MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HEALTH FUND

Summary Plan Description
And Plan Document

Effective October 1, 2025

MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HEALTH FUND

c/o Zenith American Solutions, Inc.
P. O. Box 257
Minneapolis, Minnesota 55440-0257
Telephone: 1-651-256-1801
Toll Free: 1-800-879-4412

BOARD OF TRUSTEES

The Board of Trustees is the Plan Administrator and Plan Sponsor, as defined by law. The following are the members of the Board of Trustees, as of October 1, 2025.

UNION TRUSTEES:	**EMPLOYER TRUSTEES:**
Mr. Douglas Schroeder BAC Local #1 312 Central Avenue NE, Room 328 Minneapolis, Minnesota 55414	**Mr. John Nesse** Minnesota Concrete & Masonry Contractors Association 1305 Corporate Center Dr Suite 320 Eagan, MN 55121
Mr. Michael Ganz BAC Local #1 11654 37th Street Clear Lake, Minnesota 55319	**Mr. Frank Grazzini II** Carciofini Company 14380 W. Burnsville Pkwy Burnsville, MN 55306
Mr. Matthew Hopkins, Sr. BAC Local #1 312 Central Avenue NE, Room 328 Minneapolis, Minnesota 55414	**Ms. Amy Thompson** McGough Construction 2737 Fairview Ave. N. St. Paul, MN 55113
Mr. Eric Vik BAC Local #1 312 Central Avenue NE, Room 328 Minneapolis, Minnesota 55414	**Mr. Ron Rasley** Blattner Energy, Inc. 392 Country Road 50 Avon, Minnesota 56310
ALTERNATE TRUSTEES:	
Mr. Jake Nelson BAC Local #1 312 Central Ave., Room 328 Minneapolis, MN 55414	**Mr. Robert Miller** Advanced Masonry Restoration 2956 Yorkton Blvd St. Paul, MN 55117 **Mr. Trent Schieffer** Northland Concrete and Masonry Company, LLC 1125 Stagecoach Road Shakopee, MN 55379

Contacts

If you need information about:	Contact:	At:
Billing and Eligibility	Zenith American Solutions	800-879-4412 or 651-256-1801
Medical Claims	HealthPartners Administrators, Inc. (HPAI) Submit Claims to: HealthPartners P.O. Box 1289 Minneapolis, MN 55440-1289	952-883-5000 800-883-2177 www.healthpartners.com
General Medical Benefits Questions	HealthPartners Administrators, Inc. (HPAI)	952-883-5000 800-883-2177 www.healthpartners.com
General Non-Medical Benefits Questions: Hearing, Vision, Weekly Accident and Sickness, Death	Zenith American Solutions	800-879-4412 or 651-256-1801
Finding a Network Provider	HealthPartners Administrators, Inc. (HPAI)	952-883-5000 800-883-2177 www.healthpartners.com
Finding a Dentist	Delta Dental	800-553-9536 www.deltadental.org
Finding a Network Pharmacy	OptumRx, Inc.	800-763-0044 www.optumrx.com
Employee Assistance Program	T.E.A.M	651-642-0102 www.teammn.org
Radiology Services	RAYUS (formerly known as Center for Diagnostic Imaging	(800) 342-0304 www.rayusradiology.com

CONSULTANT TO THE HEALTH FUND

Reza Vahid
Milliman

ATTORNEY FOR THE HEALTH FUND

Scott Crossman, Esq.
Shumaker, Loop & Kendrick

Please remember that it is very important that you keep the Fund Office (Zenith American Solutions) informed when any of the following changes occur. The Fund Office contact information can be found on the first page of this booklet.

- You change your home/mailing address;
- You wish to change your beneficiary;
- You are receiving Workers' Compensation benefits;
- You become disabled or return to work after a disability ends;
- You enter the Uniformed Services of the United States;
- You acquire a new Dependent; (You must provide evidence of dependent status to the Fund Office when enrolling a new Dependent.)
- You have a change in marital status;
- You have a Dependent who no longer meets the Plan's definition of a Dependent, to ensure that you receive proper COBRA notice;
- You become eligible for Medicare.

MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HEALTH FUND

To All Plan Participants:

The Board of Trustees is pleased to present you with this updated Summary Plan Description. This booklet describes the Health Plan in effect on January 1, 2025. The Plan has adopted many changes to your health benefits since the printing of the last booklet. We encourage you to carefully review this document.

If you read this booklet carefully, you will know exactly the benefits for which you are eligible, what you must do to qualify for those benefits, and how to file a claim for benefits. We suggest that you keep this booklet in a safe place, along with your other valuable papers, so that you have easy access to it. If you have questions about the Plan, or if you need information about your eligibility for benefits, contact the Fund Office. The Fund Office and the Board of Trustees will assist you with any matter related to the Plan.

Throughout this booklet, the masculine term includes the feminine and the singular term includes the plural. “You” includes your Covered Dependent(s) unless they are expressly excluded.

Sincerely,

BOARD OF TRUSTEES

This Summary Plan Description booklet is also the Plan Document. It explains your benefits under the Health and Welfare Plan. Every effort has been made to assure that the information contained in this booklet is accurate and up-to-date as of the time of its printing. This Document replaces and supersedes any prior Summary Plan Description and Plan Document.

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PLAN OPTIONS

You have the option of selecting between several Plan Options and Coverage Levels. Each Plan Option and Coverage Level covers the same services and treatments at the same level of coinsurance. The only differences between them are the deductible, the annual Out-of-Pocket Maximum, and the monthly premium. In addition to the overall deductible and annual Out-of-Pocket Maximum, there may be separate deductibles or annual Out-of-Pocket Maximums for specific items and services. The deductibles, annual Out-of-Pocket Maximums, and premiums may vary each year. If these change, you will be notified in writing. The premium rates for 2025 are set forth in Exhibit A. When these rates change you will be notified in writing.

2025 Plan Options

Medical Plan Coverage (administered by HealthPartners)	**Network Benefits**	**Out-of-Network Benefits**
Calendar Year Deductible		
Plan A200 Individual Family	 $200 $300	 $200 $300
Plan B1000 Individual Family	 $1,000 $1,500	 $1,000 $1,500
Plan C2000 Individual Family	 $2,000 $3,000	 $2,000 $3,000
Plan D3000 Individual Family	 $3,000 $4,500	 $3,000 $4,500
Plan E4350 Individual Family	 $4,350 $6,525	 $4,350 $6,525
	The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.	

Medical Plan Coverage (administered by HealthPartners)	Network Benefits	Out-of-Network Benefits
Calendar Year Out-of-Pocket Maximum		
Plan A200, Plan B1000, Plan C2000, Plan D3000 Individual Family	 $2,000 $5,000	 $2,000 $5,000
Plan E4350 Individual Family	 $1,250 $4,675	 $1,250 $4,675
	The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.	
	Deductibles do not apply to the out-of-pocket limit.	
	Medically necessary hospital and anesthesia for dental care do not apply to the out-of-pocket limit.	
	Out-of-Network Benefits above the reasonable and customary charge do not apply to the out-of-pocket limit.	
	A separate out-of-pockets limit applies for Prescription Drugs. See the following section.	

Prescription Drug Coverage (administered by OptumRx)	Network Benefits	Out-of-Network Benefits
Calendar Year Out-of-Pocket Maximum		
Plan A200, Plan B1000, Plan C2000, Plan D3000 and Plan E4350 Individual Family	 $1,000 $2,000	 $1,000 $2,000
	The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.	

Plan	Medical Deductible (HealthPartners)	Medical Out-of-Pocket Maximum (HealthPartners)	Prescription Drug Out-of-Pocket Maximum (OptumRx)	Total Out-of-Pocket Maximum
Plan A200				
Individual	$200	$2,000	$1,000	$3,200
Family	$300	$5,000	$2,000	$7,300
Plan B1000				
Individual	$1,000	$2,000	$1,000	$4,000
Family	$1,500	$5,000	$2,000	$8,500
Plan C2000				
Individual	$2,000	$2,000	$1,000	$5,000
Family	$3,000	$5,000	$2,000	$10,000
Plan D3000				
Individual	$3,000	$2,000	$1,000	$6,000
Family	$4,500	$5,000	$2,000	$11,500
Plan E4350				
Individual	$4,350	$1,250	$1,000	$6,600
Family	$6,525	$4,675	$2,000	$13,200

Schedule of Benefits

The Schedule of Benefits is a helpful summary which highlights your benefits under the Plan. The benefits are described in greater detail throughout this booklet.

The percentages reflect the amount the Plan will pay after you have reached your deductible and before you reach the Out-of-Pocket Maximum, except as noted below.

