 maximum per pregnancy Caesarian Section – $4,900.00 maximum per pregnancy Miscarriage - $1,540.00 maximum
• CONSULTATION BENEFITS (with Specialist) (pg. 61)	$250 limit per Specialist per year per person (in addition to $5,000.00 Medical Expense Benefits maximum and Second Surgical Opinion maximum)

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **Eligible Retirees (pg. 22) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 20) age 64 and under not on Medicare:**

• ROUTINE PHYSICAL EXAM EXPENSE (pg. 62)	**In addition to $5,000.00 Medical Expense Benefits maximum** • **Routine Physical Exam - $135.00 per year per person for physician charges** • **Routine Gynecological Examination - $100.00 per person per year for physician charges** • **Prostate Examination - $100.00 per person per year for physician charges** **<u>Note</u>: This benefit is not available for those receiving Well Baby Care coverage.**
• DIAGNOSTIC TESTING AND LABORATORY EXPENSE BENEFIT (OUTPATIENT) (pg. 64) • MRI Testing (pg. 64) • EFFECTIVE 1/1/2011 – Inner Imaging Annual Health Screening. Free for those who are eligible (pg. 62-63) • EFFECTIVE 7/1/2013 - HEARTSCAN/CARDIOVASCULAR SCREENING $20.00 Co-payment for those who are eligible – every two years (pg. 62-65)	$5,000.00 per person maximum per year including $800 per occurrence for MRI testing. In addition: Routine Mammogram - $140.00 per person per year, Pap Smear - $60.00 per person per year, Genetic Profile Workup Maximum benefit per fetus - $500.00
• SHOCK THERAPY TREATMENT EXPENSE BENEFITS (pg. 65)	In addition to other Plan Benefits: $2,500.00 maximum per year

BENEFITS FOR:

- **Active Employees (pg. 18)**
- **All Eligible Retirees (pg. 22) (even Medicare recipients)**
- **Eligible Dependents (pg. 20)**

• MEDICAL SUPPLIES AND EQUIPMENT BENEFITS (pg. 67)	prescribed by a licensed physician, $1,500.00 per person per year, for those supplies not covered by Medicare
• DENTAL EXPENSE BENEFITS (pg. 68)	$6,000 per family maximum (including Orthodontia), and procedure maximum per Schedule, pg. 68.
• PRESCRIPTION EYEGLASS EXPENSE BENEFITS (pg.71)	$200 per year including examination. (Service Provider Discounts may be Available)

• PRESCRIPTION DRUG EXPENSE BENEFIT (pg. 72)*	Administered by Express Scripts - $6,000.00 per family per year No reimbursement (Fund payment) at higher than the generic rate if generic replacement available. (This is a generic preferred program.)
The day supply is 30 days retail and 90 days mail order per one co-pay.	*For Active Employees*: - $5.00 per prescription co-pay for generic drugs, - $10.00 per prescription co-pay for brand name drugs, and - $125.00 specialty drugs
*You may be eligible for outpatient pharmacy services provided by the Department of Veterans Affairs, call: 1-800-827-1000	*For Retirees*: - $7.00 per prescription co-pay for generic drugs, - $12.00 per prescription co-pay for brand name drugs - $125.00 specialty drugs
Eligible Retiress age 65 and Older on Medicare Alternate Benefit (pg. 73, pg. 74)	Fertility Drugs: $1,500 maximum per year per family in addition to family maximum This benefit is restricted to identified drugs. Discount brand or generic drugs are available up to 90 day supply, through mail order Express Scripts.
• HEARING AID EXPENSE BENEFITS (pg. 76)	A maximum of $1,000.00 per person during a period of three (3) consecutive years

BENEFITS

EXTENSION OF BENEFIT COVERAGE

SCHEDULE OF BENEFITS: ***Maximum :*** **Up to one year of extended benefit coverage**	• ***ACTIVE EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS***

If you receive a Notice of Decision from the Workers' Compensation Board that your Workers' Compensation injury prevents you from returning to work during a period, you will have your benefit coverage extended for up to 12 consecutive months from termination of your active employee benefits, provided you do not return to work during this period. Upon your return to work, the extension of benefits will terminate even if you have not received the full 12 consecutive month extension. In such a case, you must again establish eligibility.

DISABILITY BENEFITS

SCHEDULE OF BENEFITS:	• ***ACTIVE EMPLOYEES***
Maximum : **$400.00 per week for maximum of 26 weeks**	• ***PARTICIPANTS***

You as an Active Employee or Participant Eligible for Disability Benefits will be paid the Disability Benefit indicated in the schedule of benefits if, while covered under the Plan, you are totally and continuously disabled so as to be prevented from performing the duties of your occupation because of non-occupational accident or sickness.

This benefit begins on the 1st day of disability due to accident and on the 8th day of disability due to sickness.

The maximum benefit payable will be 26 weeks for any disability resulting from accident or sickness.

To be eligible for this benefit you must become sick or disabled while employed in Covered Employment or within four (4) weeks after termination of such employment.

Successive periods of disability separated by less than two weeks of continuous active work shall be considered one period of disability unless the subsequent disability is due to an injury or sickness entirely unrelated to the cause of the previous disability and commences after return to active work for at least one full day.

MEDICARE DEDUCTIBLE AMOUNT REIMBURSEMENT

SCHEDULE OF BENEFITS:

Maximum : **Effective January 1, 2004**

This will be reimbursed to you by your Welfare Fund <u>provided</u> your Medicare Health Insurance Card is first submitted to the Welfare Fund Office:

Part B – Fund Reimburses

No co-insurance is paid.

- ***ELIGIBLE RETIREES WHO BECAME AGE 65 AFTER DECEMBER 31, 2003, OR OTHERWISE ON MEDICARE AFTER DECEMBER 31, 2003***
- ***ELIGIBLE DEPENDENTS WHO BECAME AGE 65 AFTER DECEMBER 31, 2003, OR OTHERWISE ON MEDICARE AFTER DECEMBER 31, 2003***

1. <u>Under Medical Benefits Coverage</u>
   The current amount established by Medicare as the deductible under Part B for covered services during any one calendar year.

   This amount is to be paid only once in any calendar year.

Certain benefits not provided by “Medicare” but covered under the Welfare Fund Program will also be provided for persons eligible to receive “Medicare.”

No Medicare Coinsurance, the difference between what Medicare pays and the charges, is paid.

MEDICARE QUARTERLY PREMIUM AND DEDUCTIBLE AMOUNT REIMBURSEMENT

SCHEDULE OF BENEFITS:

Maximum : **Effective January 1, 2004**

These will be reimbursed to you by your Welfare Fund <u>provided</u> your Medicare Health Insurance Card is first submitted to the Welfare Fund Office:

Part A – Fund Reimburses

Part B – Fund Reimburses

No co-insurance is paid.

- ***ELIGIBLE RETIREES AGE 65 BEFORE JANUARY 1, 2004 OR OTHERWISE ON MEDICARE STARTING BEFORE JANUARY 1, 2004***
- ***ELIGIBLE DEPENDENTS AGE 65 BEFORE JANUARY 1, 2004 OR OTHERWISE ON MEDICARE STARTING BEFORE JANUARY 1, 2004***

If you are eligible for Medicare 50% of the quarterly premium you pay to Medicare will be reimbursed to you by your Welfare Fund provided your Medicare Health Insurance Card is first submitted to the Welfare Fund Office. You will also be reimbursed for certain deductible amounts that are required by the Medicare program. The following amounts as well as the premium will be revised from time to time to correspond to changes made by "Medicare."

1. <u>Under Hospital Benefits Coverage</u>

   The current amount established by Medicare as the deductible under Part A for covered services during any confinement on which Medicare imposes the deductible.

2. <u>Under Medical Benefits Coverage</u>

   The current amount established by Medicare as the deductible under Part B for covered services during any one calendar year.

   This amount is to be paid only once in any calendar year.

Certain benefits not provided by "Medicare' but covered under the Welfare Fund Program will also be provided for persons eligible to receive "Medicare."

