

CEMENT AND CONCRETE WORKERS
DISTRICT COUNCIL

WELFARE FUND

PLAN

And

SUMMARY PLAN DESCRIPTION

THE EFFECTIVE DATE OF THIS PLAN IS JANUARY 1, 2003

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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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HAYDON, STRACI & COOPER
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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.

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.

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 question 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, 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.
- 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. 79.*
- COBRA options are available under this plan.
- If a change occurs in your marital status or dependent status (for example: birth, adoption of child, unmarried child between 19 and 23 becomes a full time student), 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 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. 83.*

- 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. 86.*
- 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. 87.*
- 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. 76.*
- 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 your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for 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

Assistant Secretary, PWBA: Olena Berg, (202) 219-8233

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
1633 Broadway
Rm. 226
New York, NY 10019

Regional Director: John E. Wehrum, Jr.
(212) 399-519

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 @(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 CERTIFIED copy of marriage certificate, birth certificate, legal adoption papers.

Member's name: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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

Name: _____

Social Security Number: _____

Date of Birth: _____

Coverage by any other
Insurance: _____

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 81.

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 27-39 and identified and explained in the section, see pages 41- 73, and DEATH BENEFITS, see page 74.

“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)” or “(b)” as follows:

(a) If the Employee does not have coverage on the day when the Employee acquires 900 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 900 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 450 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 900 hours of credit.

* You may qualify for eligibility under both *(i) and (ii)*, however this would not 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.

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 450 Hours of Credit in the immediately preceding six (6) months or 900 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.

Dependent" means your spouse and eligible dependents.

An unmarried child whose coverage would otherwise terminate solely due to reaching the age of 19 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 19;
- c. written evidence of such incapacity is sent to the Trust Fund office within 30 days after the child reaches age 19; 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 68. 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 First Commencing Covered Employment After January 1, 2000**

Participants first commencing covered employment after January 1, 2000 and their dependents shall not be eligible for a death benefit.

“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 13.

“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 the American Medical Association (the “AMA”).

“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:		FOR:
Maximum :	<ul style="list-style-type: none">• <i>Semi-private Charge of the Confining Hospital - 150 day maximum per person</i>• <i>In Psychiatric (Mental Health) Hospitals per year - 30 days</i>• <i>Miscellaneous Hospital Services Benefit - unlimited during the period room and board benefits are payable</i>	<ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER• ELIGIBLE DEPENDENTS AGE 64 AND UNDER
	\$1,000 maximum for Routine Newborn Well Baby Care	

“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

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. 40, 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. 40 - 77.

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. 41-73 .

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 27-39) 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 41-73 , under the appropriate heading as follows:

THOSE ELIGIBLE:

BENEFITS:

For Participants Eligible for a Disability Benefit (pg. 23)	DISABILITY BENEFITS.....42
For Participants Eligible for a Death Benefit (pg. 23)	DEATH BENEFITS.....74
Active Employees (pg. 18) receiving Workers' Compensation Benefits	EXTENSION OF BENEFIT COVERAGE.....41
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BENEFIT FOR:

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

- | | |
|-------------------------------|---|
| • DISABILITY BENEFIT (pg. 42) | \$300 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. 23)**

- | | |
|--------------------------|---|
| • DEATH BENEFIT (pg. 74) | Paid to your beneficiary as designated by you to Fund Office or to you if your spouse dies, pg. 74 (amount varies according to years of credited service under the pension plan). |
|--------------------------|---|

BENEFIT FOR:

- **Active Employees (pg. 18) receiving Workers' Compensation Benefits**

- | | |
|--|---|
| • Extension of Benefit Coverage (pg. 41) | 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 (pg.22) age 65 before January 1, 2004 or otherwise on Medicare starting before January 1, 2004.**
- **Eligible Dependents (pg. 20) 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. 43)

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.

