AGC Health Benefit Trust

For Employees of

_____

Summary Plan Description

As an employee of the employer named above (the "Employer"), you may be eligible for health coverage and other benefits under an employee benefit plan (the "Plan") established by the trustees (the "Trustees") appointed under the AGC Health Benefit Trust sponsored by Oregon-Columbia Chapter, The Associated General Contractors of America, Inc. ("AGC"). The purpose of this Summary Plan Description, including the attached benefit summaries (together, the "SPD"), is to inform you about the benefits the Employer provides through the Plan. This SPD reflects the terms of the Plan as of January 1, 2020.

This SPD, the Employer's Master Application on file with AGC, the insurance contracts and policies issued by the insurance companies that provide benefit coverage, and the enrollment forms on which you and your dependents sign up for coverage collectively constitute the Plan document. While this SPD, including the attached benefit summaries, describe the principal features and limitations of Plan benefits in general, they are not intended to explain every detail. The Employer's Master Application, the insurance contracts and policies, and the enrollment forms will control in the event of any conflict between them and the information in this SPD.

The Plan Administrator has the Employer's Master Application and the insurance contracts and policies available for your examination. If you have questions about the Plan or a benefit it provides, you can find more information at http://www.agchealthplansnw.com/AGCOR.htm or by calling the Plan Administrator at 503-450-9796.

Employee Eligibility

Employees of the Employer who have satisfied conditions stated in the Employer's Master Application are eligible to participate in the Plan. These conditions may include one or a combination of the following:

- Limitation to employees scheduled to work at least a specified number of hours per week, not to be less than 17.5 hours.
- Limitation to a particular class or classes of employee.
- Completion of a probationary period, not to exceed 60 days.

Dependent Eligibility

Dependents of an eligible employee of the Employer shall be eligible for Plan benefits to the extent described in the attached benefit summaries and the enrollment form for each benefit. Dependents include a spouse, which could be a same-sex spouse.

Dependents also include domestic partners. Unless a domestic partnership is registered with the state, you will be required to certify its existence on a form available from the Plan Administrator. Any premium paid by the Employer on behalf of an employee's domestic partners and children of domestic partners (if the children are not also children of the employee) for health plan coverage is considered taxable income to the employee if the domestic partner and/or child of the domestic partner is not an eligible tax dependent of the employee. In addition, any contributions made by the employee toward premiums for such a domestic partner or children of a domestic partner must be paid on an after-tax basis.

You should consult a lawyer or other tax professional if you have any questions concerning these issues.

Benefits Provided to You under the Plan

You and your eligible dependents are provided benefits as described in the attached benefit summaries, but only if you have enrolled yourself and dependents in that benefit on a form provided by the Plan Administrator and have paid any required employee premium contribution disclosed at the time of enrollment. The description of each benefit in the benefit summary may include: cost-sharing provisions; annual or lifetime caps or other limits on benefits; coverage of preventive services, drugs, medical tests, devices, or procedures; provisions governing network providers; conditions or limits on selection of primary or specialty care providers or emergency care; and provisions on preauthorization or utilization review.

Premium Only Plan

If your Employer has adopted the Premium Only Plan ("POP") made available from the Plan's contract administrator, Benefit Solutions, Inc. ("BSI"), the premiums you are required to pay as a condition for coverage by health insurance, certain disability insurance, and employee-only group term life insurance are made on a pre-tax basis.

The POP does not provide or insure any benefits. It is a way for you to choose certain benefits and use, in most cases, pre-tax dollars to pay for them through payroll deductions. You will be buying certain benefits with part of your pay before federal income and Social Security taxes are withheld. As a result of the POP, you pay less tax on your income.

Your Social Security benefit may be affected by use of pre-tax dollars. If your pay is at or below the Social Security taxable wage base, using pre-tax dollars will not count toward the amount of pay upon which your Social Security benefit is based, which may reduce your ultimate Social Security benefits. In most cases, the reduction is very small.