No Medicare Coinsurance, the difference between what Medicare pays and the charges, is paid.

Members and/or their dependents eligible for Welfare Benefits who are residing abroad will be reimbursed for comparable Medicare coverage to the extent that either Medicare or some equivalent program in their country of residence does not cover such members (whether temporary or permanent).

Note: Eligible Retirees and eligible dependents of age 65 or older and those on Medicare Disability Coverage must submit a copy of their Medicare Health Insurance Card to the Welfare Fund Office in order to be eligible for benefits under this Plan.

HOSPITAL EXPENSE BENEFITS

SCHEDULE OF BENEFITS:

Maximum :

- ***Semi-private Charge of the Confining Hospital - 150 day maximum per person per confinement***
- ***Including Mental Health, Alcohol, Substance Abuse, Detox and Rehabilitation confinements.***
- ***Miscellaneous Hospital Services Benefit - covers certain other expenses as necessary during the period of confinement***

$4,000 maximum per baby per confinement for Routine Newborn Nursery Care; $7,000 maximum per baby per confinement for Newborn Nursery Care associated with a cesarean section birth

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Daily Benefit

Payment will be made as payment in full of the semi-private room charge for each day you or one of your dependents is confined in a legally constituted accredited general hospital as an inpatient and a charge is made for room and board.

This benefit is payable for room and board up to 150 days for any one period of hospital confinement. Successive periods of confinement resulting from or contributed to by the same or a related cause or causes and separated by less than one day of active employment, if the insured person is an Employee or by less than a sixty (60) day intervening period, if the insured person is a dependent, or Employee or Retiree who has not had one day of active employment in the intervening period, shall be considered one period of confinement.

This benefit is limited to a maximum of $4,000 per baby per confinement for payment to the hospital toward charges incurred for Routine Newborn Nursery Care and a maximum of $7,000 per baby per confinement for Newborn Nursery Care associated with a cesarean section birth.

Hospital Miscellaneous Service Benefit

Payment will be made as payment in full for expenses incurred during the period for which room and board benefits are payable and charges are made:

(1) *By the hospital* for necessary miscellaneous services and treatments. This does include fees of physicians and surgeons who are Employees of the hospital for the administration of an anesthetic in connection with a surgical operation. This does not include physicians', surgeons', nurses' or dentists' fees, during the period that hospital room and board benefits are payable under the Plan unless included in the room charge as service by a resident; Room charges are to include all special equipment; and

(2) *By a physician or professional anesthetis*t who is not an Employee of the hospital for the administration of an anesthetic in connection with a surgical operation; and

(3) *By the hospital* for necessary services for emergency care rendered for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonable result in deterioration to the point of placing the insured person's life in jeopardy or cause serious impairment to bodily functions of the insured person, provided the care is rendered within twelve hours after the first appearance of the symptoms of the illness or within 72 hours after an accident; and

(4) *By the hospital* for the use of out-patient facilities of a hospital for tests ordered by a physician which are performed as a planned preliminary to admission of the insured person as an in-patient for surgery in the same hospital, provided that (1) tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed, (2) reservations for a hospital bed and for an operating room shall have been made prior to the performance of the tests, (3) the surgery actually takes place within seven days of such presurgical tests and (4) the insured person is physically present at the hospital for such tests; and

(5) *By a professional ambulance service* for transportation to or from a hospital; and

(6) *By physicians or professional radiologists* who are or are not Employees of the hospital for diagnostic testing and laboratory services which are necessary for the care and treatment of the patient during the period that the hospital room and board benefits are payable under the Plan.

OUT-PATIENT EXPENSE BENEFIT

SCHEDULE OF BENEFITS:	
Maximum : • ***Out-Patient Benefit - $10,000.00 per person per occurrence***	• ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

If you or your insured dependent incurs expenses for hospital out-patient treatment, you will be reimbursed, subject to a maximum of $10,000.00 per person per occurrence, the sum of the actual charges made:

(1) *By the hospital* for the necessary hospital services and treatments (other than physicians, surgeons, nurses, and dentists' fees) in connection with a surgical operation performed as part of out-patient treatment or in connection with out-patient emergency treatment within twenty-four (24) hours after, and as a result of, accidental bodily injury; and

SURGICAL EXPENSE BENEFITS

SCHEDULE OF BENEFITS:		
Maximum :	• ***$30,000.00 per person per surgical operation*** • ***Second Surgical Opinion - $250.00 per person per surgical operation*** • ***Usual, customary and reasonable physician charges (lesser amount for two operation procedure)*** • ***$300 maximum for ancillary services out-of-hospital*** • ***Laser Vision maximum of $3,200 per person***	• ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

If you or your insured dependent undergoes a surgical operation as a result of bodily injury or sickness, you will be reimbursed not more than the amount actually charged by the physician, but only in an amount up to the maximum amount specified for such operation according to the CPT code, except for two or more surgical procedures performed in the same operative session. The reimbursement provided by the Cement and Concrete Workers District Council Welfare Fund is further limited to the usual, customary and reasonable charges for medical procedures in a specific locality.

For any operation involving two or more surgical procedures performed in the same operative session, the amount paid is determined on the following basis unless otherwise specified in the Schedule:

(1) When two or more surgical procedures are performed the amount of your claim is limited to the reimbursement of the more expensive procedure plus 1/2 the amount for the other procedures.

In addition, an eligible person will be reimbursed the actual charges up to a maximum of $300 for ancillary services in connection with a surgical operation performed out of hospital.

The total benefit payable during any one period of disability for all surgical operations, including Radiotherapy, resulting from or contributed to by the same or a related cause or causes is $30,000.00. Successive periods of disability resulting from or contributed to by the same or a related cause or causes and separated by less than one day of active employment, if the insured person is an Employee or by less than a sixty (60) day

intervening period, if the insured person is a dependent, or Employee or Retiree who has not had one day of active employment in the intervening period, shall be considered one period of disability.

Benefits for Operations

Your benefits include payment for surgical operations but they are subject to limits. The Fund will not reimburse you more than the usual, customary and reasonable charges based upon tables provided by MAG Mutual Healthcare Solutions, Inc. for each procedure provided by the CPT Code.

Second Surgical Opinion

If you or your insured dependent, as a result of sickness or accidental bodily injury, incurs expense for a second surgical opinion given by a qualified specialist, benefits will be payable up to $250.00 per person per surgical operation, but such benefits shall not be applicable:

(1) For a surgical procedure of an emergency nature;

(2) If an insured person is not examined in person and a written report submitted to the Fund Office;

(3) If a surgical procedure is performed by the specialist giving the second surgical opinion;

(4) For diagnostic testings or laboratory tests performed in connection with the second surgical opinion.

Laser Vision Correction Surgery

Effective April 1, 2003 the maximum allowance for laser vision correction surgery is $3,200.00.

ANESTHESIA BENEFITS

SCHEDULE OF BENEFITS:	
Maximum :	This is in addition to other Plan Benefits: Usual, Customary and Reasonable amount for anesthesia

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Usual, Customary and Reasonable amount is reimbursed for anesthesia in connection with medical procedures (in addition to other benefits).

CATASTROPHIC EXPENSE BENEFIT

SCHEDULE OF BENEFITS:	
Maximum : ***$150,000.00 per person over a consecutive annual period of two years .***	• ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

This benefit will be equal to the reimbursement, as otherwise would be determined by the plan, for each necessary treatment or procedure only to the ailments listed below. The maximum amount payable under this benefit is $150,000.00 per person over a consecutive annual period of two years.

Benefits covered by the Catastrophic Expense Benefit are:

1. Treatment of malignancies. As well, reconstructive surgery relating to a mastectomy (see further, pg. 93).
2. Cardiac problems including heart surgery, coronary artery bypasses, catheterization and all procedures relating to these problems.
3. Kidney failure including surgery and/or dialysis.
4. Lupus.
5. Hepatitis C.
6. Pulmonary Disease.
7. Multiple Sclerosis.