(a) ADDITIONAL BENEFITS NOT PROVIDED BY MEDICARE (See pg. 38)

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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. 38 and pgs. 66-73.

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:**

<ul style="list-style-type: none"> • HOSPITAL EXPENSE BENEFITS (pg. 45) <p style="text-align: center;">Daily Benefits</p>	<p>Room and board benefits for up to 150 days per person during any one period of hospital confinement</p> <ul style="list-style-type: none"> • In Psychiatric (Mental Health) Hospitals per year - 30 days • \$1,000 maximum per baby per confinement for Routine Newborn Nursery Care
<p style="text-align: center;">Miscellaneous Hospital Service Benefits (pg. 46)</p>	<p>Non-surgical care while admitted to hospital:</p> <ul style="list-style-type: none"> • ambulance transportation to or from a hospital • diagnostic testing and laboratory services <p>certain other expenses as necessary while admitted to hospital</p>
<ul style="list-style-type: none"> • HOSPITAL OUT-PATIENT BENEFITS (pg. 47) 	<p>Up to \$5,000.00 maximum per person per occurrence</p>
<ul style="list-style-type: none"> • SURGICAL EXPENSE BENEFITS (pg. 48) 	<p>\$10,000.00 maximum per person per surgical operation at 95% of reasonable charges – lesser amounts for two operations</p> <p>\$300 maximum for ancillary services out-of-hospital</p>

FOR:

- Active Employees (pg. 10)
- Eligible Retirees (pg. 14) age 64 and under not on Medicare
- Eligible Dependents (pg. 12) age 64 and under not on Medicare:

• SECOND SURGICAL OPINION (pg. 50)	given by a qualified specialist per required conditions, \$100.00 Maximum per operation
• ANESTHESIA BENEFITS (pg. 51)	Usual, Customary and Reasonable amount for anesthesia in connection with medical procedures (in addition to other benefits)
• CATASTROPHIC EXPENSE BENEFIT (pg. 52)	For Treatment of Malignancies, Cardiac Problems, Kidney Failure and Lupus, Hepatitis C, Pulmonary Disease and Multiple Sclerosis (an additional \$50,000.00 maximum per person per year.
• PRIVATE DUTY NURSES (pg. 53)	\$2,400.00 maximum per hospital confinement (\$120.00 per 8-hour shift, up to 20 shifts)
• HOME HEALTH CARE EXPENSE BENEFITS (Nursing Care, Etc.) (pg. 54)	While under the continuing care of a physician: <ul style="list-style-type: none">• Deductible of \$50.00 per person per year.• Coinsurance -75% of Usual, Customary and Reasonable Maximum of forty (40) Visits per person per year

- CONTINUED

FOR:

- Active Employees (pg. 10)
- Eligible Retirees (pg. 14) age 64 and under not on Medicare
- Eligible Dependents (pg. 12) age 64 and under not on Medicare:

- MEDICAL EXPENSE BENEFITS (Home and Office Calls) (pg. 56)

\$3,000.00 maximum per family per year

- Home - 60.00 per day per treatment per provider
- Office - 60.00 per day per treatment per provider
- Hospital - 50.00 per day per treatment per provider
- Not more than one treatment per day per provider

- CHIROPRACTIC/PHYSICAL THERAPY BENEFIT (pg. 57)

Maximum of 30 visits per family per year

Maximum of \$60.00 per visit

If exhausted, coverage can continue as a medical expenses benefit.