Medical Benefits Administered by HealthPartners		
Benefit	**Network Benefits**	**Out-of-Network Benefits**
Hospital Expenses	80%	0%
Physician Services and Surgery	80%	0% (for inpatient services) 80% (for out-patient services)
Emergency Care	80%	80%
Ambulance Service	80%	80%
Prescription Drugs	80%	80%
Chiropractic Treatment	80%	80%
	Chiropractic Network Benefits and Out-of-Network Benefits, combined, are limited to eight visits per calendar year.	
Treatment of Mental and Nervous Disorders and Alcohol, Chemical Dependency and Drug Addiction Includes: Mental Health Outpatient Mental Health Day Treatment Mental Health Inpatient Substance Abuse Outpatient Substance Abuse Day Treatment Substance Abuse Inpatient	80%	0% (for in-patient services) 80% (for out-patient services)
Radiology Services (including MRIs and CT scans)	80%	80%
	100% if at a RAYUS (formerly Center for Diagnostic Imaging (CDI)) Facility	Not applicable.

Benefit	Network Benefits	Out-of-Network Benefits
Neck and Back Rehabilitation	80%	80%
Home Health Care Expenses	80%	80%
	Home Health Care Network Benefits and Out-of-Network Benefits, combined, are limited to 90 visits per calendar year.	
Hearing Benefit	*The hearing benefit maximums are combined under Network Benefits and Out-of-Network Benefits. Routine hearing exams for dependent children up to age 18 are not subject to, or count towards, the five calendar-year maximum.*	
Hospice Care	80%	80%
Body Organ Transplant	80%	$0 for inpatient services 80% for outpatient services
Wig Expenses	80%	80%
	Wigs for hair loss resulting from illness or treatment of an illness are limited to a $350 maximum benefit every two calendar years for Network Benefits and Out-of-Network Benefits combined, subject to a lifetime maximum benefit of $1,400.	

Benefit	Network Benefits	Out-of-Network Benefits
General Anesthesia & Outpatient Hospital Charges for Specific Dental Restorations	50%	50%
	General anesthesia & Outpatient Hospital for specific dental restorations services do not apply to the out-of-pocket limit.	
Nutritional Counseling/Diabetic Education Program	80%	80%
Oxygen and CPAP	80%	80%
Electronic Diagnostic Testing (on-line diagnostic clinic)	80%	80%
Preventive Care	100%. Deductible does not apply.	80% Deductible does not apply.

Vision Benefit for Adults
(Not subject to the Out-of-Pocket Maximum)
Administered by VSP

For members who reside more than 50 miles from the nearest VSP Network Provider, out-of-network benefits will be paid according to in-network cost-sharing amounts

SERVICE	IN NETWORK	OUT OF NETWORK	FREQUENCY
Exam	$20 copayment, then covered at 100%.	Member is reimbursed up to a maximum payment of $45.	Every Calendar Year.
Frames	The purchase of glasses is subject to a $20 copayment, then covered at 100%. Members have up to a $160 frame allowance. There is a $70 allowance on frames purchased at Costco.	Member is reimbursed up to a maximum payment of $70 for the frame only.	Every Other Calendar Year.
Lenses	Single Vision, Lined Bifocal and Lined Trifocal lenses are included in the above $20 copayment.	Member is reimbursed as follows: up to a maximum payment of $30 for Single Vision, $50 for Lined Bifocal, $65 Lined Trifocal.	Every Calendar Year.
Progressive Lenses (Lens Enhancements)	Members who need Progressive lenses have a higher copayment as follows: Standard Progressive Lenses: $55 co-pay then covered at 100%, Premium Progressive Lenses: $95-$105 co-pay then covered at 100%, Custom Progressive Lenses: $150-$175 then covered at 100%.	Member is reimbursed up to a maximum payment of $50.	Every Calendar Year.
Contacts	No copayment, $150 Allowance for contacts and contact lens exam (fitting and evaluation).	No copayment, $150 Allowance.	Every Calendar Year.

		Members must submit paper claims to VSP for Out-of-Network reimbursements.	

Vision Benefits for Pediatrics (Up to Age 19) (Not subject to the Out-of-Pocket Maximum) Administered by VSP			
SERVICE	**IN NETWORK**	**OUT OF NETWORK**	**FREQUENCY**
Exam	Covered at 100%, no copayment.	50% coinsurance	Every Calendar Year.
Frames	Covered in full one time (limited to a frame from a Pediatric Exchange Collection).	50% coinsurance	Every Calendar Year.
Lenses	Covered at 100%, no copayment.	50% coinsurance	Every Calendar Year.
Progressive Lenses (Lens Enhancements)	Coverage includes lenses in Polycarbonate plastic or glass. Scratch resistant and UV coatings are also covered.	50% coinsurance	Every Calendar Year.
Contacts	Covered at 100%. Limited to one pair annually for standard lenses, six-month supply for monthly lenses, three-month supply for bi-weekly lenses, and three-month supply for daily lenses).	50% coinsurance	Every Calendar Year.

SERVICE	IN NETWORK	OUT OF NETWORK	FREQUENCY
Low Vision Benefit Testing	Covered at 100%. (Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions.) Subject to a maximum payment of $1,000 (excluding copayment) every two years	Up to a maximum payment of $125	Every other Calendar Year Maximum Payment is up to $1,000
Low Vision Benefit Supplementary Care	75% of cost.	75% of cost.	Every other Calendar Year Maximum Payment is up to $1,000

Dental Expense Benefit (Participants 19 and older, Non-Retirees) (No Deductible, Not Subject to Out-of-Pocket Maximum) Administered by Delta Dental		
Benefit	**Network**	**Out-of-Network**
Dental Expense Benefit	Calendar Year maximum of $1,250. *All expenses related to Pediatric dental services are not included in the Calendar Year Maximum (see section below on Pediatric Benefits)*	Calendar Year maximum of $1,250, not including pediatric dental services, which are limited to two routine visits/cleanings per year and coverage as follows:
Diagnostic and Preventive Services	100% (Limited to two examinations and cleaning per Calendar Year)	100% (Limited to two examinations and cleaning per Calendar Year)
Basic Services (e.g., Fillings)	80%	80%
Endodontics (Root Canal Therapy)	80%	80%
Periodontics (Gum Disease)	80%	80%
Oral Surgery (Extractions)	80%	80%
Major Restorative (Crowns)	80%	80%
Prosthetics (Bridges and Dentures)	80%	80%
Prosthetic Adjustments	80%	80%

Pediatric Dental Expense Benefit – (Under Age 19) (No Deductible, Not Subject to Out-of-Pocket Maximum) Administered by Delta Dental		
Benefit	**In-Network**	**Out-of-Network**
Dental Expense Benefit	Calendar Year maximum payment of $1,250.	
Diagnostic and Preventive Services (including routine visits and cleaning)	100% (Does not count towards $1,000 Calendar Year maximum payment.) Limited to two per Calendar Year.	
Basic Services (e.g., Fillings)	80%	80%
Endodontics (Root Canal Therapy)	80%	80%
Periodontics (Gum Disease)	80%	80%
Oral Surgery (Extractions)	80%	80%
Major Restorative (Crowns)	80%	80%
Prosthetics (Bridges and Dentures)	80%	80%
Prosthetic Adjustments	80%	80%
Orthodontia Benefit	$1,200	$1,200
	Network Benefits and Out-of-Network Benefits for orthodontia, combined, are limited to a Lifetime Maximum payment of $1,200 per Covered Dependent child.	

Retiree Dental Expense Benefit (No Deductible, Not Subject to Out-of-Pocket Maximum) Administered by Delta Dental		
Benefit	**In-Network**	**Out-of-Network**
Preventive Dental Expense Benefit	$5 Deductible per Examination Limited to two examinations and cleanings per Calendar Year	$5 Deductible per Examination Limited to two examinations and cleanings per Calendar Year
Oral Exams and Routine Cleaning	Twice per Calendar Year	Twice per Calendar Year
Bitewing X-rays	Once every 12 months	Once every 12 months
Full mouth X-rays	Once every 5 years	Once every 5 years

Other Benefits Administered by the Fund Office	
Death Benefit (Active Collectively Bargained Employees only)	$10,000 Maximum Benefit.
Weekly Accident and Sickness Benefit (Active Collectively Bargained Employees only)	$300 (Maximum 26 weeks, benefits payable beginning on 4th day after non-occupational Injury or 8th day after non-occupational Sickness)
Worker Wellness Program	See Exhibit E for a complete description of this benefit, added in 2024.