PRIVATE DUTY NURSES

SCHEDULE OF BENEFITS:	
Maximum : • ***Overall maximum per 8-hour shifts - $120.00*** • ***Overall maximum number of shifts - 20 shifts*** • ***Overall maximum during any one hospital confinement - $2,400.00***	• ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

If you or your insured dependents incur expenses for the services of a Private Duty Nurse ordered by the attending physician during a hospital confinement, you will be reimbursed for the actual charges incurred up to $120.00 for each 8-hour shift, to a maximum of 20 shifts. The Overall Maximum amount payable during any one hospital confinement is $2,400.00.

For benefits to be payable, the nurse must be a Licensed Practical Nurse or a Registered Graduate Nurse (other than a close relative).

The term "close relative" includes the insured person, the spouse, and a child, grandchild, brother, sister and parent of the insured person or of the spouse.

HOME HEALTH CARE EXPENSE BENEFITS

SCHEDULE OF BENEFITS:	
Maximum :	• ***Deductible of $50.00 per person per year.*** • ***75% of Usual, Customary and Reasonable Charge*** • ***Forty Maximum visits per person per year***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

If you or your insured dependent incurs expenses for home health care as a result of sickness or accidental bodily injury, benefits will be subject to the following limitations:

- Deductible of $50.00 per person per year.
- Benefits will be paid up to 75% of Usual, Customary and Reasonable Charge
- Forty Maximum visits per calendar year

Benefits will include the Usual, Customary and Reasonable Charges for part-time or intermittent nursing care by or under the supervision of a registered professional nurse, part-time or intermittent home health aide service which consist primarily of caring for the patient, physical therapy, occupational therapy, and speech therapy provided by the home health care agency. The home health care agency shall, as well, be reimbursed for medical supplies, drugs, medications prescribed by a physician and laboratory service, to the extent such items would have been covered under this plan if the insured person had been hospitalized.

No benefits are payable for expenses for:

(a) any period during which the insured person is not under the continuing care of a physician;

(b) service or supplies of a home health care agency unless hospitalization or confinement in a Skilled Nursing Facility would otherwise have been required;

(c) service or supplies not included in the home health care plan established and approved by a physician;

(d) services of a person who ordinarily resides in the insured person's home or is a member of the family of either the insured person or the insured person's spouse;

(e) custodial care; or

(f) transportation services.

MEDICAL EXPENSE BENEFITS
(Home and Office Calls, In-Hospital Visit)

SCHEDULE OF BENEFITS:

Maximum : **Overall maximum per family for treatment rendered out of hospital - $5,000.00 per year**

Overall maximum during hospital confinement - $2,500.00 per person

- ***Home - $160.00 per day per person per treatment per provider***

  Office - Initial visit, new patient, $130

  Established patient, $90

  Established Low Complexity, $70.00

  Basic Office Visit, $60.00
- ***Hospital - $60.00 - $130.00 per day per person per treatment per provider***
- ***Maximum $5,000 per person per year for out-patient alcohol and substance abuse including detoxification and rehabilitation. Treatments $60.00 - $130.00 based on complexity of treatment***
- ***Not more than one treatment per day per provider***
- ***Chiropractic/Physical Therapy - Overall maximum of $1,800 per family per year or 30 visits per family per year. Maximum of $60.00 per visit.***

If exhausted, coverage can continue as an above medical expense benefits.

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Medical Expense Benefits* will be paid for you and your dependents age 64 and under, as shown in the Schedule of Benefits, as a result of medical treatment furnished by your legally licensed physician, podiatrist or chiropractor. Benefits are payable only for care and treatment of actual sickness and injury. The overall family maximum with respect to Home and Doctor's Office Medical Expense is $5,000.00 during any one year.

"Medical treatment" means professional services rendered personally by a legally licensed physician, podiatrist or chiropractor but does not include dental care or treatment, eye examination for fitting of glasses, examination for fitting of hearing aids, diagnostic testing examinations or supplies such as drugs, medicines or dressings, or post-operative treatment rendered in connection with a surgical operation.

* Medical Expense Benefits do not include surgical benefits that the plan covers elsewhere under surgical benefits.

Chiropractic/Physical Therapy Benefit

Each participant family group shall be entitled to the separate benefit of up to $60.00 per visit with a maximum of 30 visits per family per year to a licensed Chiropractor or a licensed Physical Therapist. Additional visits may be applied against office visit coverage under the this category.

In-Hospital Medical Expense Benefits

In-Hospital Medical Expense Benefits will also be paid, as a result of medical treatment furnished by your physician during hospital confinement.

Benefits are payable from the first day of hospital confinement during the period for which the room and board benefits are payable, for doctor medical treatment visits in the amount and not in excess of the maximum per visit and up to the Overall Maximum during hospital confinement as shown in the Schedule of Benefits.

Successive periods of hospital confinement as an inpatient resulting from or contributed to by the same or related causes and separated by less than one (1) day of return to active employment, if the insured person is an Employee, or by less than sixty (60) day intervening period, if the insured person is a dependent or Employee or Retiree who has not had one day of active employment in the intervening period, will be considered one period of hospital confinement.

WELL BABY CARE

SCHEDULE OF BENEFITS:	• ***ELIGIBLE DEPENDENTS 24 MONTHS OF AGE AND UNDER***
Maximum : **In Addition to other Plan Benefits:** • ***Home & Office (per visit) - $50.00*** • ***Maximum office visits during first two (2) years of life - Twelve per child***	

Home and Office visits for routine Pediatric Well Baby Care for check-ups on infants will be paid up to $50.00 per visit to a maximum of twelve (12) visits during the first two (2) years of a child's life, in addition to any other coverage.

IMMUNIZATION

SCHEDULE OF BENEFITS:	• ***ACTIVE EMPLOYEES AND ELIGIBLE FEMALE DEPENDENTS BETWEEN THE AGES OF 9 TO 26 YEARS.***
Maximum : • ***For active employees and eligible male/female dependents between the ages 9 to 26 years, a maximum payment of $500.00 for three human papillomavirus (HPV) injections over a 6 month period***	• ***ELIGIBLE DEPENDENT CHILDREN***
• ***For eligible dependent children, immunization inoculation (other than HPV) $50.00 per inoculation;***	
These benefits are additional to an independent of other Plan Benefits.	

For active employees and eligible dependents between the ages of 9 to 26 years a maximum payment of $500.00 for three human papillomavirus (HPV) injections over a 6 month period.

For eligible dependent children, immunization inoculation (other than HPV) - $50 per inoculation.

These benefits are additional to and independent of other Plan Benefits.

PREGNANCY EXPENSE BENEFITS (OBSTETRICAL BENEFIT)

SCHEDULE OF BENEFITS:	
Maximum :	**This benefit is for delivery physician services in lieu of and replacing other physician or surgeon benefits otherwise provided by the Plan** • ***Normal delivery of child or children - $3,500.00*** • ***Cesarean section or abdominal operation or extra-uterine – pregnancy - $4,900.00*** • ***Miscarriage - $1,540.00***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

For physician charges incident to the delivery of a child or children, and incident to a miscarriage.

The Schedule of Benefits above identifies the maximum benefits for the expenses identified in this category heading. No expenses for these services will be paid under a different category or heading.

CONSULTATION BENEFITS

SCHEDULE OF BENEFITS:	
Maximum :	***$250.00 per specialty per year per person (in addition to $5,000.00 Medical Expense maximum and Second Surgical Opinion Maximum).***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Consultation services of a specialty will be payable for hospital or office visits up to $250.00 per specialty per year per person. This benefit is in addition to the $5,000.00 Medical Expense maximum and Second Surgical Opinion maximum.