- IN-HOSPITAL MEDICAL EXPENSE BENEFITS (pg. 57)

For professional services rendered personally by licensed physician during period of confinement:
\$50.00 per day per treatment per Provider

- Overall maximum during hospital confinement - \$1,500.00 per person

- CONTINUED

FOR:

- Active Employees (pg. 10)
- Eligible Retirees (pg. 14) age 64 and under not on Medicare
- Eligible Dependents (pg. 12) 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)

- 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)

\$100 limit per Specialist per year per person (in addition to \$3,000.00 Medical Expense maximum and Second Surgical Opinion maximum)

- CONTINUED

FOR:

- Active Employees (pg. 10)
- Eligible Retirees (pg. 14) age 64 and under not on Medicare
- Eligible Dependents (pg. 12) age 64 and under not on Medicare:

<ul style="list-style-type: none">• ROUTINE PHYSICAL EXAM EXPENSE (pg. 62)	<p>In addition to \$3,000.00 Medical Expense maximum</p> <ul style="list-style-type: none">• 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 <p>Note: This benefit is not available for those receiving Well Baby Care coverage .</p>
<ul style="list-style-type: none">• DIAGNOSTIC TESTING AND LABORATORY EXPENSE BENEFIT (OUTPATIENT) (pg. 63)	<p>\$2,000.00 per person maximum per year</p> <p>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</p>
<ul style="list-style-type: none">• SHOCK THERAPY TREATMENT EXPENSE BENEFITS (pg. 65)	<p>In addition to other Plan Benefits:</p> <p>\$2,500.00 maximum per year</p>

- CONTINUED

FOR:

- **Active Employees (pg. 10)**
- **Eligible Retirees (pg. 14) age 64 and under not on Medicare**
- **Eligible Dependents (pg. 12) age 64 and under not on Medicare:**

- **ALCOHOL & SUBSTANCE ABUSE BENEFITS (pg. 66)***

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

In addition to other Plan Benefits:

- **Inpatient Detoxification:**
Maximum days per confinement per person in semi-private room - 7 days
- **Inpatient Rehabilitation:**
 - Maximum days per confinement per person - 30
 - Maximum of one confinement per person per year
 - Maximum confinements per lifetime per person - 3
- **Out Patient Benefits:**
 - Outpatient treatment, per treatment - \$50.00
 - Maximum treatments per year per person - Sixty

FOR:

- **Active Employees (pg. 16)**
- **All Eligible Retirees (pg. 20) (even Medicare recipients)**
- **Eligible Dependents (pg. 18)**

• MEDICAL SUPPLIES AND EQUIPMENT BENEFITS (pg. 68)	prescribed by a licensed physician, \$750.00 per person per year, for those supplies <u>not</u> covered by Medicare
• DENTAL EXPENSE BENEFITS (pg. 69)	\$4,000 per family maximum during any one year (including Orthodontia), <u>and</u> procedure maximum per Schedule, pg. 69.
• PRESCRIPTION EYEGLASS EXPENSE BENEFITS (pg.73)	Per person maximum during a period of two (2) consecutive years: Single Lens \$100.00 Bifocal 125.00 Trifocal 140.00 Cataract 160.00 Eye Examination 25.00 (Service Provider Discounts may be Available)

FOR:

- Active Employees (pg. 10)
- All Eligible Retirees (pg. 14) (even Medicare recipients)
- Eligible Dependents (pg. 12)

- PRESCRIPTION DRUG EXPENSE BENEFIT (pg. 74)*

Administered by the National Prescription Drug Administrators, Inc.-

\$2,500.00 per family per year

For Active Employees:

- \$3.00 per prescription co-pay for generic drugs,
- \$5.00 per prescription co-pay for brand name drugs, and

For Retirees:

- \$5.00 per prescription co-pay for generic drugs,
- \$10.00 per prescription co-pay for brand name drugs

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 100 day supply, through mail order CFI.