Rules of Eligibility, Enrollment and Coverage

I. Rules of Eligibility

Individuals eligible to participate and receive coverage in the Plan include Active Employees, Self-Employed Employers and Other Non-Collectively Bargained Employees, Apprentices, Pre-Medicare Retirees and Dependents of each of these. Following are the rules to establish eligibility for each of these various types of individuals.

A. Active Employees are eligible for benefits under the Plan provided they:

1. Are employed or available for employment under the jurisdiction of the Union; and

2. Have paid the applicable premium, either through their Dollar Bank or self-payment, if eligible.

B. Self-Employed Employers and Other Non-Collectively Bargained Employees are eligible for benefits under the Plan provided they:

1. Have signed a current Participation Agreement or are employed by an Employer who has signed a Participation Agreement approved by the Board of Trustees and continue to meet all requirements of the Participant Agreement or other rules and regulations prescribed by the Board of Trustees; and

2. Have paid the applicable premium.

C. Self-employed employers and other non-collectively bargained employees will be eligible to enroll in all Plan options and Coverage Levels.

D. Apprentices are eligible for benefits under the Plan provided they:

1. Are registered with the applicable Division of Apprenticeship and Training; and

2. Have paid the applicable premium, either through their Dollar Bank or self-payment, if eligible.

If you attend daytime Apprentice school, your dollar bank will be credited with an amount equal to 72 hours multiplied by the current contribution rate per quarter if you remain in the program and complete all course requirements.

E. Pre-Medicare Retirees (Including Disabled Employees, Surviving Spouses) Prior to January 1, 1998

Before January 1, 1998, you must have met the following requirements to become eligible for Plan benefits as a Retired Employee:

1. You were at least age fifty-five and eligible under the Plan at retirement,

2. You were receiving monthly pension payments from the Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund, or

3. If you were not eligible for a pension from the Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund, you must have worked a minimum of 3,500 hours in covered employment for a Contributing Employer that was required to make contributions to this Welfare Fund during the sixty-month period preceding the date you become eligible for Plan benefits as a Retired Employee.

   It is also required that there were contributions paid or payable by a Contributing Employer on your behalf, to this Welfare Fund in each of the five calendar years preceding the calendar year during which you become eligible for Plan benefits as a Retired Employee.

4. You must also pay the required contribution when it is due.

If you became Permanently and Totally Disabled and received a Social Security disability award, but you were also unable to satisfy the preceding requirements, then you became eligible for Plan benefits as a disabled Covered Employee on the effective date of your Social Security disability pension. This is the case only if some contributions were paid or payable by your Contributing Employer to this Welfare Fund during the calendar year preceding the calendar year during which the Social Security disability pension became effective.

If a surviving spouse was covered by this Plan immediately prior to the Participant's death, then the surviving spouse may continue coverage by making self-payments until he or she remarries or becomes covered under another group plan. However, if the surviving spouse chooses to make these self-payments, he or she rejects COBRA.

Members who retired prior to January 1, 1998 will receive a monthly HRA contribution of $130.00 per month for the member only, or $260.00 per month for the member and his or her spouse.

F. Pre-Medicare Retirees (Including Disabled Employees, Surviving Spouses) After December 31, 1997

1. Disabled or Retired Employees or Surviving Spouses Retiree Contribution Allowance Plan General Eligibility Requirements:

   (a) You must earn at least 10 service credits and reach age 55 (except in the case of pre-retirement death or disability).

   (b) You must have worked at least 160 hours in covered employment for a Contributing Employer after May 1, 1997, and retired on or after January 1, 1998.

   (c) You must be eligible for coverage under the Plan at the time of retirement, death, or disability.

   (d) If you are eligible for a pension from the Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund, you must be receiving monthly payments from that fund.

   (e) Contributions must have been paid by your Contributing Employer to the Plan for your hours worked in each of the five calendar years preceding the calendar year during which you become eligible for the retiree health benefit. This requirement does not apply to retirees who became active participants by returning to covered employment and who then resume retiree status upon re-retirement. The remaining provisions of this section apply, including the requirement set forth in section(g), below, requiring that retiree coverage be continuous from active employment.

   (f) Self-employed contractors are not eligible for the retiree contribution allowance.

   (g) Retiree coverage must be continuous from your status as an Active Employee (it cannot be delayed for any reason). However, the spouse of a retiree who retired on or after January 1, 1998, may delay coverage under the Plan if he or she has other group coverage through an employer. A spouse who delays coverage may also return on a one-time only basis if coverage through the spouse's employer is terminated. In that case, the retiree must notify the Fund within 31 days of the date the spouse's coverage was terminated and send in any required self-payment contribution. The spouse's coverage under this Plan would become effective on the first day of the month following the date the notification and self-payment contribution was received.

(h) If, after a retiree/spouse has resumed retiree coverage under this Plan, the retiree/spouse decides once again to terminate participation under this Plan, then that retiree/spouse will never again be eligible for coverage under this Plan. Likewise, if a retiree/spouse does not elect to resume retiree eligibility under this Plan when the retiree/spouse becomes eligible for Medicare, then the retiree/spouse loses the option to be covered under this Plan ever again.

(i) For a spouse to resume eligibility for coverage under this Plan, the retiree must be covered under this Plan on the date the spouse becomes eligible. If the retiree is deceased at the time the surviving spouse becomes Medicare eligible, then the surviving spouse can become eligible again under this Plan if the deceased retiree was eligible on the date of death or had not yet become Medicare eligible at the time of death.

(j) The Plan is not obligated to and will not notify the retiree and/or spouse who has delayed coverage under this Plan that their specific date to regain eligibility is approaching. It is entirely the responsibility of the retiree and/or spouse to notify the Fund when becoming eligible again under this Plan.

(k) For general eligibility and service credit determinations for purposes of computing retiree contribution allowances, the Plan will recognize contributions and service for participants of local unions that have been merged into Bricklayers and Allied Craftworkers Union Local #1 of Minnesota and North Dakota. The Board of Trustees will determine what records provide the best evidence of a participant's history with a merged local union's prior health plan, and the Board of Trustees will use that history in computing retiree contribution allowances.

2. Retiree Prefunded Plan: The Accrued Contribution Allowance provides eligible participants with a service credit. If you qualify for this plan, your premium will be automatically reduced by your Allowance, which is $20.00 per service credit to a maximum of 35 credits (56,000 hours) per person ($40.00 per couple). Maximum contribution allowance is $700.00 for retiree only and $1,400.00 for retiree and spouse, per month. Couples with one Medicare eligible and one-pre-Medicare eligible will receive a monthly premium subsidy of $26.00.

3. Service Credit

(a) For past service, cumulative contribution hours under Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund through December 31, 1997, are divided by 1,600 (rounded to nearest full credit). If you are not a Pension Fund participant, years of covered employment under this Health Fund prior to January 1, 1998, will be determined by the Trustees.

(b) For future service, cumulative contribution hours under the Health Fund on and after January 1, 1998, are divided by 1,600 (rounded to nearest full credit).

(c) Service credits are provided for Contributing Employer hours only. Self-pay hours and self-employed contractor premiums are not counted.

(d) Prior service is lost if you have two consecutive One-Year Breaks in Service. Prior to January 1, 1998, a One-Year Break in Service is defined as a calendar year in which you did not have at least 160 hours of covered employment under the Pension Fund or any other pension plan, annuity plan, or defined contribution plan sponsored by the International Union of Bricklayers and Allied Craftworkers or any affiliate thereof. After January 1, 1998, a One- Year Break in Service is defined as a calendar year in which you did not have at least 160 hours of covered employment under the Health Fund.

(e) The Break in Service requirements will be waived for Plan years 2008 through 2011 for any participant who meets the following criteria:

i. Has 10 or more service credits as of January 1, 2008; and

ii. Was unable to avoid a break in service at any point between January 1, 2008, and December 31, 2011, due to insufficient hours.

G. Pre-Medicare Retiree – Eligibility/Allowance Summary

Retirement	Eligibility	Contribution Allowance
Normal	Age 60 with 10 service credits	Full Accrued Amount
Early	Age 55 with 10 service credits	Accrued Amount reduced 0.25% for each month retirement precedes age 60
Disability	10 service credits and Permanently and Totally Disabled as defined in the Plan	Full accrued amount prior to Medicare Eligibility; Same as for Normal Retirement after Medicare Eligibility
Surviving Spouse	10 service credits	100% of the early retirement amount that would have been provided at retiree's earliest retirement age, provided immediately to surviving spouse

H. Where a Retiree is Medicare eligible, or receives coverage elsewhere, but his or her spouse is not yet Medicare eligible, the spouse may continue coverage under this Plan until he or she becomes Medicare eligible.