ROUTINE PHYSICAL EXAM EXPENSE

SCHEDULE OF BENEFITS:

Maximum : **In addition to $5,000.00 Medical Expense maximum**

- ***Routine Physical Exam - $135.00 per year per person for physician charges***
- ***Routine Gynecological Examination - $100.00 per person per year for physician charges***
- ***Pap Smear - $60.00 per person per year.***
- ***Routine Mammogram - $140.00 per person per year.***
- ***Prostate Examination - $100.00 per person per year for physician charges***
- ***Effective 1/1/2011 Inner Imaging Annual health screening exam of heart, lungs, abdomen and pelvis – FREE OF CHARGE FOR THOSE WHO ARE ELIGIBLE. <u>Men must be 35 or older and women 40 or older to qualify for the screening test.</u>***

  Effective 7/1/2013 – Heart Scan Services – Echocardiogram, Carotid Artery Ultrasound, ABI Index and Thyroid Screen - $20.00 co-payment every two years

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE, EXCEPT THOSE ELIGIBLE FOR WELL BABY CARE***

You will be reimbursed the physician expenses incurred by you and or your spouse for a comprehensive physical examination performed or ordered by your physician. This benefit shall be limited to $135.00 per year and is not available to persons eligible for Medicare. Diagnostic testing and Laboratory charges are covered under the Diagnostic testing and Laboratory Expense Benefit.

Effective 1/1/2011 - An arrangement has been made with INNER IMAGING, P.C., an affiliate of the Heart Institute at Beth Israel Medical Center. In this arrangement your Benefit Fund will pay for Four Screening Tests. There is **no co-pay** for eligible participants and dependents.

"Who is eligible and who should have the test?"

These tests are free of charge for those who are eligible. Those who are eligible as defined in the Welfare Plan are active employees and eligible dependents and eligible retirees and their spouses age 64 or under not on MEDICARE. Who should have the test under the plan? The provider offers these tests to a targeted health group: Men over 35, and women over 40. Those with one or more risk factors should consider the Heart Scan.

Program is available at:
INNER IMAGING
Location:
307 East 63rd Street
New York, New York 10065
Tel. # 212-991-5445
Fax # 212-991-5450

Effective 7/1/2013 – An arrangement has been made with Heartscan Services.

THE SCREENING PROGRAM
Heartscan Services identifies early risk factors of Heart Disease, Stroke, PAD (peripheral arterial disease and diabetes), and Thyroid nodules. The screening is non-invasive, takes approximately 30 minutes and no preparation is required. Heartscan Services is mobile and can perform screening at locations close by your work place or home.

ECHOCARDIOGRAM - looks at size, shape and movement of the heart.

CAROTID ARTERY ULTRASOUND - can identify plaque in the carotid arteries, which can lead to stroke.

ABI INDEX - looks for peripheral arterial diseases and early diabetes.

THYROID SCREEN - looks for nodules.

The Welfare Fund will contribute $179 towards the Heartscan Serviecs screening. **This** will reduce the cost to a $20 co-pay. This benefit will be offered once every two (2) years.

Plan Eligibility - Eligible active employees, retired participants and their spouses age 64 and under not on Medicare.

Program is available by calling Heartscan Services 1-866-518-1112

DIAGNOSTIC TESTING AND LABORATORY EXPENSE BENEFIT (OUT PATIENT)

SCHEDULE OF BENEFITS:		
Maximum :	*$5,000.00 per person maximum per year – Including $800.00 MRI testing per person, per occurrence.* *In addition:* *Routine Mammogram - $140.00 per person per year,* *Pap Smear - $60.00 per person per year,* *Genetic Profile Workup Maximum benefit per fetus - $500.00*	• ***ACTIVE EMPLOYEES*** • ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE*** • ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Benefit

You will receive benefits equal to the actual ordinary and necessary charges incurred by you or your insured dependents as an outpatient for diagnostic testing or laboratory examinations.

In addition, you will be reimbursed $140.00 per person per year for a routine mammogram, $60.00 per person per year for a pap smear and $500.00 for a genetic profile workup associated with amniocentesis per fetus.

In no event will the aggregate maximum for all such examinations exceed $5,000.00 per person during any year, except for the additions identified.

Coverage Does Not Include

Diagnostic testing and laboratory expense benefits are not payable:

(1) for any examinations for which benefits are provided under other provisions of this Plan, except to the extent, if any, that the amount provided in this provision exceeds the total amount payable for such examination under all such other provisions; or

(2) for any examination not recommended and approved by a physician; or legally licensed chiropractor or podiatrist, or

(3) for dental diagnostic testing examination unless it is the result of accidental bodily injury; or

(4) for radiation therapy.

SHOCK THERAPY TREATMENT EXPENSE BENEFITS

SCHEDULE OF BENEFITS:	
Maximum :	**In Addition to other Plan Benefits:** • ***Maximum benefit for a single treatment - $125.00*** • ***Maximum Anesthesia benefit rendered during treatment - $125.00*** • ***Overall maximum - per year. - $2,500.00***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE***
- ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

Benefits will be paid for you and your insured dependents up to $125.00 for a single shock therapy treatment (including electro-shock, insulin-shock or other similar shock treatments) up to an overall maximum of $2,500.00 for each year.

Benefits are payable for anesthesia, when rendered in connection with shock therapy treatments, up to a maximum of $125.00 for each such treatment. This Benefit is separate from and in addition to all other Benefits.

ALCOHOL & SUBSTANCE ABUSE BENEFITS

SCHEDULE OF BENEFITS:		• ***ACTIVE EMPLOYEES***
Maximum :	• ***Inpatient Detoxification or Rehabilitation: Maximum days per confinement per person in semi-private room - 150 days combined with hospital expense benefit***	• ***ELIGIBLE RETIREES AGE 64 AND UNDER***
	• ***Out Patient Benefits:*** ***Treatments $60.00 - $130.00, maximum of $5,000 per year per person***	• ***ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE***

In-Patient Benefits
The Plan will provide for up to 150 days of coverage for detoxification or rehabilitation services in a facility approved by the Welfare Fund office prior to admission. Confinement combined with hospital expense benefit (pg. 47)

Out-Patient Benefits

All treatments shall be performed in a facility approved by the Welfare Fund office prior to the commencement of such treatments.

Note: All eligible individuals requesting this coverage will be referred to the Plan E.A.P. ("Employee Assistance Program"), Care Plus Solutions, Inc. Please contact the Fund offices for further information.

MEDICAL SUPPLIES AND EQUIPMENT BENEFITS

SCHEDULE OF BENEFITS:	
Maximum :	***$1,500.00 per person – no coverage is provided if the benefit is covered by Medicare.***

- ***ACTIVE EMPLOYEES***
- ***ALL ELIGIBLE RETIREES (EVEN MEDICARE RECIPIENTS)***
- ***ELIGIBLE DEPENDENTS***

If you or your insured dependents incur expenses for the purchase of medical supplies and equipment prescribed by a licensed physician, you will receive benefits equal to the actual charge, up to a maximum of $1,500.00 for each insured person. If you are on Medicare, you are not entitled to payment if the benefit is covered or partially covered by Medicare.

Coverage Does Not Include

(1) Examination fees, physician's fees, or any fees or charges other than as specifically provided herein; or

(2) Prosthetic devices provided by any Government agency, directly or indirectly; or

(3) Any expense for dental prosthetics of any kind.

DENTAL EXPENSE BENEFITS

SCHEDULE OF BENEFITS:

Maximum :

- ***$6,000 Overall family maximum during any one year (including Orthodontia), and to the extent specified and listed in the Schedule of Maximum Benefits (below).***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER***
- ***ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICARE RECIPIENTS)***
- ***ELIGIBLE DEPENDENTS***

For dental work performed by a licensed dentist, you will receive benefits equal to the actual charges incurred by you and your insured dependents up to the amounts specified in the Schedule of Maximum Benefits. The Benefits are available solely for the specific procedures specified in the Schedule of Maximum Benefits.

The Fund has the right to examine any dental work including diagnostic testings, and also reserves the right to require prior authorization for benefits which, according to the schedule of maximum benefits, would exceed $30.00. Any procedure for which benefits are payable under any other provision of this policy shall be payable by that provision and not under this provision.