*You may be eligible for out patient pharmacy services provided by the Department of Veteran Affairs, call: 1-800-827-1000

- HEARING AID EXPENSE BENEFITS (pg. 77)

A maximum of \$1,000.00 per person during a period of three (3) consecutive years

FOR:

- **Active Employees (pg. 10)**
- **All Eligible Retirees (pg. 14) (even Medicare recipients)**
- **Eligible Dependents (pg. 12)**

BENEFITS

EXTENSION OF BENEFIT COVERAGE

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

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:	FOR:	<ul style="list-style-type: none">• ACTIVE EMPLOYEES• PARTICIPANTS
Maximum : \$300.00 per week for maximum of 26 weeks		

You as an Active Employee 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 QUARTERLY PREMIUM AND DEDUCTIBLE AMOUNT REIMBURSEMENT

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : 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:</p> <p style="padding-left: 40px;">Part A – Fund Reimburses</p> <p style="padding-left: 40px;">Part B – Fund Reimburses</p> <p style="padding-left: 40px;">No co-insurance is paid.</p>	<p>FOR:</p> <ul style="list-style-type: none"> • ELIGIBLE RETIREES (AGE 65 AND OVER OR OTHERWISE ON MEDICARE) • ELIGIBLE DEPENDENTS AGE 65 AND OVER OR OTHERWISE ON MEDICARE
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If you are eligible for Medicare 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. Under Hospital Benefits Coverage
 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. Under Medical Benefits Coverage
 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 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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum :</p> <ul style="list-style-type: none"> • <i>Semi-private Charge of the Confining Hospital - 150 day maximum per person per confinement</i> • <i>In Psychiatric (Mental Health) Hospitals per year - 30 days</i> • <i>Miscellaneous Hospital Services Benefit - covers certain other expenses as necessary during the period of confinement</i> <p>\$1,000 maximum per baby per confinement for Routine Newborn Well Baby Care</p>	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE • ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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Daily Benefit

Payment will be made in an amount satisfactory to the confining hospital 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 shall be limited to a total of 30 days in any one year for confinements in specified hospitals registered with the American Hospital Association as specializing in and rendering psychiatric treatment and care.

This benefit is limited to a maximum of \$1,000 per baby per confinement for payment to the hospital toward charges incurred for nursery Routine Newborn Well Baby Care.

Miscellaneous Hospital Service Benefit

Payment will be made in an amount satisfactory to the confining hospital 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; and
- (2) *By a physician or professional anesthetist* 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 reasonably 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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : • Out-Patient Benefit - \$3,000.00 per person per occurrence</p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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If you or your insured dependent incurs expenses for hospital out-patient treatment, you will be reimbursed, subject to a maximum of \$3,000.00 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
- (2) *By a professional ambulance service* for transportation to or from a hospital.

SURGICAL EXPENSE BENEFITS

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum :</p> <ul style="list-style-type: none"> • \$10,000.00 per person per surgical operation • Second Surgical Opinion - \$100.00 per person per surgical operation • 95% of the usual, customary and reasonable physician charges (lesser amount for two operation procedure) • \$300 maximum for ancillary services out-of-hospital 	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE • ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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 95% of 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 \$10,000.00. 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 95% of the usual, customary and reasonable charges based upon tables provided by the HCCA (“Health Care Consultants of America of the American Medical Association”) 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 \$100 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.

ANESTHESIA BENEFITS

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : This is in addition to other Plan Benefits: Usual, Customary and Reasonable amount for anesthesia</p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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Usual, Customary and Reasonable amount is reimbursed for anesthesia in connection with medical procedures (in addition to other benefits).

CATASTROPHIC EXPENSE BENEFIT

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : \$50,000.00 per person per year benefit maximum</p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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 extent that payable expenses under any and all other provisions of the Plan have been exhausted for the ailments listed below. The maximum amount payable under this benefit is \$50,000.00 per person per year.

Benefits covered by the Catastrophic Expense Benefit are:

1. Treatment of malignancies and reconstructive surgery relating to a mastectomy (see further, pg. 94).
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. Treatment of Lupus.
5. Hepatitis C Treatment.
6. Pulmonary Disease Treatment.
7. Multiple Sclerosis.