To pay premiums on a pre-tax basis through the POP you must elect to participate on forms provided to you by a separate administrator who has been engaged by your Employer to administer the POP. Such an election generally is irrevocable for the year to which it applies. However, federal law permits mid-year changes in the election to reflect certain life events, such as marriage, divorce, birth or adoption of a child, and change in level of employment. If you elect to pay premiums on a pre-tax basis through the POP and wish to change this election mid-year, contact your Employer's POP administrator.

Please note that while the POP may be used to fund benefits under a welfare benefit plan covered by Employee Retirement Income Security Act of 1974 ("ERISA"), the POP itself is not an ERISA welfare benefit plan.

Plan Information

Plan Name and Type	Associated General Contractors Health Benefit Trust Welfare benefit plan, including group health, disability, EAP, wellness, and life insurance benefits Plan Sponsor's Trust EIN: 23-7170147 Plan Sponsor Assigned Plan No.: 501
Plan Sponsor	Oregon-Columbia Chapter, Associated General Contractors of America, Inc. 9450 SW Commerce Circle, Suite 200 Wilsonville, OR 97070
Other Participating Employers	Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer participates in the Plan
Plan Year	12-month period ending March 31
Trustee and Plan Administrator	Board of Trustees, AGC Health Benefit Trust: 503-450-9796 Norman Russell, Trustee Chair 20915 SW 105th Avenue Tualatin, OR 97062 Lance Landis, Trustee P.O. Box 50 Marylhurst, OR 97036 Sarah Smith, Trustee 3120 Cherry Avenue NE Salem, OR 97301 Leigh Tapani, Trustee 1904 SE 6th Place Battle Ground, WA 98604 Roger Silbernagel 618 N 2nd Ave Stayton, OR 97383
Agent for Service of Process	Director of Safety, Products and Education AGC Oregon – Columbia Chapter 9450 SW Commerce Circle, Suite 200 Wilsonville, OR 97070 Legal process also may be served on any of the Trustees, who collectively are the Plan Administrator.

Type of Administration	Insurer administration. Benefits are fully insured as described in the attached benefit summaries, and claims for benefits are sent to the applicable insurer. The insurance companies are responsible for paying claims, not the Trust.
Sources of Contributions	From Employers and, to the extent disclosed in enrollment information, from employees.
Funding Medium	Insurance premiums for employees and their families are paid in part by Employers out of their general assets, and in part by employees; for Employers that have elected Dollar Banks, premiums may also be paid from the Trust account.
Claims Administrator	Each insurer is the "Claims Administrator" and is responsible for paying claims and responding to inquiries, complaints and claims appeals for the benefits it insures. If you wish to appeal the denial of a claim, in whole or in part, refer to the procedures provided by the appropriate insurer and to the "Claims and Appeals Procedures" section below.

COBRA Continuation Coverage

The right to self-paid continuation of health coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA").

COBRA Qualifying Events. Continuation coverage is available if coverage would otherwise end due to one or more of the following events:

- For you – employment termination, other than for gross misconduct, or reduction of hours.
- For your dependent spouse or domestic partner – divorce or legal separation from you or termination of your domestic partnership.
- For your dependent spouse or children – your death or entitlement for Medicare.
- For your dependent children – loss of eligibility as a covered dependent (for example, because he or she reaches the maximum age provided by the Plan).

Notification of Certain COBRA Events. If coverage would end because of divorce or legal separation, or termination of a domestic partnership, or because a child is no longer eligible to be a dependent, the employee or covered dependent must notify the Employer within 60 days.

COBRA Elections. When the Employer receives notification of one of the above events, or when any other qualifying event occurs, you or the individual losing coverage will be notified of the right to continue coverage. If continuation is desired, an election must be made within 60 days of the date the notice was sent, or the date coverage terminates, whichever is later. Each covered member of the family may individually decide whether or not to continue coverage, but an election of

coverage by the employee or spouse will be considered to be an election by all covered individuals, unless another covered individual rejects coverage.