Service provider discounts may apply and be available from service providers having agreements with the Welfare Fund office. Please contact the Welfare Fund office for particulars.

The Schedule of Maximum Benefits is as follows:

DENTAL SERVICES
Schedule of Maximum Benefits

	Maximum Benefit
DIAGNOSTIC	
Examination - Including a full charting of all dental defects (limit of two per year) (Initial)	$ 55.90
Diagnostic testings - full set	93.17
- single	18.63
(maximum amount per year- $95.20)	

Prophylaxis, including scaling and polishing twice per year	89.45
Child Prophy	74.54
Fluoride Treatment (limit of two per year)	27.96
Peridontia Treatment - per treatment	111.80
Peridontia Scaling – (with root planning) – Per Quad	130.44
Peridontia Treatment – (with root planning) Entire Mouth	354.05

ORAL SURGERY - PERFORMED OUT OF HOSPITAL	
Extraction - single, per tooth	111.80
- Surgical - single, per tooth	177.03
- Impaction - (Bony)	379.33
- Impaction (Tissue)	259.54
- Osseous Surgery per quadrant	838.53
- Apicoectomy - per root	221.75
- Endosseous Implant (in the bone)	506.84

RESTORATIVE DENTISTRY	
Fillings - except gold inlays, per tooth	
- one surface	117.39
- two surfaces	158.40
- three surfaces	214.30
- four surfaces	245.97
- with pins - per pin	126.71
Gold inlays per tooth	
- one surface	289.50
- two surfaces	373.35
- three surfaces	424.71
Cast crowns & caps, jackets per tooth	From 459.19 up to 1,157.89
Root Canal Therapy	
- Per Tooth - single rooted teeth	559.02
- Per Tooth - multi-rooted teeth	From 745.36 up to 931.70

PROSTHETICS	
Bridgework - per unit	From 509.11 up to 1,118.04
Full denture - upper or lower, per denture	1118.04
Partial denture	From 441.22 up to 1,197.90
Denture reline	159.72
Teeth added to partial denture to replace natural extracted teeth, per tooth	149.74
Repairs	149.74
Bridge pontic	129.78
Broken denture, no teeth involved	149.74

Broken denture, teeth involved, first tooth	
- additional teeth	59.89
Recementing bridge, inlay or crown	from 63.88 up to 95.20
Night Guard – Replacement of appliance is one (1) a year with Letter of Medical Necessity. No replacement provided for lost or stolen appliance	$291.94

Replacement – replacement of a similar or near similar prosthetic is limited to one no earlier than five (5)years from delivery date of previous prosthetic; how-ever, no benefits are provided for replacement of lost or stolen bridges or dentures.

ORTHODONTIA (for Dependent Children as defined in the Group Policy)	
Diagnosis, Study Models and Initial Orthodontic Appliances	1,118.04
Active Orthodontic Treatments	
- Maximum per month	139.76
- Maximum months payable	24 months
Passive Orthodontic Treatments	
- Maximum per 6 months treatment	55.90
- Maximum months payable	18 months
GENERAL ANESTHESIA	
- If determined in connection with an oral surgical operation other than while an inpatient in the hospital	130.44
- If General Anesthesia is administered by a physician or professional anesthetist in connection with an oral surgical operation while an inpatient in a hospital,	You will be reimbursed up to a maximum of 20% of the surgical benefit subject to a minimum of $29.95.
OVERALL DENTAL MAXIMUM PER BENEFIT YEAR PER FAMILY (including Orthodontia)	$6,000.00

PRESCRIPTION EYEGLASS EXPENSE BENEFITS

SCHEDULE OF BENEFITS:

Maximum : ***Per person during any one year $200.00 including eye examination***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER***
- ***ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICARE RECIPIENTS)***
- ***ELIGIBLE DEPENDENTS***

When you or your insured dependents incur expense for the purchase of prescription eyeglass lenses prescribed by a licensed optometrist or a licensed ophthalmologist, you will be reimbursed up to the maximum benefit of $200.00 including an eye examination.

Service provider discounts may apply and be available from service providers having agreements with the Welfare Fund office. Please contact the Welfare Fund office for particulars.

PRESCRIPTION DRUG EXPENSE BENEFIT

SCHEDULE OF BENEFITS:

Maximum : ***Overall family maximum during any one year - $6,000.00***

No reimbursement or Fund payment at higher than the generic drug rate if generic drug replacement is available. (This is a generic preferred program).

The day supply is 30 days retail and 90 days mail order per one co-pay.

<u>For Active Employees and their Eligible Dependants and for Eligible Retirees and their Eligible Dependants not on Medicare</u>: $5.00 per prescription co-pay for generic drugs, $10.00 per prescription co-pay for brand name drugs and an additional family benefit for injectable prescription drugs, excluding insulin and fertility drugs, of $20,000 maximum with co-pay of $125.00 per prescription

<u>For Eligible Retirees and their Eligible Dependants</u>: $7.00 per prescription co-pay for generic drugs, $12.00 per prescription co-pay for brand name drugs.

Eligible Retirees Age 65 and older: Alternate Benefit, this is a Medicare Part D prescription drug plan.

Fertility Drugs: $1,500 maximum per family in addition to family maximum

This benefit is restricted to identified drugs

Discount brand or generic drugs are available up to 90 day supply, through mail order Express Scripts.

You may be eligible for outpatient pharmacy services provided by the Department of Veterans Affairs, call: 1-800-827-1000

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER***
- ***ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICARE RECIPIENTS)***
- ***ELIGIBLE DEPENDENTS***

(1) The Prescription Drug Program is administered by the Express Scripts, the firm so designated by the Trustees of the Welfare Fund. Each eligible Employee or eligible

Retiree will receive an identification card covering him and his eligible dependents for the purchase of prescription drugs necessary for the treatment of sickness, accidental bodily injury or for the control of a diagnosed illness. This is a generic drug preferred program. No reimbursement or Fund payment will be provided at higher than the generic drug rate if a generic drug replacement is available. If you prefer the brand name drug, you will have to pay from your own pocket the price difference between the brand name and the generic drug, in addition to the co-pay. This difference is not chargeable against the maximum yearly amount.

The program is administered on a co-payment basis of $5.00 per prescription co-pay for generic drugs, $10.00 per prescription co-pay for brand name drugs, for active Employees and their Eligible Dependents and $7.00 per prescription co-pay for generic drugs, $12.00 per prescription co-pay for brand name drugs for Eligible Retirees and their Eligible Dependents. The day supply is 30 days retail and 90 days mail order per one co-pay. The co-payment is the amount you must pay to the supplying pharmacist at the time the prescription is dispensed.

(2) Drugs under this program must be obtained from a licensed pharmacist or physician, or where applicable a licensed chiropractor, podiatrist or dentist.

(3) The program will cover Legend Drugs (prescription drugs) in quantities not to exceed legal limits providing they are necessary to and consistent with the condition for which prescribed.

(4) In no event shall the total benefit payable under this provision during any one year exceed $6,000.00 per family.

(5) Prescriptions for self-administered injectables must state dosage.Fertility Drugs prescribed by a licensed physician for the treatment of infertility will be reimbursed directly by the Welfare Fund Office for the amount actually charged, but not more than $1,500.00 per year per family, which amount will be in addition to the overall family maximum.

ELIGIBLE RETIREES AGE 65 AND OLDER
ALTERNATE BENEFIT

Eligible Retirees age 65 and older for an Alternate to the coverage described above may select an individual special Medicare Express Scripts Prescription Drug Plan. This is a Medicare Part D prescription drug plan. If you select this alternative, you will individually be eligible for the Prescription Drug Program for which this is an alternate benefit.

You cannot be enrolled in more than one creditable Medicare Part D plan. If you have medical and drug coverage from any other source, you may be in jeopardy of losing your medical coverage if you enrolled in another Part D Prescription Drug Plan. You must contact your other plan issuer to let them know that you have joined another Medicare Prescription Drug Plan.