PRIVATE DUTY NURSES

SCHEDULE OF BENEFITS: Maximum : <ul style="list-style-type: none">• 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	FOR: <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum :</p> <ul style="list-style-type: none"> • <i>Deductible of \$50.00 per person per year.</i> • <i>75% of Usual, Customary and Reasonable Charge</i> • <i>Forty Maximum visits per person per year</i> 	<p>FOR:</p> <ul style="list-style-type: none"> • <i>ACTIVE EMPLOYEES</i> • <i>ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE</i> • <i>ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE</i>
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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 Treatment)

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : Overall maximum per family for treatment rendered out of hospital - \$3,000.00 per year</p> <p>Overall maximum during hospital confinement - \$1,500.00 per person</p> <ul style="list-style-type: none">• <i>Home - \$60.00 per day per person per treatment per provider</i>• <i>Office - \$60.00 per day per person per treatment per provider</i>• <i>Hospital - \$50.00 per day per person per treatment per provider</i>• <i>Not more than one treatment per day per provider</i> <p>In addition:</p> <ul style="list-style-type: none">• <i>Chiropractic/Physical Therapy Benefit (if this benefit is exhausted, charges may be applied against the overall maximum medical expense benefits)</i><ul style="list-style-type: none">– <i>Maximum of 30 visits per family per year</i>– <i>Maximum of \$60.00 per visit</i>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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 \$3,000.00 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.

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.

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

WELL BABY CARE

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : In Addition to other Plan Benefits:</p> <ul style="list-style-type: none">• <i>Home & Office (per visit) - \$50.00</i>• <i>Maximum office visits during first two (2) years of life - Twelve per child</i>	<p>FOR:</p> <ul style="list-style-type: none">• ELIGIBLE DEPENDENTS 24 MONTHS OF AGE AND UNDER
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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: Maximum : • <i>For dependent children, immunization inoculation - \$50.00 per inoculation (this benefit is additional to other Plan Benefits)</i>	FOR: • ELIGIBLE DEPENDENT CHILDREN
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For dependent children, immunization inoculation - \$50.00 per inoculation (this benefit is additional to and independent of other Plan Benefits).

PREGNANCY EXPENSE BENEFITS (OBSTETRICAL BENEFIT)

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : This benefit is for delivery physician services in lieu of and replacing other physician or surgeon benefits otherwise provided by the Plan</p> <ul style="list-style-type: none"> • <i>Normal delivery of child or children - \$3,500.00</i> • <i>Cesarean section or abdominal operation or extra-uterine – pregnancy - \$4,900.00</i> • <i>Miscarriage - \$1,540.00</i> 	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE • ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : <i>\$100.00 per specialty per year per person (in addition to \$3,000.00 Medical Expense maximum and Second Surgical Opinion Maximum).</i></p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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Consultation services of a specialty will be payable for hospital, home, or office visits up to \$100.00 per specialty per year per person. This benefit is in addition to the \$3000.00 Medical Expense maximum and Second Surgical Opinion maximum.

ROUTINE PHYSICAL EXAM EXPENSE

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : In addition to \$3,000.00 Medical Expense maximum</p> <ul style="list-style-type: none">• <i>Routine Physical Exam - \$135.00 per year per person for physician charges</i>• <i>Routine Gynecological Examination - \$100.00 per person per year for physician charges</i>• <i>Prostrate Examination - \$100.00 per person per year for physician charges</i> <p>Note: <i>This benefit is not available for those receiving Well Baby Care coverage.</i></p>	<p>FOR:</p> <ul style="list-style-type: none">• 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
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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.

NOTE: This benefit is not available for those receiving Well Baby Care coverage.