You May Have Other Options Available to You When You Lose Group Health Coverage
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Cost for COBRA coverage. Continuation is at the covered individual's expense. The monthly cost of this continued coverage will be included in the notice. Premiums are the same for all individuals who are in the same type of classification – e.g. adult single individuals have the same cost and family groups have the same cost. For coverage to continue, the first premium must be received within 45 days after the continuation coverage is elected. Premiums for each following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30-day grace period for these monthly premiums. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated.

Duration of COBRA Continuation Coverage. If coverage is lost due to the employee's termination of employment or reduction in hours, continuation coverage may continue until the earliest of the following:

- 18 months from the date coverage would have otherwise ended
- The date on which a premium payment was due but not paid.
- The date, after continuation coverage has been elected, the person continuing the coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects a covered individual's pre-existing condition.
- The date, after continuation coverage has been elected, the person becomes entitled to Medicare.
- The date the employer terminates all of its group health plans.
- The date the funds in the Plan are depleted.

If coverage would otherwise end for a covered dependent (spouse, domestic partner or child) because of divorce, legal separation, termination of a domestic partnership, death, or a child's loss of dependent status, continuation coverage may continue until the earliest of the following:

- 36 months from the date the covered dependent's coverage would have otherwise ended.
- The date on which the premium payment was due but not paid.
- The date, after continuation coverage has been elected, the person continuing coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects a covered individual's pre-existing condition.
- The date, after continuation coverage has been elected, the person continuing coverage becomes entitled to Medicare.
- The date the employer terminates all of its group health plans.
- The date the funds in the Plan are depleted.

Extension of COBRA Coverage. If continuation coverage was elected by a covered dependent because your employment ended or your hours were reduced, and during the period of continued coverage another event occurs that is itself an event that would permit continuation coverage to be offered, the maximum period of continued coverage for the covered dependent is extended for up to 18 months to a maximum of 36 months from the date of the initial event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Spouse and dependents of Medicare-eligible employees. If continuation coverage was elected by your spouse, domestic partner or dependent child and you became entitled to Medicare while an employee, the maximum period of continuation coverage for your spouse, domestic partner or child is the greater of 36 months from the date you became entitled to Medicare or 18 months from the date you lost coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals. If a covered individual is disabled, according to the criteria for disability under the Social Security Act, at the time he or she first becomes eligible for continuation or within 60 days of that date, the maximum period of continuation coverage is extended to 29 months. (Coverage will still end for any other reason listed above, such as failure to pay premiums when due, etc.) The covered individual must notify the employer within 60 days of the date he or she is determined to be disabled under the Social Security Act, or within 60 days of continuation coverage beginning, whichever is later, and within 30 days of the date he or she is determined not to be disabled. (Coverage will end on the first day of the month beginning 30 days after the covered individual is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage, and may be adjusted from time to time when group rates are adjusted.

Alternatives to COBRA Coverage
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Further Information. If you need more information regarding COBRA or wish to elect continuation coverage, contact your Employer, who can connect you to the COBRA administrator that assists the Employer with COBRA compliance.

Your COBRA rights are subject to change. Coverage will be provided only as required by law. This description is only a general summary of the law. Federal and state continuation coverage law and the applicable plan provisions will control over this summary in the event of a conflict. If the law changes, your rights will change accordingly.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting your group health coverage, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses

and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.healthcare.gov.

Claims and Appeals Procedures

Any participant or covered dependent claiming a benefit or questioning an interpretation, ruling, or provision under the medical, dental or vision benefits described in this SPD shall follow the procedure specified by the appropriate insurer; if the insurer does not provide claims procedures or if the procedures do not satisfy the minimum requirements of ERISA, then the procedures listed below shall apply.

Any claim for benefits incurred in a plan year must be submitted in the manner and within the time period specified by the appropriate insurer or the following procedures, whichever apply. Claims and appeals shall be approved or denied in accordance with the procedures provided by the appropriate insurer or the following procedures, whichever apply.

Submission of Claim

A claim for benefit payment shall be considered filed when a written request is submitted to a Claims Administrator. The Claims Administrator shall respond to a claim in writing or electronically. An authorized representative may act on behalf of a Claimant. "Claimant" means an individual who makes a claim for benefits and includes an authorized representative of such individual.