ELIGIBLE RETIREES AGE 65 AND OLDER
ALTERNATE BENEFIT SUMMARY
EFFECTIVE JANUARY 1, 2013

Initial Coverage

This plan covers common Legend Drugs (prescription drugs) generally, the plan only covers drugs, vaccines, biological and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on the plan's formulary. For specific coverage, the certificate of coverage must be consulted.

There is no deductible: You will pay the following when you get your prescription drugs.

Retail: $7 for Generic Drugs, $15 for Preferred Brands, $30 Non-Preferred Brands and $125 for Specialty Drugs

Mail Order: $14 for Generic and $30 for Preferred Brands, $60 Non-Preferred Brands and $125 for Specialty Drugs

There is no beneficiary premium to participate in this prescription drug plan.

In-Network Retail Pharmacy
All retail pharmacies in your plan's network can provide you with a one-month or up to 30-day supply of your prescription. Certain retail pharmacies may be able to provide you with a three-month supply of your prescription. To find out if your pharmacy offers a three-month or up to 90-day supply, contact Express Scripts, Inc. at the number listed on the back of your ID card.

Part B vs. Part D Drugs
The plan does cover drugs that are covered under Medicare Part B as prescribed and dispensed.

Mail Order through Express Script's Home Delivery
You may receive a three-month or up to a 90-day supply of maintenance drugs (drugs you take for a chronic condition, such as asthma) through our Home Delivery service.

Coverage After You Reach Your Initial Coverage Limit
There is no coverage Gap or donut hole in your Employer Plan. Your copays above apply until out-of-pocket costs have reached the catastrophic coverage amount below.

Catastrophic Coverage
After your yearly out-of-pocket costs for 2013 reach $4,700, you pay the greater of:

- $2.65 for generic or preferred brand drug that is a multisource Drug and $6.60 for single source brand drug, or
- 5% coinsurance

General Information
In some cases, you may need to first try one drug to treat your medical condition before your plan will cover another drug for that condition.

Certain prescription drugs will have maximum quantity limits.

Your provider must get prior authorization from Express Scripts for certain prescription drugs.

IMPORTANT CONTACT INFORMATION

Express Scripts (1-888-837-0302) or Ms. Silvana Baldo, Fund Administrator of Cement & Concrete Workers District Council Welfare Fund, at 718-762-6133, Monday through Friday 8:00 a.m. – 3:30 p.m. Please refer to the term "D84" when discussing the Special Medicare Part D program coverage.

Medicare limits when you can make changes to your coverage. You can join a new Medicare Prescription Drug Plan or Medicare Health Plan from **November 15 to December 31 each year.** Coverage starts in January. You may not join a new plan during other times of the year except in special cases. If Medicare decides that you need extra help with paying plan costs, you may join or leave a plan at any time. If Medicare decides that you no longer need extra help, you may make changes for two months after Medicare tells you about its ruling.

Discount Drugs
Discount brand or generic drugs are available up to 90 day supply, through mail order Express Scripts. Express Scripts is an pharmacy service from which the purchase of such drugs may be arranged. See pg. 80.

Coverage Does Not Include
The Prescription Drug Expense Benefit does not include certain drugs or medicine such as:

(a) Drugs, or medicines, which are lawfully obtainable without the prescription of a licensed physician (except for prenatal vitamins, Kwell and co-lyte); or

(b) Drugs and medicines administered or obtained while confined in a hospital, nursing home, rest home, or similar institution, or which are administered by a physician; or

(c) Drugs obtained from any Government agency, directly or indirectly; or

(d) Prescriptions containing vitamins and dietary supplement; or

(e) Injectable drugs (except insulin); or

(f) Drugs in quantities that exceed a six (6) month supply;

(g) Birth control pills or devices;

(h) Propecia and Rogaine;

(i) Drugs or medicine not listed by the National Prescription Drug Administrators, Inc.;

(j) Experimental Drugs;

(k) The foregoing is not a complete list of all prescription drugs not covered under this Plan. If you have a question about whether a specific drug is covered, please call the Fund Office.

HEARING AID EXPENSE BENEFITS

SCHEDULE OF BENEFITS:

Maximum : ***Overall maximum per person for three (3) consecutive years - $1,000.00***

- ***ACTIVE EMPLOYEES***
- ***ELIGIBLE RETIREES AGE 64 AND UNDER***
- ***ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICARE RECIPIENTS)***
- ***ELIGIBLE DEPENDENTS***

A maximum of $1000.00 per person during a period of three (3) consecutive years will be allowed for the purchase, repair, or replacement of a hearing aid which is prescribed by a licensed physician.

Service Provider discounts may apply and be available. Contact the Welfare Fund Office.

DEATH BENEFITS

Participants eligible for a death benefit are those Participants in the Welfare Plan who have past or current service credits in force at the time of death within the meaning of the Cement and Concrete Workers District Council Pension Plan in accordance with the following schedule. The beneficiary of such Participant shall be entitled to death benefits paid directly from the Welfare Fund in amounts as designated.

5 to 8 years	$ 8,000.00
9 to 15 years	$10,000.00
16 to 19 years	$14,000.00
20 years or more	$20,000.00

In the case of accidental death, death benefits will be payable as follows:

5 to 8 years	$10,000.00
9 to 15 years	$12,000.00
16 to 19 years	$17,000.00
20 years or more	$23,000.00

Any Participant eligible for a death benefit, whose legal spouse predeceases him or her, will be paid one-half the amount that would otherwise be payable to the Participant under similar circumstances had the Participant predeceased the spouse. To qualify for this benefit, the Participant and spouse will have had to be legally married for at least twelve (12) consecutive months at the time of the spouse's death. This spousal benefit will be limited to once in a Participant's lifetime, and the benefit will be paid only if the Participant is alive at the time of death of the spouse. In the event of a common disaster, the Participant will be deemed to have predeceased the spouse.

- **Deceased Eligible Employee/**
  Health Coverage for Eligible Dependents

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One who is an Eligible Spousal Dependent of a deceased Active Employee or Eligible Retiree who, at the time of death, was receiving or eligible to receive a pension based on the number of years of credited service under the Cement and Concrete Workers District Council Pension Plan outlined in the schedule below, shall be eligible for the number of months of continuing Eligible Dependent welfare coverage indicated, starting from the Active Employee's or Eligible Retiree's date of death or when active coverage would lapse.

15 to 19 years	-	12 Months
20 to 24 years	-	48 Months
25 to 29 years	-	84 Months
30 or more Years	-	120 Months

To qualify for the above benefits, a surviving spouse must have been legally married to the deceased Employee for at least 12 consecutive months prior to the Employee's date of death. In addition, the continuation of coverage shall be predicated on the months of coverage shown or up to the date of remarriage, which ever shall come first.

One who, at the time of death, was an Eligible Dependent, other than an Eligible Spousal Dependent, shall receive benefits based on the above schedule only to the extent that such dependent would have remained eligible for benefits, assuming the employee or retiree was eligible, to the extent provided by the plan.

PAYMENT OF BENEFITS - PROCEDURE

A. File Application For Welfare Fund Benefit Eligibility Form

Any other provision of the Plan and Summary 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 Application For Welfare Fund Benefits form, listing claimed Eligible Dependants, claiming eligibility for coverage. The Fund will determine if you or your claimed dependants are eligible for coverage. You will not be entitled to payments of any claim incurred at a time previous to your submission of the Eligible Active Coverage or Eligible Retiree Coverage application form that establishes your coverage. This provision is effective September 1, 2002.

B. Notifying Providers of Coverage

When a covered individual appears at the office of the medical service provider, they should present a copy of their health insurance card and our claim form. The provider will also routinely check with the Fund office to verify that the covered individual has current coverage in effect.

C. Welfare Fund Cost Reduction Providers

The Welfare Fund has a number of coverage programs to reduce the costs of coverage provided. If these programs are applicable to your situation and you benefit from them, effectively you receive greater benefits.
To avail yourself of this reduction as applicable to any personal share for payment, your payment may be due within 30 days.