DIAGNOSTIC TESTING AND LABORATORY EXPENSE BENEFIT (OUT PATIENT)

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : \$2,000.00 per person maximum per year <i>In addition:</i> <i>Routine Mammogram - \$140.00 per person per year,</i> <i>Pap Smear - \$60.00 per person per year,</i> <i>Genetic Profile Workup Maximum benefit per fetus - \$500.00</i></p>	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE • ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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Benefit

You will receive benefits equal to the actual ordinary and necessary charges incurred by you or your insured dependents as an out patient 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 \$2,000.00 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: <ul style="list-style-type: none">• Maximum benefit for a single treatment - \$25.00• Maximum Anesthesia benefit rendered during treatment - \$125.00• Overall maximum - per year. - \$2,500.00	FOR: <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER NOT ON MEDICARE• ELIGIBLE DEPENDENTS AGE 64 AND UNDER NOT ON MEDICARE
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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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : In addition to other Plan Benefits:</p> <ul style="list-style-type: none"> • Inpatient Detoxification: Maximum days per confinement per person in semi-private room - 7 days • Inpatient Rehabilitation: <ul style="list-style-type: none"> - Maximum days per confinement per person <ul style="list-style-type: none"> - 30 days - Maximum confinements per lifetime per person <ul style="list-style-type: none"> - 3 confinements - Maximum – one confinement per year per person • Out Patient Benefits: <ul style="list-style-type: none"> - Outpatient treatment, per treatment <ul style="list-style-type: none"> - \$50.00 - Maximum treatments per year per person <ul style="list-style-type: none"> - Sixty Treatments 	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER • ELIGIBLE DEPENDENTS AGE 64 AND UNDER
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In-Patient Benefits

The Plan will provide for up to 7 days of coverage for detoxification and for up to 30 days coverage for rehabilitation services in a facility approved by the Welfare Fund office prior to admission. The above benefits will be limited to one confinement per year with a limit of three confinements in a lifetime.

Out-Patient Benefits

The plan will allow up to 60 out-patient visits per plan year for diagnosis and treatment of which 20 days may be used for family therapy for family members of the person with the alcohol or substance abuse problem whether or not that person is receiving

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

This Benefit is separate from and in addition to all other Benefits.

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

MEDICAL SUPPLIES AND EQUIPMENT BENEFITS

<p>SCHEDULE OF BENEFITS:</p> <p><i>Maximum : \$750.00 per person per year – no coverage is provided if the benefit is covered by Medicare.</i></p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ALL ELIGIBLE RETIREES (EVEN MEDICARE RECIPIENTS)• ELIGIBLE DEPENDENTS
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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 \$750.00 per year 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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : • \$4,000 Overall family maximum during any one year (including Orthodontia), <u>and</u> to the extent specified and listed in the Schedule of Maximum Benefits (below).</p>	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER • ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICAIRE RECIPIENTS) • ELIGIBLE DEPENDENTS
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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)	\$ 33.00
(Follow-up)	33.00
Diagnostic testings - full set	47.30
- single	5.50
(maximum amount per year- \$50.00)	
Prophylaxis, including scaling and polishing twice per year	52.80
Peridontia Treatment - per treatment	66.00
Peridontia Treatment – (with root planning) Entire Mouth	209.00
 ORAL SURGERY - PERFORMED OUT OF HOSPITAL	
Extraction - single, per tooth	66.00
- Surgical - single, per tooth	104.50
- Impaction - (Bony)	209.00
- Impaction (Tissue)	143.00
- Osseous Surgery per quadrant	495.00
- Apicoectomy - per root	130.90
 RESTORATIVE DENTISTRY	
Fillings - except gold inlays, per tooth	
- one surface	44.00
- two surfaces	62.70
- three surfaces	82.50
- four surfaces	93.50
- with pins - per pin	15.40
 Gold inlays per tooth	
- one surface	159.50
- two surfaces	205.70
- three surfaces	234.00
 Cast crowns & caps, jackets per tooth	 From \$253 up to

	\$638.00
Root Canal Therapy	
- Per Tooth - single rooted teeth	330.00
- Per Tooth - multi-rooted teeth	From \$440 up to 550.00