I. Medicare eligible retirees will receive a monthly deposit to their Health Reimbursement Account of $6 per service credit for single coverage, or $12.00 per service credit for couples.

J. Dependents are eligible for benefits under the Plan provided they:

1. Meet the definition of Dependent; and

2. The applicable premium has been paid on their behalf.

Proof of Dependent status must be filed with the Fund Office before any benefits are paid.

Dependents will become eligible on the same day that you become eligible, and, except as this Plan otherwise provides, their eligibility will terminate on the same day as yours. Eligible Dependent Children born after coverage begins for you will be eligible on the date of their birth. If you acquire new dependents by

virtue of marriage, the new dependents will become covered on the date of your marriage. Children placed with you for adoption will become covered on the date of placement. If a surviving spouse was covered by this Plan immediately prior to the Participant's death, then the surviving spouse may continue coverage by making self-payments until he or she remarries or becomes covered under another group plan. However, if the surviving spouse chooses to make these self-payments, he or she rejects COBRA.

II. Enrollment

You will receive an enrollment form from the Plan during the Open Enrollment period of October 1st through November 15th each year, or when you first enroll in the Plan.

Once you choose a Plan Option and Coverage Level you cannot change it until the next Open Enrollment period unless you experience a Qualifying Status Change. If you change your Plan Option or Coverage Level during the Open Enrollment period, the change will become effective on January 1st of the next Plan Year.

See the section below regarding the timing of when your eligibility will commence.

III. Payment of Premiums and Timing of Eligibility

A. Active Employees, Apprentices, and their Dependents

1. **Employer Contributions:** Contribution amounts received from your Employer will be deposited into your Dollar Bank. The balance in your Dollar Bank will be used to pay for your monthly premiums. The Fund will automatically deduct from your Dollar Bank the premium amount for the Plan option that you enroll in. If you do not submit an enrollment form you will be automatically placed into the Default Plan with single coverage (Plan E4350).

2. **Dollar Bank:** You may accumulate up to six months of premium, at whatever Plan Option and Coverage Level that you have selected, in your Dollar Bank. After you have accumulated six months of premium for your plan choice, additional contributions will be credited to your HRA. If your Dollar Bank becomes less than the six-month capacity due to debiting for continuing eligibility, future employer contributions will be deposited into the Dollar Bank until the six-month capacity is restored.

After the six-month capacity has been restored, employer contributions will then be deposited into your HRA. There is no maximum balance that you can accumulate in your HRA.

If after losing eligibility you fail to accrue sufficient funds in your Dollar Bank to reestablish eligibility within sixty (60) consecutive months of your prior eligibility, you will forfeit your remaining Dollar Bank and HRA account balance.

3. **Self-Payments:** If you do not have sufficient funds in your Dollar Bank, you can self-pay to maintain coverage. The Fund Office will send you a self-payment notice and a COBRA notice. (See COBRA Continuation Coverage Section for information on COBRA coverage.)

   (a) If you do not elect COBRA Continuation Coverage, your self-payment will be equal to your premium, less any funds in your Dollar Bank. If you elect COBRA Continuation Coverage you waive any right to make self-payments. Similarly, if you elect self-payment, you waive any right to COBRA Continuation Coverage.

   (b) You are only eligible for self-payment if you are working in Covered Employment, or available for work in Covered Employment or receiving benefits from the Workers' Compensation insurer of a Contributing Employer. Contact the Fund Administrator for additional information.

   (c) There is no limit on the number of partial self-payments. However, if you have to self-pay the full premium, you are limited to six consecutive months. If you have a month of partial self-payment before you reach the six consecutive months of full self-pay, you can start counting the full self-pay months again. After the sixth month of full self-pay, you will no longer be eligible to make a self- payment.

   (d) In addition, if you do not have a sufficient Dollar Bank balance, you have not worked any hours in the month, and you are receiving Workers' Compensation Benefits from a Contributing Employer during the month, you will be allowed to self-pay the required amount for continued coverage. A self-payment under these circumstances will <u>not</u> count against the maximum number of consecutive self-payments allowed under the Plan. There is a limit of twelve self-payments under these circumstances.

(e) Self-payments will only be accepted from you or your spouse. Any self-payment made on your behalf by a third-party will be refused, and eligibility for you and/or your dependents may be immediately terminated.

(f) If you lose eligibility because of insufficient funds in your Dollar Bank and do not elect to self-pay, and later accrue sufficient funds in your Dollar Bank to pay for the lowest level of coverage available under the Tier you previously selected and the applicable premium deducted from your Dollar Bank. For example, if before you lost eligibility, you were enrolled in Plan A with family coverage. You would be defaulted to Plan E with family coverage for the remainder of the year.

4. **Timing of Eligibility:** For hours you work in January, your employer will submit a report along with contributions on your behalf to the Fund Office in February. If you have a sufficient Dollar Bank balance based on contributions for hours worked in January to pay the premium for the plan option you elected, your Dollar Bank will be debited and you will be eligible for this coverage effective April 1st.

If you do not have a sufficient Dollar Bank balance based on contributions for hours worked in January to pay the premium for the plan option you elected, in March the Fund Office will send you a self-pay notice for the difference.

If you make the self-payment within the time prescribed, you will be eligible for this coverage effective April 1st. If you do not make the self-payment within the time prescribed, and you have a sufficient Dollar Bank balance to pay the premium for the Default Plan at the Tier you had previously elected, your Dollar Bank will be debited and you will be eligible for this coverage effective April 1st.

If you do not make the self-payment within the time prescribed, and you do not have a sufficient Dollar Bank balance, you will not be eligible for coverage effective April 1st.

See the chart below for examples:

If Your First Hour of Work is in This Month	Premium Will Be Deducted from Dollar Bank at the End of This Month	If There Is Not Enough To Cover the Full Month, A Self-Pay Will Be Due This Month	The Effective Date of Your Coverage Will Be the First of This Month
January	February	March	April
February	March	April	May
March	April	May	June
April	May	June	July
May	June	July	August
June	July	August	September
July	August	September	October
August	September	October	November
September	October	November	December
October	November	December	January
November	December	January	February
December	January	February	March

B. Self-Employed Contractors and other Non-Collectively Bargained Employees

Premiums are due in accordance with the billing process established by the Fund. The Fund Office will provide an invoice to the employer monthly. Eligibility will commence on the 1st day of the following month.

C. Pre-Medicare Retirees

Premiums are due in accordance with the billing process established by the Fund. The Fund Office will provide a statement to you monthly. Eligibility will commence on the 1st day of the following month. The premiums for retiree coverage are set forth in Exhibit A.

If your monthly premium is more than your Accrued Contribution Allowance, and you receive a monthly pension payment that is sufficient to cover the remaining balance of your premium, the remaining premium may be deducted from your pension payment. If your monthly pension payment is not sufficient to cover your remaining premium, or you do not receive a pension, you will be billed. Failure to make timely payment may result in termination of benefits.

Unless you become totally disabled or retire, you must be either working in Covered Employment or available for work in Covered Employment to participate in the Plan. If you are working within the geographic and trade jurisdictions of the Union for an employer that does not contribute to this Fund, your Dollar Bank and HRA balance will be immediately forfeited to the Fund.

IV. Continuing Eligibility

You will remain eligible and covered in the Plan so long as you pay your premium, or self-pay where applicable, and, for Active Employees, continue to work in Covered Employment, or are available for work in Covered Employment.

V. Reinstatement of Eligibility

If you were previously covered under the Plan and terminated, you must again meet all eligibility requirements and make your premium payments as outlined under Enrollment and Payment of Premiums.

VI. Qualifying Status Change

There are certain circumstances in which you can change your Plan Option and Coverage Level outside the open enrollment period.

If you have a new Dependent (spouse, child) because of marriage, birth, adoption, or placement for adoption, you may enroll the new Dependent in the Plan within 60 days of the event. If this changes your coverage Tier, your costs may also change and the Fund Office will notify you of any additional premiums that may be due. If an additional premium is due, coverage will not be effective for the new Dependent until the Fund Office has received that premium.

A. **Adding newborns:** You must request an enrollment form from the Fund office and return the completed form to the Fund office within 60 days after the birth for coverage to become effective on the date of the birth.

B. **Adding children placed for adoption:** You must request an enrollment form from the Fund office and return the completed form to the Fund office within 60 days after the placement for coverage to become effective on the date of the placement.

Your Dependents may also enroll in this Plan if your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and your Dependents lose eligibility for that coverage. Enrollment must be requested within 60 days after the Medicaid or CHIP coverage ends.