Notice of Denial

If the Claims Administrator issues an Adverse Benefit Determination, the Claimant may request to have his or her claim reviewed and reconsidered. "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any determination that a Participant is not eligible to participate in the Plan or a benefits component of the Plan. "Adverse Benefit Determination" also includes denial of benefits because the service is experimental, investigational, or not medically necessary or is a reduction or termination of an ongoing course of treatment (except due to Plan or component plan amendment or termination). "Adverse Benefit Determination" also includes, if required by federal law, any rescission in coverage, regardless of whether there is an adverse effect on any particular benefit at that time.

Content of Notice of Denial. The written explanation of the denial shall be provided by the Claims Administrator, and it shall state, in a culturally and linguistically appropriate manner:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable) and the availability, upon request, of the diagnosis and treatment codes and their meanings);
- The specific reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Plan's or issuer's standard, if any, that was used in denying the claim;
- A reference to the group health plan provision on which the denial is based;
- If the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, either a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such

a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion shall be provided free of charge to the Claimant upon request;

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request;
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if the Claimant wishes to appeal the Claims Administrator's determination, including an explanation of the internal appeals and the external review process; how to initiate and follow those internal appeals and external review procedures; the right to submit written comments, documents, records and other information relating to the claim and to have them considered; and the right to have reasonable access to, and copies of (on request and at no charge), relevant documents and other information;
- If the claim involves urgent care, a description of the expedited review process available to such claims;
- The right to file suit under ERISA with respect to any Adverse Benefit Determination after appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act § 2793 to assist individuals with the internal claims and appeals and external review processes.

Additionally, if the claim involves benefits upon disability or a disability determination, the written explanation will state the following:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of a treating health care professional, vocational professional, or medical or vocational expert whose advice was obtained;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration, if applicable;
- Either the specific internal rule, guideline, protocol or other similar criterion relied on in the decision to deny the claim or, alternately, a statement that such rule, guideline, protocol, standard or other similar criterion does not exist; and
- A statement that the Claimant is entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to the claim, free of charge upon request.

Categories of Claims

Claims for benefits under a group health plan fall into four categories: a claim for urgent care; a claim requiring advance approval; a claim following approval of an ongoing course of treatment; and a Post-Service Claim. Claims for benefits upon disability or a disability determination constitute a fifth category. The time frame within which notification is provided shall depend on what kind of a claim has been made.

- **Urgent Care Claims.** If a claim is urgent, the Claimant shall be notified of the Claims Administrator's decision, adverse or not, as soon as possible, taking into account the medical circumstances. Notification shall not be later than 72 hours after the Claims Administrator received the claim, unless the claim does not contain sufficient information on which to base a decision. If the claim is incomplete and additional information is required, the Claimant shall be notified as soon as possible, but not later than 24 hours after the Claims Administrator received the claim. The Claimant shall be advised of the information required and shall be given at least 48 hours to provide it. The Claimant shall then be notified of the Claims Administrator's decision as soon as possible, but not later than 48 hours after the earlier of (i) the Claims Administrator's receipt of any additional information or (ii) the end of the 48 hours given to the Claimant to provide additional information. A claim is "urgent" where application of the 30 day time period for non-urgent care claims could reasonably be expected to seriously jeopardize the Claimant's life or health or ability to regain maximum function. After discussion between the patient's physician and the Claims Administrator's physician, it shall be determined if the application of the 30 day time period for non-urgent care claims would subject the Claimant to severe pain that could not be adequately managed without the care that is the subject of the claim. If a physician with knowledge of the Claimant's medical condition determines that a claim is urgent, the Claims Administrator shall accept such a determination. In the case of an Adverse Benefit Determination involving an urgent care claim, the information provided in the Notice of Claim Denial may be provided orally within the time frames described herein, provided that written or electronic notification is furnished to the Claimant not later than three days after the oral notification.
- **Claims Requiring Advance Approval or Preauthorization.** If a claim is for a benefit requiring advance approval by the Claims Administrator, the Claimant shall be notified of the Claims Administrator's decision, adverse or not, within a reasonable period appropriate to the medical circumstances, but not later than 15 days after the Claims Administrator received the claim. This period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the Claims Administrator's control. If an extension is required, the Claimant shall be notified before the end of the original 15 day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, the Claims Administrator shall specifically describe it in the notice and give the Claimant a period of at least 45 days to provide it.
- **Approval of an Ongoing Course of Treatment.** If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or approved a number of treatments, the following shall apply: (i) unless the Plan or Component Plan is amended or terminated, any reduction or termination in the course of treatment shall be treated as an Adverse Benefit Determination on a claim (or a claim denial); and (ii) the Claims Administrator shall notify the Claimant sufficiently in advance to allow the Claimant to appeal and obtain a decision on appeal before the reduction or termination.
- **Post-Service Claim.** If the claim is for the payment of medical services after they have been received, the Claims Administrator shall decide the claim within a reasonable time, but not longer than 30 days after the Claims Administrator received the claim. This time period may be extended for an additional 15 days if the claim