PROSTHETICS

Bridgework - per unit	From 280.50 up to \$660.00
Full denture - upper or lower, per denture	\$660.00
Partial denture	From \$243.10 up to \$660.00
Denture reline	88.00
Teeth added to partial denture to replace natural extracted teeth, per tooth	82.50
Repairs	82.50
Bridge pontic	71.50
Broken denture, no teeth involved	82.50
Broken denture, teeth involved, first tooth	
- additional teeth	33.00
Recementing bridge, inlay or crown	from \$35.20 up to 55.00

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; however, 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	\$660.00
Active Orthodontic Treatments	
- Maximum per month	82.50
- Maximum months payable	24 months

Passive Orthodontic Treatments	
- Maximum per 6 months treatment	33.00
- Maximum months payable	18 months
GENERAL ANESTHESIA	
- If determined in connection with an oral surgical operation other than while an inpatient in the hospital	\$55.00
- 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 \$16.50.
OVERALL DENTAL MAXIMUM PER BENEFIT YEAR PER FAMILY (including Orthodontia)	\$4,000.00

PRESCRIPTION EYEGLOSS EXPENSE BENEFITS

SCHEDULE OF BENEFITS: Maximum : <i>Per person maximum during a period of two (2) consecutive years:</i> <i>Single Lenses - \$100.00</i> <i>Bifocal Lenses - \$125.00</i> <i>Trifocal Lenses - \$140.00</i> <i>Cataract Lenses - \$160.00</i> <i>Eye Examination - \$25.00</i>	FOR: <ul style="list-style-type: none"> • <i>ACTIVE EMPLOYEES</i> • <i>ELIGIBLE RETIREES AGE 64 AND UNDER</i> • <i>ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICAIRE RECIPIENTS)</i> • <i>ELIGIBLE DEPENDENTS</i>
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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 as specified in the following schedule:

Type of Lenses	Two Benefit Year Maximum
Single	\$ 100.00
Bifocal	125.00
Trifocal	140.00
Cataract	160.00

ALSO:

Eye Examination	25.00
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If more than one expense is incurred during two consecutive years, the applicable maximum benefit will be the lens having the greater maximum benefit. No other examination fees, physicians' fees, or any fees or charges other than as specifically provided above shall be paid as part of this benefit.

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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : <i>Overall family maximum during any one year - \$2,500.00</i></p> <p><u>For Active Employees and their Eligible Dependants:</u> <i>\$3.00 per prescription co-pay for generic drugs, \$5.00 per prescription co-pay for brand name drugs</i></p> <p><u>For Eligible Retirees and their Eligible Dependants:</u> <i>\$5.00 per prescription co-pay for generic drugs, \$10.00 per prescription co-pay for brand name drugs</i></p> <p>Fertility Drugs: <i>\$1,500 maximum per year per family in addition to family maximum</i></p> <p>This benefit is restricted to identified drugs</p> <p>Discount brand or generic drugs are available up to 100 day supply, through mail order CFI.</p> <p>You may be eligible for out patient pharmacy services provided by the Department of Veteran Affairs, call: 1-800-827-1000</p>	<p>FOR:</p> <ul style="list-style-type: none"> • ACTIVE EMPLOYEES • ELIGIBLE RETIREES AGE 64 AND UNDER • ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICAIRE RECIPIENTS) • ELIGIBLE DEPENDENTS
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- (1) The Prescription Drug Program is administered by the National Prescription Drug Administrators, Inc., 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. The program is administered on a co-payment basis of \$3.00 per prescription co-pay for generic drugs, \$5.00 per prescription co-pay for brand name drugs, for active Employees and their Eligible Dependents and \$5.00 per prescription co-pay for generic drugs, \$10.00 per prescription co-pay for brand name drugs for Eligible Retirees and their Eligible Dependents. The co-payment is the amount you must pay to the 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 \$2,500.00 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.

Discount Drugs

Discount brand or generic drugs are available up to 100 day supply, through mail order CFI. CFI is a CFI Pharmacy Service from which the purchase of such drugs may be arranged. See pg. 81.