In general, your child is no longer eligible for coverage when he or she reaches age 26, or no longer meets the definition of Covered Dependent. You must notify the Fund Office when one of these events occurs.

Your child may elect to continue coverage under COBRA for up to 36 months after your child loses eligibility due to attaining age 26. You or your child must notify the Fund Office within 60 days of the date he or she no longer meets the definition of a dependent to obtain COBRA continuation coverage.

If your child is not capable of self-supporting employment upon reaching the limiting age because of a mental or physical disability or handicap, you may continue coverage for that child for as long as your own coverage continues and the child meets the definition of a disabled dependent child. To qualify, your child's disability must begin before his or her coverage would otherwise end. The Fund Office will periodically request medical documentation of the child's continuing disabled status.

There are certain other mid-year changes in status events which may allow you to change your Plan Option and Coverage Level:

A. **Change in legal marital status (e.g., divorce/legal separation, death).** If you and your Spouse get a divorce or legal separation, your Spouse will no longer be eligible for coverage as of the date of the divorce or legal separation. Your Spouse may elect to continue coverage under COBRA for up to 36 months upon divorce or legal separation. You or your Spouse must notify the Fund Office within 60 days of the divorce or legal separation date for your Spouse to obtain COBRA continuation coverage.

B. **Adding a spouse**: A spouse is eligible on the date of legal marriage. You must request an enrollment form from the Fund office and return the completed form to the Fund office within 60 days after the legal marriage for coverage to become effective on the date of the legal marriage.

C. **Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.**

D. **Coverage of a child due to a Qualified Medical Child Support Order (QMCSO).**

E. **Entitlement or a loss of entitlement to Medicare or Medicaid.**

F. **Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.**

G. Changes consistent with Special Enrollment rights and the Family Medical Leave Act.

The Family and Medical Leave Act of 1993 (FMLA) creates a federal right for Active Employees who qualify to take up to twelve weeks of unpaid leave if they are seriously ill, after the birth or adoption of a child, or to care for their seriously ill spouse, parent, or child. Your employer must be subject to the FMLA, grant the leave in accordance with the law, and continue contributing to the Fund on your behalf.

You must notify the Fund if you qualify to take a family or medical leave. If your Contributing Employer is required to comply with the FMLA, it must give the Fund the necessary information to verify that the leave qualifies under the FMLA. Your Contributing Employer must certify eligibility and pay the required premium for the extension of coverage.

VII. In The Event of Your Death

In the event of your death, your Spouse and Eligible dependent children may continue coverage for up to 36 months by electing COBRA continuation coverage and making the necessary payments or, if eligible, by electing continuing coverage for surviving spouses and dependents.

The Trustees have the right to require an autopsy in the event of the death of a Plan Participant whose Injury or Sickness is the basis of a claim, provided the law does not forbid an autopsy.

VIII. Continuation of Coverage Due to Military Service

If you leave work for military service and the military service is for 30 or fewer days, your eligibility will continue under the same terms and conditions as apply to active participants.

If your military service lasts more than 30 days, your Dollar Bank and HRA account under the Plan will be frozen. During the time you are on military leave, you should be covered under a health insurance program provided through the military. However, you may elect to continue health coverage under the Plan for yourself and your covered dependents. If you elect to continue health coverage under the Plan, you will be required to pay the premium in the same manner and amount as a person electing COBRA coverage.

The maximum period during which you may continue health coverage under the Plan while on military leave is the lesser of:

A. The 24-month period beginning on the date on which the military leave began; or

B. The period beginning on the date on which the military leave began, and ending on the day you fail to timely apply for or return to a position of covered employment with a participating employer.

When you return from a military leave and resume active employment with a Contributing Employer, your Dollar Bank and HRA account will be unfrozen.

COBRA Continuation Coverage

If you or your Dependent(s) become ineligible to participate in the Plan or the HRA, you may qualify to continue your participation under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Coverage will begin on the day that coverage under the Plan would otherwise have been lost. Under COBRA Coverage, your benefits will be the same as those of a similarly situated Participant who does not have COBRA Coverage. However, you must pay a monthly premium for COBRA Coverage. If you elect to maintain eligibility under the Special Continuation Rule, you may not elect COBRA Coverage. For more information about COBRA Coverage, contact the Fund Office.

I. Qualifying for COBRA Coverage

A COBRA qualifying event occurs when you cease to be Eligible because:

- Your Employer reduced your hours;
- Your Employer terminated your employment (for any reason other than gross misconduct); or,
- You depleted your hour bank.

A COBRA qualifying event occurs for your Dependent(s) when your Dependent(s) lose eligibility because:

- You died;
- You were divorced or legally separated;
- Your child failed to continue qualifying as a Dependent; or,
- You became eligible for Medicare.

You must notify the Fund Office within 60 days of the date you or your Dependent ceased to be Eligible due to a qualifying event (except if the qualifying event is due to a reduction of your hours or your termination, in which case the Fund Office will determine whether you experienced a qualifying event). If you do not notify the Fund Office within 60 days, you cannot elect COBRA Coverage.

II. Maximum Period of Cobra Coverage

If your COBRA qualifying event is a reduction in your hours or termination of your employment, the maximum period of COBRA Coverage for you and your Dependents is 18 months, beginning on the day coverage would otherwise end. However, if a second qualifying event occurs during this 18-month period, the maximum period of COBRA Coverage extends to 36 months. If you or one of your Dependents is totally disabled at the time of the initial qualifying event (or within 60 days of the initial qualifying event, as determined by the Social Security Administration), the maximum period of COBRA Coverage will be is 29 months. You must notify the Fund Office within 60 days of the date that Social Security determines that you or your Dependent is totally disabled. If the qualifying event is divorce, separation, failure to continue qualifying as a Dependent, or Medicare eligibility, the maximum period of COBRA Coverage is 36 months.

III. Termination of Cobra Coverage

Your COBRA Coverage will end on the earliest of the following dates:

- The date on which you become entitled to receive benefits under Medicare;
- The end of the applicable maximum period of COBRA Coverage;
- The date on which the Plan terminates;
- The date you become covered under another group health plan;
- The date you become entitled to Medicare benefits; or
- The date you engage in conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving COBRA Coverage (such as fraud).

IV. HRA COBRA Coverage

The HRA is a reimbursement mechanism, which generally means that only the amounts contributed by your Employer are available for reimbursement. If a divorce occurs, the divorce decree will need to specify who has access to the account; the Plan will continue to recognize all pre-COBRA event Dependents, if claims are submitted. If your child is no longer Eligible due to no longer being a Dependent, then the Plan will continue to recognize your child as Eligible for the applicable COBRA period. You must make the proper COBRA election. After the COBRA event, contributions for you will go into a new HRA Account, with an amended list of participants Eligible to receive reimbursements. The subsequent COBRA contributions will be used only for claims of your post-COBRA Dependents, and they are not subject to claims of former Dependents.

V. Health Insurance Marketplace Alternatives

There may be other coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Zenith American Solutions, Inc.:

Minnesota and North Dakota Bricklayers and
Allied Craftworkers Health Fund
Zenith American Solutions, Inc.
P.O. Box 257
Minneapolis, MN 55440-0257
Telephone: (651) 256-1801
Toll free: (800) 879-4412

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov.ebsa.

VI. Keep the Fund Informed of Address Changes

To protect your family's rights, you should keep the Fund informed of any changes in your address or the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund.

Death Benefit (Active Collectively Bargained Employees Only)

If you are covered as an Active, Collectively Bargained Employee, the Death Benefit is payable to your beneficiary if you die from any cause while you are eligible for benefits under the Plan. The amount of the Death Benefit is shown in the Schedule of Benefits, and it is paid in a lump sum after your beneficiary submits a death certificate, valid state issued identification card or driver's license, and social security card to the Fund Office.

Dependents are not eligible for Death Benefit coverage.

I. Beneficiary

Your beneficiary is any person or persons named on a beneficiary designation form kept on record with the Fund Administrator.

You may change your beneficiary designation at any time by submitting a new beneficiary form to the Fund Administrator. You do not need the consent of your current beneficiary to change your beneficiary designation. A change of beneficiary will become effective when the new beneficiary form is received by the Fund, and it will automatically replace any previously submitted beneficiary form.

If you have not named a beneficiary, or if your beneficiary dies before you, then payment will be made equally to the members of the first applicable category:

A. Surviving spouse, if any,

B. Child and/or children, if any, in equal shares,

C. Parents, in equal shares, or

D. Your estate.

Weekly Accident and Sickness Benefit (Active Collectively Bargained Employees Only)

The Weekly Accident and Sickness Benefit (also known as the Loss of Time Benefit) is payable if you are temporarily disabled due to an Injury or Sickness that is not employment-related. You must be unable to perform the duties of your occupation and you must not be engaged in any other occupation for wage or profit. In addition, at the time of your Injury or Sickness, you must have been working for or available for work with a Contributing Employer.