does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the Claims Administrator's control. If an extension is required, the Claimant shall be notified before the end of the original 30 day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, the Claims Administrator shall specifically describe it in the notice and give the Claimant a period of at least 45 days to provide it. The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide the claim.

- **Benefits Upon Disability or a Disability Determination.** If a claim involves benefits upon disability or a disability determination, the time for response will be not later than 45 days after receipt of the claim, subject to extension by as many as two additional 30-day periods if necessary due to matters beyond the control of the Plan. If an extension is necessary, the Claims Administrator will notify the Claimant in writing before each extension of the circumstances requiring extension and the date by which the Claims Administrator expects to render a decision. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve the issues. If the Claimant needs to provide additional information, the Claimant will be given 45 days.

Right to Request Internal Review

Any Claimant who has had a claim for benefits denied by the Claims Administrator, who disputes the benefit determination, who has a rescission of coverage, or who is otherwise adversely affected by action of the Claims Administrator shall have the right to request internal review by the Plan Administrator. The Plan Administrator or its delegate shall provide a full and fair review that takes into account all comments, documents, records and other information submitted relating to the claim, without regard to whether the information was previously submitted or considered in the initial benefit determination. There is no fee imposed as a condition of requesting review.

To initiate an internal review, the Claimant or his or her representative must submit a written statement explaining the reasons for disagreeing with the Adverse Benefit Determination. Such request for internal review must be made no later than 180 days (365 days in the case of self-insured health benefits) after the Claimant is advised of the Adverse Benefit Determination. If written request for review is not made within such 180 day period (365 day period in the case of self-insured health benefits), the Claimant shall forfeit his or her right to review.

The Claimant shall have the right to review his or her file. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. The Claimant may, but is not required to, submit written comments, notarized statements, declarations, testimony, documents, records and other information relating to the claim.

Internal Review of Claim and Timing of Benefit Determination on Internal Review

The Plan Administrator or its delegate shall review and render a decision on the appeal within the time frames outlined below and shall notify the Claimant of its decision in writing. The decision maker shall not be an individual who participated in or decided the original claim, nor shall he or she be a subordinate to the original decision maker. No deference shall be given to the

initial decision. The Plan Administrator or its delegate may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide the claim, except that any medical expert consulted in connection with the Claimant's appeal shall be different from any expert consulted in the initial claim and shall not be a subordinate of that expert. The identity of a medical expert consulted in connection with the appeal shall be provided upon request, whether or not the advice was relied on in deciding to deny the claim.

The Claimant shall also be provided with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a Final Adverse Benefit Determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

The Plan Administrator or its delegate may hold a hearing if it is deemed necessary and shall issue a written decision affirming, modifying, or setting aside the initial determination by the Claims Administrator within a reasonable time and not later than the time frames outlined below, unless an extension is necessary. The Claimant may present evidence and testimony as part of the review process.