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 and fertility drugs); or
- (f) Drugs in quantities that exceed a six (6) months supply;
- (g) Birth control pills or devices;
- (h) Viagra, Propecia and Rogaine;

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

<p>SCHEDULE OF BENEFITS:</p> <p>Maximum : Overall maximum per person for three (3) consecutive years - \$1,000.00</p>	<p>FOR:</p> <ul style="list-style-type: none">• ACTIVE EMPLOYEES• ELIGIBLE RETIREES AGE 64 AND UNDER• ELIGIBLE RETIREES AGE 65 AND OLDER (MEDICAIRE RECIPIENTS)• ELIGIBLE DEPENDENTS
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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 first commencing covered employment after January 1, 2000 and their dependents shall not be eligible for a death benefit.

Participants eligible for a death benefit are those Participants in the Welfare Plan on or before December 31, 1999 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	4,400.00
9 to 15 years	5,500.00
15 to 19 years	7,700.00
20 years or more	11,000.00

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

1 to 4 years	\$ 4,400.00
5 to 8 years	5,500.00
9 to 15 years	6,600.00
15 to 19 years	9,350.00
20 years or more	12,650.00

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

One who is an Eligible 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.

PAYMENT OF BENEFITS - PROCEDURE

A. File Application For Welfare Fund Benefits 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 Dependents, claiming eligibility for coverage. 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 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.

1. Physicians Network – MultiPlan

You are eligible for discounted benefits if you use a doctor included in the MultiPlan network. You have been provided a book or can obtain a book from the Welfare Fund Office a book that lists doctors who participate in the network. MultiPlan is a nationwide system for low cost medical care. We have been using them for many years to obtain discounted hospital, diagnostic testing & laboratory claims and now their network of doctors is available to participants.

The doctors 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.

1. All benefits must be assigned to the provider.
2. You should check your booklet to see if your doctor is part of the MultiPlan network. If you have any questions, you can ask your doctor or contact MultiPlan at (800) 672-2140 (this number is available 24 hours everyday) or through their website at <http://www.multiplan.com> (this website can inform you regarding which doctors are within the network in your area – click on “Practitioners”). If your doctor is participating, you should present your MultiPlan card (enclosed) at your doctor’s office so he or she knows that the bill will be discounted.
3. The doctor’s office will contact the Fund Office for eligibility. 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.

2. Hospital – Multiplan discounts available where applicable.

3. Laboratory – Multiplan discounts available where applicable.

If any lab tests are needed, please remind the doctor that you are part of the MultiPlan network because we also are entitled to large discounts for laboratory and diagnostic testing services.

4. Mail Order Prescription Drugs – CFI

For those of you who take drugs for a chronic condition (*high blood pressure, diabetes, etc.*) there is a mail order program, CFI Pharmacy Service, which provides generic or Legend drugs, *usually a 100 day*

supply, usually at a much lower cost than your local pharmacy. If you need information about this program, please contact:

CFI Pharmacy Service
P.O. Box 2000
East Hanover, NJ 07936-2000
1-800-628-0717

Website: <http://www.e-npa.com/ECM/app/families/cfi>

5. Eyeglass and Hearing Aid Benefits – Discounts available through General Vision Services and General Hearing Services.
6. 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
30-56 Whitestone Expressway
Flushing, NY 11354
(718) 762-6133

D. 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.
- (b) 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.

- (c) 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.
- (d) 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 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:

If participant was terminated or merely worked too few hours to otherwise qualify for welfare coverage.

If participant is disabled at the time welfare coverage would otherwise have ended.

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***

Entitlement:

18 Months

18 Months with an 11 month extension available

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

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 be automatically be entitled to these foregoing reimbursement/subrogation rights

SPECIAL LEGAL PROTECTIONS

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.

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 Dependents, claiming eligibility for coverage. 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 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.
- (g) 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, 2002.

(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.