Dependents are not eligible for Weekly Accident and Sickness Benefits.

The amount of the weekly rate and the maximum number of weeks payable are shown in the Schedule of Benefits at the beginning of this booklet. The Weekly Accident and Sickness Benefit will begin on the fourth day of a disability that is due to an Injury and on the eighth day of a disability that is due to a Sickness. Sickness includes physical illness, including pregnancy, and Mental and Nervous Disorders.

I. Successive Periods of Disability

Two or more periods of disability are considered one period of disability unless you return to active full-time work for at least two weeks between disability periods. Subsequent disabilities due to entirely unrelated causes are considered separate periods of disability if you return to active full-time work for at least one day between disability periods.

During partial weeks of disability, you will be paid at the daily rate of one-seventh (1/7) of the Weekly Rate.

II. Weekly Accident and Sickness Benefit Exclusions and Limitations

No benefits are payable under the Weekly Accident and Sickness Benefit (Loss of Time) for any disability that is:

A. A result of Sickness or accidental Injury for which you are not under the care of a legally qualified Medical Doctor (M.D.);

B. Covered by workers' compensation or any occupational sickness law;

C. Due to an occupational Injury that occurred while working for pay or profit; or

D. After retirement, even if you are using your Dollar Bank to retain active coverage.

Please note that any benefit that you receive as Weekly Accident and Sickness Benefits (such as under the provisions of this benefit program) are not tax exempt and must be included as part of your annual gross income. The Weekly Rate shown in the Schedule of Benefits has already been reduced by the amount of your share of FICA tax.

Wellness Program

The Plan provides services to help you manage your health care needs.

- Partners in Quitting. The Plan covers tobacco cessation office visits and HealthPartners telephone coaching at no cost. Over-the-counter tobacco cessation aids, including, but not limited to, transdermal patches, nicotine gum and nicotine lozenges, are covered at no cost. You must pay for these aids and submit the receipts to HealthPartners for reimbursement.

- Health & Wellbeing Program – Beginning in 2025, Bricklayer participants will be eligible to earn a reward of up to $300 for completing the following three steps: 1) Completing a 10-minute online health assessment; 2) completing one of the list well-being activities, and 3) completing an annual preventive care exam/screening. To begin the process and claim your reward, visit www.healthpartners.com/signup.

Preventive Care Benefit

The Plan covers Network Preventive Care at 100% of the Covered Expenses, without deductible, coinsurance, or copayment. The Plan covers Out-of-Network Preventive Care subject to the deductible, copayment, and coinsurance stated in the Schedule of Benefits.

I. Summary

This summarizes the items and services covered under the Preventive Care Benefit, broken down by age and gender group. This list is representative only and may be subject to change or limitation at any time. The Trustees have taken action to expand the coverage of preventive care to include some services beyond those identified on the list, depending upon the diagnostic code from your provider.

A. All Members:

1. Age and gender appropriate Preventive Medicine visits (Wellness visits, including Well-woman and Well-child).

2. All routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control.

B. All Members at an appropriate age and/or risk status:

1. Counseling and/or screening for elevated cholesterol and lipids.

2. Counseling and/or screening for colorectal cancer, including colonoscopies which are limited to one (1) procedure per Participant every five (5) Calendar Years beginning at age 50, unless prescribed more often by a Physician.

3. Counseling and/or screening for certain sexually transmitted diseases and HIV.

4. Counseling and/or screening for alcohol or substance abuse in a primary care setting.

5. Tobacco cessation interventions, including pharmacological aids and behavioral therapy.

6. Low dose CT Scan for Lung Cancer for current smokers aged 55-80 who meet the following eligibility criteria: One pack per day for 30 years; Two packs a day for 15 years; same history but quit within the past 15 years.

7. Counseling and/or screening for obesity, diet, and nutrition.

8. Counseling and/or screening for high blood pressure, diabetes, and depression.

9. Vitamin D Supplementation for community dwelling adults (age 65 or older).

C. Women's Health:

1. Screening and evaluation for genetic testing for BRCA breast cancer gene.

2. Screening for cervical cancer including Pap smears.

3. Screening for gonorrhea, Chlamydia, syphilis.

4. Screening pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility.

5. Instructions to promote and aid with breast-feeding.

6. Osteoporosis screening (age 60 or older).

7. Breast Cancer Mammography screenings.

8. Breast Cancer Chemoprevention counseling.

9. Counseling regarding medications to reduce the risk of breast cancer, and, for women who are at increased risk for breast cancer and at low risk for adverse medication effects, risk-reducing medications.

10. Folic Acid supplements.

11. Tobacco Use screening and interventions, with expanded counseling for pregnant women.

12. Contraception (FDA approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs).

13. Domestic and interpersonal violence screening and counseling.

14. Gestational diabetes screening.

15. HPV DNA Test.

16. Aspirin, to reduce the risk of myocardial infarction (age 55-79).

17. Personal-use electric breast pump, limited to one pump per birth, including necessary supplies to operate.

D. Men's Health:

1. Screening for prostate cancer for men (age 40 and older).

2. Abdominal Aortic Aneurysm screening for men who have smoked (age 65-75).

3. Aspirin, to reduce the risk of myocardial infarctions (age 45-79).

E. Children:

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia.

2. Standard metabolic screening panel for inherited enzyme deficiency diseases.

3. Counseling for fluoride treatment and fluoride supplementation.

4. Vision screening.

5. Developmental and autism screening.

6. Screening for lead and tuberculosis.

7. Counseling for obesity.

8. Assessment for alcohol and drug use.

9. Blood pressure screening.

10. Iron supplementation.

11. Dyslipidemia screening.

12. Gonorrhea preventive medication for eyes of all newborns.

13. Height, Weight, and Body Mass Index measurements.

14. HIV and sexually transmitted infection preventing counseling and screening.

15. Oral Health risk assessment.

II. Preventive Services Compared to Diagnostic Services

Certain services can be done for preventive or diagnostic reasons. When a service is performed for the purpose of preventive screening and is appropriately reported, it will be adjudicated under the Preventive Care Services benefit.

A. Preventive Services are those performed on a person who:

1. Has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or

2. Has had screening done within the recommended interval with the findings considered normal; or

3. Has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or

4. Has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g., polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

Examples include, but are not limited to:

- A woman who had an abnormal finding on a preventive screening mammography and the follow up study was found to be normal, and the patient was returned to normal mammography screening protocol, then future mammography would be considered preventive

- If a polyp is encountered during preventive screening colonoscopy, the colonoscopy, removal of the polyp, and the associated facility, lab and anesthesia fees done at the same encounter are covered under the Preventive Care Services benefit.

When a service is done for diagnostic purposes, it will be adjudicated under the applicable non-preventive medical benefit.

B. Diagnostic services are done on a person who:

1. Had abnormalities found on previous preventive or diagnostic studies that require further diagnostic studies; or

2. Had abnormalities found on previous preventive or diagnostic studies that would recommend a repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals; or

3. Had a symptom(s) that required further diagnosis.

Examples include, but are not limited to:

- A patient had a polyp found and removed at a prior preventive screening colonoscopy. All future colonoscopies are considered diagnostic because the time intervals between future colonoscopies would be shortened.

- A patient had elevated cholesterol on prior preventive screening. Once the diagnosis has been made, further testing is considered diagnostic rather than preventive. This is true whether the patient is receiving pharmacotherapy.

- If a Preventive Service results in a therapeutic service at a later point in time, the Preventive Service would be adjudicated under the Preventive Care Services benefit and the therapeutic service would be adjudicated under the applicable non-preventive medical benefit.

III. Preventive Care Benefit Exclusions, Limitations and Additional Information

A. Items and services not covered under the Preventive Care Benefit may be covered under another portion of the Comprehensive Major Medical Benefit.

B. Certain criteria, such as age, gender, or risk factors, for coverage of items listed as Preventive Care must be met as spelled out in the U.S. Government guidelines. If those criteria are not met, the item may not be covered at all or may not be covered 100% In-Network.

C. Certain drugs, medications, vitamins and/or supplements, or over-the-counter contraceptive methods must be prescribed to be covered under the Preventive Care Benefit.