Effective January 1, 2013 – You will receive a MagnaCare card

1. Medical/Hospital/Laboratory Ancillary Network – MagnaCare in NY/NJ.

You are eligible for discounted benefits if you use a doctor/hospital included in the MagnaCare Network when your residence is in New York or New Jersey. The MagnaCare network offers access to providers in New York and New Jersey. For those who reside in the other 48 states, PHCS/MultiPlan will continue to be utilized through our new relationship with MagnaCare.

All MagnaCare Providers are offering us their services at a discounted rate because they expect prompt payment from the Fund and if necessary, from you, the participant. If we all cooperate, the savings will be substantial.

a. All benefits must be assigned to the provider.

b. If you have questions, you can ask your doctor or contact MagnaCare at 800-352-6465 or through their website at www.magnacare.com and simply click on “provider search” to find a specific type of provider in a specific zip code, city/state, or by name. If your provider is participating, you should

present your ID card at your doctor's office so he/she knows that the bill will be discounted.

c. The doctor's office will contact the Fund Office for eligibility directly. If the entire bill is covered by your Plan benefits, the Fund will pay the doctor at the reduced rate and you will pay nothing. If your benefits are not entirely covered by the Plan, the Fund Office will notify you of the amount still owing. It is your obligation to pay the doctor within 30 days of the date of service to obtain these discounts.

Outside of NY/NJ, PHCS/MultiPlan will continue to be used for those residing in any states outside of NY/NJ. If you have any questions you can ask your provider also, or have them contact PHCS/MultiPlan at 1-800-575-7427 or through their website at http://www.multiplan.com

1. Mail Order Prescription Drugs – Express Scripts

   For those of you who take drugs for a chronic condition (*high blood pressure, diabetes, etc.*) there is a mail order program, Express Scripts Pharmacy Service, which provides generic or Legend drugs, *usually a 90 day supply*, usually at a much lower cost than your local pharmacy. If you need information about this program, please contact:

   Express Scripts
   Home Delivery Service
   P.O. Box 866
   Bensalem, PA 19020-0866

   Website: http://member.express-scripts.com

   For further information, contact the Fund Office

2. Eyeglass and Hearing Aid Benefits – Discounts available through General Vision Services and General Hearing Services.

3. Dental – Discounts available through Sele-Dent providers

If your doctor is not part of the aforementioned networks and you want to continue using him or her, the Welfare Plan will continue to pay benefits as it does now.

If you have any questions, please call the Fund Office.

D. Obtain Claim Form

If an event occurs for which a member is or will be entitled to receive benefit under the program, secure a claim form from the Welfare Fund Office or at your

Local Union Office, or where applicable make arrangement for the assignment of benefits to the service provider.

If you have any questions regarding the appropriate procedure, contact the Fund Office.

E. Completion and Submission of Claim Form

The claim form contains an explanation of how it is to be completed. Claim forms must be completed in writing THOROUGHLY, PROPERLY, and SIGNED by all parties concerned.

A medical services supplier may receive direct payment under the benefits provisions in this plan only if the medical services supplier receives completed and signed Assignment of Benefits from the plan member. There is an optional Assignment of Benefits provision provided on all official claim forms.

Under certain circumstances the Welfare Fund Office will accept the medical services providers bill in lieu of the official claim form if that bill is submitted for payment in conjunction with a completed and signed Assignment of Benefits from the member or the medical provider's bill service if acceptance of such bill is generally accepted in keeping with the practice of the industry.

Claim forms in writing must be submitted in writing to the Welfare Fund Office within a reasonable period of time, but not to exceed 90 days from the date of termination of the period of disability or hospital confinement, the date a surgical operation is performed, the date doctor's in hospital, home, or office calls are made, the date of laboratory or diagnostic testing examination, the date expenses are incurred for prescription eyeglasses, and prescription drugs, and not to exceed 180 days from the date a dental expense is incurred (or thirty days after disability has commenced). If the payment forms are not submitted within this specified time, the Fund has the right to refuse and deny payment and you will be fully responsible for the payment.

When the necessary claim information has been completed, mail the form, together with any doctor's or dentist's bills, plus any prescription eyeglasses, and hospital bills to:

CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL WELFARE FUND
35-30 Francis Lewis Blvd., Suite 201
Flushing, NY 11358
(718) 762-6133

F. Claims Procedures – Denial of Claim and Appeal Procedure

For purposes of the Plan, a claim for benefit is a written application for benefit filed with the Plan. This written application must be made to the Welfare Fund even though the original claim, which was denied, for the benefit was not in writing. In the event that

any Participant or other person claims to be entitled to a benefit under the Plan, or claims to be entitled to a benefit in an amount which is different from the amount determined 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 90 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. Such notification shall:

(i) Be written in a manner reasonably expected to be understood by such Participant or other person;
(ii) Set forth the pertinent sections of the Plan relied on; and
(iii) Set forth an explanation of how the claimant can obtain review of such denial.

(a) Within 60 days after the mailing or delivery by the Plan of such notice, such claimant may request, by mailing or delivery of written notice to the Trustees, a review by the Trustees of a decision denying the claim. If the claimant fails to request such a review within such 60 days period, it shall be conclusively determined for all purposes of this Plan that the denial of such 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.

(b) 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 by the Trustees of its determination that he intends to institute legal proceedings challenging the determination of the Trustees, and actually institutes such legal proceeding within 180 days after such mailing or delivery.

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

G. Action of Trustees

Action of Trustees - The Trustees shall be the sole judges of the standard of proof required in any matter or ambiguity 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 under this Plan will be paid 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.

COBRA - RULES GOVERNING VOLUNTARY SELF PAYMENTS

(Consolidated Omnibus Budget Reconciliation Act of 1986)

Under the federal law known as "C.O.B.R.A.", you are eligible to continue welfare 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 C.O.B.R.A. coverage can vary between 18 and 36 months, depending on the Qualifying Event.

Qualifying Event:	**Entitlement:**
If participant was terminated or merely worked too few hours to otherwise qualify for welfare coverage.	**18 Months**
If participant is disabled at the time welfare coverage would otherwise have ended.	**18 Months with an 11 month extension available**
If participant dies, becomes divorced, legally separated, eligible for Medicare while on C.O.B.R.A., 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 our Welfare Plan **NOT MORE THAN 30 DAYS** after this qualifying event in order for the participant and/or his 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 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 classifications, etc.) which results in a loss of Benefits Coverage.

Under the law, the employee or one of his family members have up to 60 days to file an election with the Fund Administrator for continuation of Benefits 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.

Benefits Coverage

The employee or an eligible dependent, who qualified under the direct payment provisions set forth above, will, at their option, be covered for either the Full Benefit package, which includes Hospitalization, Medical and Surgical, Prescription Drugs, Dental and Optical Benefits or, the Core benefit package which includes all of the foregoing Benefits with the exception of Dental and Optical. There will no continuation of the Employee Weekly Disability Benefits. C.O.B.R.A. 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 established the COBRA rates pursuant to statute, which rates are directly related to the actual cost of you coverage.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans. Coordination of benefits 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 plan involved. The secondary and subsequent plans will pay the balance 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. This 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) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) 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 HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO 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. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) 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 a laid-off or 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 Eligible Retiree. 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.

(c) Dependent Children Of Parents Not Separated Or Divorced:

(i) 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.

(ii) The Transition Rule: 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.

However, when a child's parents are divorced or separated, these rules will apply:

(I) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(II) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(III) This rule will be in place of items (I) and (II) above when it applies. 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.

(IV) 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.

(d) 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.

(3) 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.

Right of Recovery:

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan. If necessary, lawsuit may be commenced to accomplish any such repayment.

Patient Payment Option

A patient under the Plan retains the right to select his service provider and payment option relating to any service provider and the Plan is authorized to act in the patient's behalf to select the lowest total payment, but the Plan's liability is limited to the terms of the plan and the Plan shall not pay more or in excess of amounts the Plan specifically determines, states or establishes.