The time frame for review of the appeal depends on whether it is an urgent care claim, a claim requiring advance approval or preauthorization, a claim following approval of an ongoing course of treatment, a Post-Service Claim, or a claim for benefits upon disability or a disability determination.

Urgent Care Claim. If the appeal is in connection with an urgent care claim, the Claimant shall be notified of the decision on appeal as soon as possible, taking into account medical circumstances, but not later than 72 hours after the Claims Administrator received the appeal.

Claim Requiring Advance Approval or Preauthorization. If the appeal is in connection with a claim for benefits requiring advance approval, the Claimant shall be notified of the decision on appeal, adverse or not, within a reasonable period appropriate to the medical circumstances, but not later than 30 days after the Claims Administrator received the appeal.

Approval of an Ongoing Course of Treatment. If the appeal is in connection with a claim for an ongoing course of treatment, the Claimant shall be notified of the decision on appeal as soon as possible, but not later than the date the treatment ends or is reduced.

Post-Service Claim. If the appeal is in connection with a claim for payment of medical services after they have been received, the Claimant shall be notified of the decision on appeal, adverse or not, not later than 60 days after the Claims Administrator received the appeal.

Benefits Upon Disability or a Disability Determination. If the claim involves benefits upon

disability or a disability determination, the decision will be made within 45 days after the Claims Administrator received the appeal.

Content of Notification on Internal Review

The Plan Administrator or its delegate shall provide a Claimant with written or electronic notification of the benefit determination following an appeal described above. Any electronic notification shall comply with the standards imposed by 29 C.F.R. §§ 2501.104b-1(c)(l)(i), (iii) and (iv). In the case of a Final Adverse Benefit Determination, the notification shall set forth, in a culturally and linguistically appropriate manner calculated to be understood by the Claimant:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and the availability, upon request, of the diagnosis and treatment codes and their meanings);
- The specific reason for the denial, including the denial code and its corresponding meaning, a description of the Plan's or Insurer's standard, if any, that was used in denying the claim, and a discussion of the Final Adverse Benefit Determination decision;
- A reference to the Plan provision on which the denial is based;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits; and
- A statement of the Claimant's right to bring an action under ERISA § 502(a).

Additionally, if the claim is for benefits under a group health plan, the notification shall set forth:

- A description of the external review process, including information regarding how to initiate an external review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion shall be provided free of charge to the Claimant upon request;
- If the Adverse Benefit Determination is based on a lack of medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."; and
- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act § 2793 to assist individuals with the internal claims and appeals and external review processes.

Additionally, if the claim involves benefits upon disability or a disability determination, the notification shall set forth:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of a treating health care professional, vocational professional, or medical or vocational expert whose advice was obtained;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration, if applicable;
- If the determination is based on a medical, scientific or technical judgment, the determination will include either an explanation of the judgment that applies Plan terms to the Claimant's medical circumstances, or a statement that an explanation will be provided free of charge upon request;
- Either the specific internal rule, guideline, protocol or other similar criterion relied on in the decision to deny the claim or, alternately, a statement that such rule, guideline, protocol, standard or other similar criterion does not exist; and
- Any applicable contractual limitations period that applies to the Claimant's right to bring an action under ERISA § 502(a).

Request for External Review of Claim

Timing of Request for Review. Claimants shall have the right to request an external review of an Adverse Benefit Determination or a Final Adverse Benefit Determination to the extent such right is required by federal law. For example, a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of the Plan is not eligible for external review. "Final Adverse Benefit Determination" means (1) an Adverse Benefit Determination that has been upheld by the Plan at completion of the Plan's internal appeals procedures; or (2) an Adverse Benefit Determination for which the internal appeals procedures have been deemed exhausted under 29 C.F.R. § 2590.715-2719(b)(2)(iii)(F).