D. Certain Services that are directly related to the performance of a preventive service are adjudicated under the Preventive Care Benefit; however, in certain cases where the preventive service is incidental to another procedure performed during an admission, only the preventive service will be covered under the Preventive Care Benefit. For example, if a woman is admitted to an inpatient facility for another reason, and has a sterilization performed during that admission, the sterilization surgical fees (surgical fee, device fee, anesthesia, pathologist, and physician fees), are covered under the Preventive Care Benefit. However, the facility fees are not covered under the Preventive Care Benefit because the sterilization is incidental to, and is not the primary reason for, the admission.

Comprehensive Major Medical Expense Benefit

The Plan covers expenses for a wide range of care, services, and supplies needed to treat Illness or Injury, including Physician charges, diagnostic testing charges, Hospital charges, and surgery charges. The Plan will pay Allowable Charges for Medically Necessary care, treatment, supplies, and services, subject to any exclusions or limitations provided in this Plan Document, and subject to the Deductible(s), Copayment(s), Coinsurance(s), and Out-of-Pocket Maximum(s) shown in the Schedule of Benefits.

The Plan relies upon the standards of care for medical treatment developed and maintained by HealthPartners, Inc.

I. Covered Medical Costs, Services and Supplies

The following medical costs, services and supplies are covered under the Comprehensive Medical Expense Benefit:

A. Inpatient (in-network) and Outpatient Hospital Expenses, including:

1. Hospital room and board, up to the average semi-private room rate charged by the Hospital.

2. Operating room, medicines, drugs, blood, and blood plasma (including administration thereof), anesthetic (including administration when billed as part of Hospital charges), x-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings, and medical supplies.

B. Surgical Expenses.

C. In-Network, inpatient treatment for alcoholism, chemical dependency, drug addiction, and Mental or Nervous Disorders for confinement in a licensed Hospital or residential primary treatment program after diagnosis. Physician visits include visits by licensed psychologists and licensed consulting psychologists.

D. Outpatient treatment and day treatment for alcoholism, chemical dependency, drug addiction, and Mental or Nervous Disorders: Outpatient treatment and day treatment for alcoholism, chemical dependency, and drug addiction in a non-residential treatment program approved by an authorized state agency. Methadone treatment or similar maintenance programs are covered as any other drug addiction treatment.

E. Medical and surgical expenses for mastectomies as required by the Women's Health and Cancer Rights Act of 1998, including:

1. Reconstruction of the breast on which the mastectomy was performed,

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

3. Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

F. Maternity Expenses resulting from a pregnancy are covered immediately for Expenses incurred on or after the effective date of your coverage under the Plan.

G. Nursery care for each newborn Dependent child who is eligible for coverage will be covered for Hospital room and board and miscellaneous charges.

H. Diagnostic laboratory and x-ray charges for laboratory tests or x-rays made or recommended by a Physician while not confined in a Hospital. The following services are not covered:

1. Dental care or treatment (may be covered as Dental Expense Benefits),

2. Eye refractions (may be covered under the Vision Care Program) , or

If you use a Centers for Diagnostic Imaging (CDI) facility for your radiology or diagnostic imaging services, your services will be covered at 100%, with no deductible, if they are not limited otherwise.

I. Radiation therapy and chemotherapy, as ordered by a Physician.

J. Skilled nursing facility charges as the result of an Injury of Sickness. Benefits will be payable for the Reasonable and Customary charges incurred for the period of confinement in a Skilled nursing facility. Skilled nursing facility charges are covered only to the extent such charges meet the HealthPartners coverage criteria, which can be found at https://www.healthpartners.com/public/coverage-criteria/skilled-nursing-facility.htm. For a copy of the coverage criteria, contact HealthPartners at 952-883-5000 or 800-883-2177.Body Organ Transplants: Expenses for transplant surgery will be paid when the recipient is a Covered Person under this Plan for the following:

1. For a recipient:

   (a) The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s),

(b) Multiple transplant(s) during one operative session,

(c) Replacement(s) or subsequent transplant(s), and

(d) Follow-up expenses for covered services (including immuno-suppressant therapy).

2. For a donor:

(a) Testing to identify suitable donor (s),

(b) The Expense for the acquisition of organ(s) from a donor,

(c) The Expense of life support of a donor pending the removal of a usable organ(s),

(d) Transportation for a living donor, and

(e) Transportation of organ(s) or a donor on life support.

3. Definitions:

(a) Transplant Surgery: Transfer of a body organ(s) from the donor to the recipient.

(b) Donor: A person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

(c) Body Organ: Any of the following: kidney, heart, heart/lung, liver, pancreas (when condition not treatable by use of insulin therapy), bone marrow, bone, and cornea.

(d) Recipient: An eligible person who undergoes a surgical operation to receive a body organ transplant.

4. Benefits will not be paid for:

(a) Organ transplants unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant,

(b) Any animal organ or mechanical equipment, device, or organs, except as provided under the benefits for a recipient,

(c) Any financial consideration to the donor other than for a Covered Expense that is incurred in the performance of or in relation to transplant surgery,

(d) Organ transplants that you may not be legally required to pay for, and

(e) Anything excluded under the General Exclusions and Limitations.

L. Other Expenses, including:

1. Treatment by a legally qualified Physician.

2. Treatment by a physiotherapist.

3. Dental treatment by a Physician, dentist, or dental surgeon for a fractured jaw or for an Injury to natural teeth. Dental treatment includes replacement of teeth provided such treatment is commenced within six months of the accident and completed within 24 months of the accident.

4. Medically necessary general anesthesia and outpatient hospital facility charges incurred in conjunction with dental restoration at 50% after the calendar-year medical plan deductible. Only patients who meet the following criteria will be eligible for this benefit:

   (a) A child up to 6 years old with a dental condition (such as baby bottle syndrome) requiring repairs of significant complexity; or

   (b) A child or adult exhibiting physical, intellectual, or medically compromising conditions, for which dental treatment under local anesthesia cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result. Conditions include, but are not limited to, intellectual disabilities, cerebral palsy, epilepsy, and cardiac program; or

   (c) Member for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations, or allergy); or

   (d) Members who have sustained extensive oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

5. X-ray or radium treatment.

6. X-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment of a fractured jaw or for an Injury to natural teeth within six months after the date of the accident.

7. Professional ambulance service for Medically Necessary transportation to the nearest Hospital equipped to provide the appropriate treatment. This does not include common carriers such as railroad, ship, bus, or airplane.

8. Human growth hormone injections (injections obtained from a pharmacy will be covered under the Prescription Drug Benefit).

9. The following medical supplies:

   (a) Drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, but specifically excluding those drugs or any other form of medication that may be obtained without a prescription, except as provided by the Preventive Care Benefit or to the extent charges for such drugs and medicines meet the HealthPartners coverage criteria, which can be found at https://www.healthpartners.com/public/coverage-criteria/nutritional-support.htm. For a copy of the coverage criteria, contact HealthPartners at 952-883-5000 or 800-883-2177.

   (b) Blood and blood plasma,

   (c) Artificial limbs and eyes,

   (d) Surgical dressings,

   (e) Casts, splints, binders, braces, crutches,

   (f) Rental of wheelchairs or Hospital beds,

   (g) Oxygen and the rental of equipment for its administration; and

   (h) Rental of Durable Medical Equipment prescribed by a Physician but not to exceed the actual purchase price. Replacement of CPAP equipment is covered according to the Medicare CPAP replacement schedule.

10. Occupational, physical or speech therapy if the therapy is short term, active and progressive and performed by a licensed or duly qualified therapist as ordered and supervised by a Physician. This benefit does not cover maintenance rehabilitation, coma stimulation services, and other services

not broadly recognized as generally effective.

M. Nutritional counseling and diabetic education program designed to improve patients' knowledge and to teach techniques for self-management of diabetes and other medical conditions.

N. Services performed at retail-based clinics, such as Minute Clinics, and other similar clinics, including online clinics, such as Virtuwell and Zipnosis.

O. Routine colonoscopies and flexible sigmoidoscopy for adults age 50 and over, and for adults under age 50 due to family history, even if no cancer symptoms are present.

P. Tobacco Cessation Products when administered by OptumRx: Prescription medications, including, but not limited to Wellbutrin, Chantix and Bupropion are covered at 100%. Over-the-counter tobacco cessation aids, including, but not limited to, transdermal patches, nicotine gum and nicotine lozenges, are provided to you at no cost when you submit your receipts to HealthPartners for reimbursement.

Q. Hospice care through an agency or organization that is licensed by the state and is operating within the scope of that license. Hospice care charges are covered only to the extent such charges meet the HealthPartners coverage criteria, which can be found at https://www.healthpartners.com/public/coverage-criteria/hospice-services-hpc.htm. For a copy of the coverage criteria, contact HealthPartners at 952-883-5000 or 800-883-2177.

