AGC Health Benefit Trust

For Employees of

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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 of 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, 2021.

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 503-462-4041.

Board of Trustee Discretion

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected. The Board of Trustees has hired various insurance companies to provide benefits to eligible Plan participants. The Board of Trustees has delegated to these insurance companies and to the Plan's third-party administration office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions.

An interpretation of Plan benefits is subject to review by the relevant insurance carrier and the insurance carrier is responsible for its decision. An interpretation of Plan eligibility, Plan funding, selection of benefit providers or other non-benefit related issues is subject to review by the Board of Trustees. No individual trustee, employer, or employer association, or any individual employed by an employer or employer association, has any authority to interpret or change this SPD or the Plan.

The Trustees reserve the right to make any changes they deem necessary to promote efficiency, economy and better service for the Plan participants and their covered dependents. The Trustees have no obligation to furnish benefits beyond those that can be provided by the Trust. The Plan is provided to the extent that money is currently available to pay the cost of such Plan.

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.

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 on the enrollment form provided by the Plan Administrator and have paid any required employee premium contribution. The description of each benefit in the benefit summary may include cost-sharing provisions; caps or other limits on certain benefits; coverage of preventive services, drugs, medical tests, devices, or procedures; provisions governing network providers; and provisions on preauthorization or utilization review.

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 Trust EIN: 23-7170147 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: Leigh Tapani, Trustee Chair 1904 SE 6th Place Battle Ground, WA 98604 Johnathan Woolworth, Trustee 2213 SE Cochran Dr. Gresham, OR 97080 Stacy Lewallen 550 SW 12th Ave Portland, OR 97205 Phone: (503) 462-4041
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	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 –termination of employment, other than for gross misconduct, or reduction of hours.
- For your dependents– your death or entitlement for Medicare.
- For your dependent spouse or domestic partner – divorce or legal separation from you or termination of your domestic partnership.
- 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 events in the above paragraph, or when one of the 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 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.

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.

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.

General Timelines for Claim Determinations. The claimant shall be notified of an adverse determination on a claim for eligibility or other Trust's decisions within a reasonable time not longer than 90 days after the claim or request was received unless special circumstances require an extension of time. The claimant must be notified in writing of the need for an extension before the end of the initial 90 days, and any extension will be no longer than another 90 days after the initial period. Any notice of extension will indicate the special circumstances requiring the extension and the date by which a determination is expected.

Notification of Adverse Determinations. The claimant shall be provided with written or electronic notification of an adverse determination on a claim, including:

- The identity of the claim.
- The specific reason or reasons for the determination.
- Reference to the specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why it is necessary.
- A description of the review procedures described below and the applicable time limits.
- A statement of the claimant's right to bring a legal action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") following any adverse determination on review.

Right to Appeal. A claimant receiving a notification of an adverse determination on a claim may request review of that determination within 180 days of the adverse determination. The decision of the claimant to request review of a claim shall have no effect on the claimant's rights to any other benefits. The claimant may submit written comments, documents, records and other information relating to the claim. Upon request and at no charge, the claimant may have copies of any document, record or other information that: was relied on in making the determination; was submitted, considered or generated in the course of making the determination, whether or not relied on; demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with the Plan documents applied consistently to similarly situated claimants. The review must take into account all comments, documents, records and other information submitted by the claimant relating to the claim, whether or not considered in the initial determination.

The review shall afford no deference to the initial determination. No individual who either participated in consideration of the initial determination or who is the subordinate of such an individual shall participate in review on appeal.

Timelines for Determination on Appeal. The claimant shall be notified of the determination on review within a reasonable time not longer than 60 days after the request for review unless an extension of time is required for a hearing or other special circumstances. The claimant shall be notified in writing of the need for any extension before the end of the initial 60 days, and no extension will be longer than another 60 days after the initial period. Any notice of extension will indicate the special circumstances requiring the extension and the date by which a decision is expected.

Notification of Determination on Appeal. The claimant shall be given written or electronic notification of the determination on appeal. If the determination is adverse, the notification will include:

- The identity of the claim;
- The specific reason or reasons for the determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that, upon request and free of charge, the claimant may have copies of any document, record or other information relevant to the claim;
- A statement of the claimant's right to bring a legal action under ERISA.

Request for External Review of Claim. Claimants shall have the right to request an external review of a appeal determination to the extent such right is required by federal law. 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 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.

Judicial Review of Denied Claims. Other than the External Review provision above, the Trust provides for no voluntary alternative dispute resolution procedures. If you remain dissatisfied after the issuance of the Trustees' decision on appeal, you may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than 180 days after the date of issuance of the Trustees' decision on an appeal. The question on review will be whether, in the particular instance, the Trustees:

- were in error upon an issue of law;
- acted arbitrarily or capriciously in the exercise of their discretion; or
- whether their findings of fact were supported by substantial evidence.

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim to the insurance carrier or Board of Trustees, or
- The insurance carrier or Board of Trustees has issued a decision on appeal; or
- You have exhausted the Plan's appeals processes for every issue you deem relevant.

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.

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 2022