Unless and until the federal law is changed, the only claims eligible for external review are those involving: (1) medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; or (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Such request must be in writing and must be made within four months after such Claimant is advised of the Adverse Benefit Determination or Final Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Preliminary Review. Within five business days following the receipt of the external review request, the Plan Administrator or its delegate shall complete a preliminary review of the request to determine whether:

- The Claimant is or was covered under the Plan at the time the health care item or service was requested, or in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination or Final Adverse Benefit Determination is one eligible for review under applicable federal law;
- The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under federal regulations; and
- The Claimant has provided all of the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan shall issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification shall include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (1-866-444-3272). If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and the Claimant shall be allowed to perfect the request for external review within the four month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

The Plan shall assign an independent review organization (IRO) and shall take action against bias and to ensure independence. Accordingly, the Plan shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other, independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO shall not be eligible for any financial incentives based on the likelihood that the IRO shall support the denial of benefits.

The contract between the Plan Administrator, its delegate, or a Claims Administrator and an IRO shall meet the requirements of 29 C.F.R. § 2590.715-2719 and any subsequent regulatory or subregulatory guidance.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or the Final Adverse Benefit Determination, the Plan shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

Eligibility for Expedited External Review. The Plan shall allow a Claimant to make a request for expedited external review at the time the Claimant receives:

- An Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition of the Claimant for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
- A Final Adverse Benefit Determination, if the Claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize

the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Preliminary Review. Immediately upon receipt of the request for expedited external review, the Plan Administrator or its delegate shall determine whether the request meets the reviewability requirements set out above for Preliminary Review. The Plan Administrator or its delegate shall immediately send the required notice to the Claimant of its eligibility determination.

Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan shall assign an IRO pursuant to the requirements for standard review. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or the Final Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review as described in federal regulatory or subregulatory guidance. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Decision. The contract with the IRO shall meet the requirements of 29 C.F.R. §§ 2590.715-2719 and any subsequent regulatory or subregulatory guidance, including any requirements in issued guidance regarding the content and timing of the notice of the final external review decision.

Time Counting. Time periods for determinations on claims run from the time the claim is submitted in writing or a request for review is submitted in writing, without regard to whether all needed information is filed. In the case of an extension of time because more information is needed, the period for making the determination is tolled from the time the Claimant is notified of the need until the Claimant responds.

Discretionary Authority. The Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Qualified Medical Child Support Orders

Participants and beneficiaries can obtain from the Plan Administrator, without charge, a copy of the Plan's procedures on Qualified Medical Child Support Orders.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

If you would like more information on WHCRA benefits, please contact the insurance carrier at the number listed on your ID card.

Maternity and Newborn Infant Coverage

Group health plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Circumstances That May Result in Loss of Plan Benefits

The following are circumstances that may result in loss of benefits a participant or beneficiary might otherwise reasonably expect the Plan to provide:

- Failure to pay a premium required as a condition for insured coverage.
- Failure to meet a deductible with respect to a particular insured coverage.
- Expenses exceeding a limit on the amount of an insured benefit.
- Coordination of benefits with coverage provided by another insurer.

- Exclusion from coverage due to liability of a third party.
- Loss of eligibility for coverage under the Plan benefit, such as a change from full-time to part-time status or termination of employment.
- The date the Plan or a benefit is terminated.

No Right to Continued Employment

Nothing in this SPD or the Plan shall create a right to continued employment or affect your Employer's right to terminate the employment relationship or alter its terms at any time.

Conclusiveness of Records

The Employer's records with respect to age, continuous service, employment history, compensation, absences, illnesses, and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of claims arising under, the Plan to the extent permitted by law.

ERISA Rights

As a participant in the AGC Health Benefit Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

Future of the Plan

The Trustees have reserved the right to amend or terminate the Plan or any Plan benefit described in this SPD for any reason or for no reason at any time. Furthermore, your Employer has the right to change or discontinue any benefit it previously had chosen to provide through the Plan for any reason or for no reason at any time. As a result, you may receive different benefits

than those described in this SPD, or such benefits on different conditions, or no benefits. This may happen while you are actively employed by the Employer or after you terminate employment. No employee of the Employer or of AGC has authority to amend or modify the Plan by any oral promise or representation nor to amend or modify any Plan benefit or provision of any insurance contract or policy.

January 2020