No Payment In Excess Of Any Plan Amount

No contract or arrangement shall commit or require the Plan to pay more or in excess of amounts the Plan specifically determines, states or establishes. Any such claimed contract or arrangement, whether with intermediaries, providers or others, shall be unauthorized, void and unenforceable under the Plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case this Plan may recover the amount of the overpayment from the source to which it was paid.

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/subrogation agreement must be signed by the Participant or his legal representative before Plan benefits will be paid. The reimbursement/ subrogation agreement requires the Participant and/or Dependent to reimburse the Plan for any benefit payments made by the Plan for the particular condition if a duplicate recovery for those expenses results from action taken by the Participant and/or Dependent against a third party. The Plan will be subrogated to the rights of the Participant and/or Dependent and may proceed directly against the third party for recovery of expenses paid by the Plan.

The reimbursement to the Plan for the proceeds awarded by a settlement, judgment, or other form, of recovery will be made after adjustment for any attorney's fees associated with recovery from the third party.

If a Participant or covered Dependent suffers an injury or illness that is caused by the negligence or fault of a third party, they must contact the Fund Office and provide full details. The Fund Office will provide the Participant with a copy of the reimbursement/subrogation agreement. The Plan is not obligated to pay any benefits for expenses related to the injury or illness unless, and until the reimbursement/subrogation agreement is signed and returned to the Fund Office.

In the event that the Participant or his covered Dependent refuses to sign a reimbursement/subrogation agreement, the Plan will automatically be entitled to these foregoing reimbursement/subrogation rights.

The plan actively reviews Workmans' Compensation reports and court records. A claimant's failure to notify the Plan as required by this subrogation provision may result in a permanent loss of benefits.

SPECIAL LEGAL PROTECTIONS

Special Enrollment for Individuals who lose coverage under Medicaid or a State Children's Health Insurance Program (CHIP)

Effective April 1, 2009, the Plan is amended to allow special enrollment must be eligible under the Plan for individuals who lose coverage under a Medicaid or State CHIP.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Fund Office.

Women's Health And Cancer Rights Act Of 1998

We are pleased to state that this Plan is in compliance with the Women'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; and

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.

Please note: The new law requires that participants be notified of this coverage in the next available communication, but not later than January 1, 1999, and annually thereafter. However, for those plans that already meet the requirements of this new 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 Family and Medical Leave Act of 1993 (FMLA) if you take or family or medical leave.

The FMLA requires that unpaid leave from work must be granted for up to twelve 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; or
- 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 12 weeks on an intermittent or reduced leave basis. Taking of intermittent leave for the birth, placement for 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 of the Fund office regarding your continuing Welfare Plan coverage during this twelve week period.

Federal Mental Health Parity Act

The federal Mental Health Parity Act went into effect on Jan. 1, 1998. Under the new law, a health plan cannot impose an annual or lifetime dollar limit on mental health benefits if dollar limits don't 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 doesn't place a dollar limit 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)

The Health Insurance Portability and Accountability Act (HIPAA) defines the permissible preexisting 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 preexisting 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 preexisting 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 a similar state continuation provision); and
- At an individual's request within twenty-four (24) months of his or her loss of coverage.

Coverage During Military Leave
Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Your right to continue participation in the group health plan benefit programs during leaves of absence for active United States military duty is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). Under USERRA, while on approved military leave, you may waive coverage or you may continue your current coverage under the Medical Program for a period of up to 24 months or, if earlier, the day after the date on which you are required to apply for or return to a position of employment in accordance with USERRA.

If you elect continuation coverage under USERRA and your approved military service exceeds 31 days, you must pay the entire premium for your Medical Program coverage, plus an additional amount of up to 2% of the total premium cost to cover administrative expenses.

Upon reemployment after military service, USERRA requires that coverage will be reinstated upon reemployment without having to satisfy any waiting period.

For purposes of USERRA, the “Uniformed Services” include the U.S. Armed Forces, the U.S. Army National Guard and the U.S. Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the U.S. in time of war or national emergency. “Service in the Uniformed Services” means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

PROVISIONS OF THE PLAN

A. Incorporation of All Previous Substantive Provisions

(a) All of the previous substantive provisions are incorporated into and are part of the Welfare Plan.

B. Administration of the Plan

(a) 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.

(b) 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.

(c) 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 counsel 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.

(d) Indemnification - Except as otherwise provided by applicable law, the Plan shall indemnify and save harmless each member of the Board of Trustees against any cost or expense (including attorneys' 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.

(e) 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 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 either 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, obligation 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 Welfare 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 expenses they may incur in the performance of their duties. The costs and expense of any suit or proceeding brought by or against the Trustees (including attorneys' fees and disbursements) shall be paid from the Welfare 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; and

(10) to purchase insurance out of Welfare 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.

(f) Requirement to File Coverage Application Form –

(1) Any other provision of the Plan and Summary 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 Dependants, claiming eligibility for coverage. The Fund will determine if you or your claimed dependants are eligible for coverage. You will not be

entitled to payments of any claim incurred at a time previous to your submission of the Eligible Active Coverage or Eligible Retiree Coverage application form that establishes your coverage. This provision is effective September 1, 2002.

(g) Claim And Appeal Procedures -

(1) For purposes of the Plan, a claim for benefit is a written application for benefit filed with the Plan. In the event that any Participant or other person claims to be entitled to a benefit under the Plan, or claims to be entitled to a benefit in an amount which is different from the amount determined 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 90 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. Such notification shall:

(i) Be written in a manner reasonably expected to be understood by such Participant or other person;

(ii) Set forth the pertinent sections of the Plan relied on; and

(iii) Set forth an explanation of how the claimant can obtain review of such denial.

(2) Within 60 days after the mailing or delivery by the Plan of such notice, such claimant may request, by mailing or delivery of written notice to the Trustees, a review by the Trustees of a decision denying the claim. If the claimant fails to request such a review within such 60 days period, it shall be conclusively determined for all purposes of this Plan that the denial of such 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.

(3) 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 by the Trustees of its determination that he intends to institute legal proceedings challenging the determination of the Trustees, and actually institutes such legal proceeding within 180 days after such mailing or delivery.

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

(h) 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 under this Plan will be paid 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

(a) 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 conditions of any law, governmental regulation, or ruling, and to meet the requirements of ERISA, as it may be amended.

(b) 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. 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

(a) 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.

(b) 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.

(c) 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.

(d) 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.

(e) 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.

(f) 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 the return of an erroneous contribution within the time limits prescribed by law.

(g) 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.

(h) Participant Fraud – If a participant engages in fraud against the Welfare Fund, the Trustees have the right to refuse to provide further Welfare benefits and take such other actions which are necessary to protect the assets of the Welfare Fund.

(i) Effective Date, Governing Documents – Restated 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 benefit and this restatement of the Plan shall become effective on January 1, 2013.

(j) 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.

(k) 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.

(l) 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.

CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL WELFARE FUND

Plan And Summary Plan Document Amendment

Use and Disclosure of Protected Health Information

A. Use and disclosure of Protected Health Information (PHI): The Plan will use protected health information 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 protected health information for purposes related to health care treatment, payment for health care, and health care operations. As relates to the Cement And Concrete Workers District Council Welfare Fund, the term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to 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 copayments 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 and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and

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 policyholders, Plan sponsors or other customers,

    c. Resolution of internal grievances, and

    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 the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

B. 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 pension plan, disability plan, reciprocal benefit plans, workers' 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, and

9. If feasible, return or destroy all PHI received from the Plan that the 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.

C. 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:

1. The Plan Administrator,

2. 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 Cement And Concrete Workers District Council Welfare Fund. As well, the consultants and business associates are designated who in the ordinary course of their business regarding the function of the Cement And Concrete Workers District Council Welfare Fund are required to render assistance relating to health care treatment, payment for health care and health care operations.

D. The persons described in section C may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor and representative Board of Trustees performs for the Plan.

E. If the persons described in section C do not comply with the Plan Document, the Plan Sponsor and representative Board of Trustees shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.