R. Wigs are covered as shown in the Schedule of Benefits, in cases where hair loss is due to illness or treatment of illness. Wigs for hair loss due to male or female pattern baldness are not covered.

S. Chiropractic charges are covered up to the number of visits set forth in the Schedule of Benefits. Chiropractic visits in excess of the amount shown in the Schedule of Benefits are your responsibility, and they will not be considered a Covered Expense under this Plan.

T. Home Health Care services that are furnished by a Home Health Care Agency in accordance with a Home Health Care Plan are covered by the Plan up to the maximum number of visits per Calendar Year shown in the Schedule of Benefits.

1. Benefits will be payable for the following services and supplies:

   (a) Part-time or intermittent nursing care, provided by a:

   (b) Registered nurse, or

   (c) Licensed practical nurse supervised by a registered nurse.

2. Part-time or intermittent home health aide services, which consist primarily of medical care or therapy for the Covered Person.

3. Physical, occupational or speech therapy.

4. Medical supplies, drugs and medicines, and related pharmacy and laboratory services that are prescribed by a Physician and would be covered if the Covered Person were confined in a Hospital.

5. Benefits will not be paid for:

   (a) Services that consist primarily of the duties of a housekeeper, companion, or sitter,

   (b) Services and supplies not included in the Home Health Care Plan,

   (c) Services of a person who is a member of the Covered Person's immediate family or otherwise lives in the Covered Person's home,

   (d) Expenses for which benefits are payable under any other provisions of the Plan, and

   (e) Services provided outside the Covered Person's home.

U. Antiviral medications like Tamiflu (oseltamivir) and Relenza (zanamivir) for the treatment or prevention of influenza in high-risk patients, defined as:

1. Adults and children who have chronic disorders of the pulmonary or cardiovascular system, including asthma;

2. Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases, renal dysfunction, hemoglobinopathies (abnormal hemoglobin/anemia), or immunosuppression;

3. Children and adolescents aged 6 months to 18 years who are receiving long-term aspirin therapy; and

4. A patient with any other condition that poses a serious complication if he or she contracts influenza.

These medications will be covered under the Prescription Drug Benefit.

V. Expenses related to the legal termination of pregnancy.

W. Genetic testing to establish a treatment plan after a diagnosis of an inheritable

disease. The Plan will not: require or request any covered individual to take a genetic test, except in the limited circumstances where the results of such a test are medically appropriate to a claims payment decision; ask for the results of a genetic test when the claim is for the payment of a genetic test; or use or disclose genetic information for underwriting purposes as defined under the terms of the Genetic Information Nondiscrimination Act (GINA). Benefits are contingent upon meeting the following criteria:

1. The patient displays clinical features, or is at direct risk of inheriting the genetic mutation in question;

2. The result of the test will directly impact that treatment being delivered to the patient; and

3. After history, physical examination, family history analysis, genetic counseling and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain, and a genetic disorder is suspected.

II. Alternative Benefit Provision

Alternative care may be recommended and covered if conditions warrant services that are medically necessary and if the alternative care can be provided at an equal or lower cost with no reduction in quality.

Each case will be considered individually.

Dental Expense Benefit (Non-Retiree Participants)

The Dental Expense Benefit is payable if you incur Expenses for covered dental charges. This benefit will not exceed the Calendar Year maximum for covered charges shown in the Schedule of Benefits at the beginning of this booklet. Expenses in excess of the Calendar Year maximum shown in the Schedule of Benefits will not be covered under the Comprehensive Major Medical Expense Benefit. Pediatric dental services are not subject to, or count towards, the Calendar Year maximum. Pediatric dental services include a maximum of two routine visits per Calendar Year.

Benefits are payable for the charges incurred for services, supplies and treatment provided by a legally qualified practitioner for oral examination and treatment of accidentally injured or diseased teeth or tissue.

The Fund has contracted with a Dental PPO network. Providers in the network will charge negotiated, discounted rates for their services. If you use a network provider, it will cost you and the Fund less than if you go to a dental provide who is not in the network. To find a network provider in your area, go online to www.deltadentalmn.org or call (800) 553-9536.

I. Covered Dental Charges

Covered dental charges include Expenses for the following:

A. Oral examinations, including scaling and cleaning of teeth, but not more than two examinations or scalings and cleanings per calendar year.

B. Topical application of sodium or stannous fluoride, once in each period of twelve consecutive months, but only if the Covered Dependent is less than sixteen years old.

C. Dental x-rays, including bitewing x-rays once every twenty-four months for adults and once every twelve months for children, up to age 19. Full-mouth x-rays will be covered once every three years.

D. Extractions.

E. Oral surgery, including excision of impacted teeth.

F. Fillings (including composite fillings).

G. General anesthetics administered in connection with oral surgery or other covered dental services.

H. Injection of antibiotic drugs by the attending dentist.

I. Drugs for treatment of dental disease that can be dispensed by a licensed pharmacist only upon a prescription by a legally qualified dentist or Physician operating within the scope of his license.

J. Space maintainers and retainers.

K. Treatment of periodontal and other diseases of the gums and tissue of the mouth.

L. Endodontic treatment, including root canal therapy.

M. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework, which is required because of an extraction of one or more natural teeth, accidentally injured or diseased, and a denture or bridgework includes the replacement of teeth so extracted.

N. The replacement or alteration of full or partial dentures or fixed bridgework, which is necessary because of:

1. Oral surgery resulting from an accident; or

2. Oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus, or redundant tissue**.**

O. The replacement of a full denture which is necessary because of:

1. Structural change within the mouth, but only if more than five years has elapsed since the initial placement;

2. The initial placement of an opposing full denture; or

3. The prior installation of an immediate temporary denture, but only within twelve months of the installation of the temporary denture.

P. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, but only if:

1. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture or bridgework was installed; or

2. The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

Q. The replacement of a crown restoration provided the original crown was installed more than five years prior to the replacement.

R. Inlays, gold fillings, crowns, including precision attachments for dentures.

S. Repair or recementing of crowns, inlays, bridgework, or dentures, or relining of dentures.

T. Orthodontia treatment for dependent children up to age 19.

U. Dental implant.

The Fund, at its discretion, may request supporting proof of loss such as clinical reports, charges, and x-rays.

Covered Dental Expenses are considered to have been incurred on the date the dental service is performed.

II. Dental Expense Benefit Exclusions and Limitations

In addition to the Exclusions and Limitations to the Comprehensive Major Medical Expense Benefit, benefits are not payable under this Dental Expense Benefit for:

A. Expenses incurred after termination of eligibility, except for prosthetic devices that were fitted and ordered prior to termination and that were delivered to an eligible Covered Person within thirty days after the date eligibilityends;

B. Prosthetic services (including bridges and crowns) started or under way prior to the date a Covered Person became eligible under this Dental Expense Benefit;

C. Denture rebasing or relining less than six months from the date of initial placement and not more often than once in any two-year period;

D. Replacement of lost or stolen prosthetics;

E. Replacement of prosthetics less than five years after placement, except as specifically provided;

F. Orthodontic care, treatment, services, and supplies, including extraction of teeth, relating to orthodontic care received after the Covered Dependent's nineteenth birthday;

G. Treatment on or to the teeth or gums for cosmetic purposes (including realignment of teeth);

H. The application of dental sealants after the Covered Dependent's sixteenth birthday; or

I. Expenses for dental treatment following an accident to the extent such expense may be covered under Section L, subsection 3 of the Plan's Comprehensive Major Medical Expense Benefit.

Dental Expense Benefit (Retirees Only)

The Preventive Dental Expense Benefit is payable if a Covered Retiree incurs expenses for covered dental charges.

Benefits are payable for the Reasonable and Customary Charges incurred for services, supplies and treatment provided by a legally qualified practitioner for preventive care.

I. Covered Dental Charges

Covered dental charges include expenses for the following:

A. Oral examinations, including routine cleaning of teeth, but not more than two examinations and cleanings per calendar year.

B. Bitewing x-rays once every 12 months. Full-mouth x-rays will be covered once every five years.

C. The Fund, at its discretion, may request supporting documentation such as clinical reports, charges, and X-rays.

D. Covered dental expenses are considered to have been incurred on the date the dental service is performed.

Hearing Benefit

Charges for hearing examinations, purchase of hearing aids and fitting of hearing aids are covered up to the maximum per five calendar years shown in the Schedule of Benefits. Pediatric hearing benefits are not subject to, or count towards, the Calendar Year maximum. Pediatric hearing benefits include routine hearing exams.

Charges in excess of the amount shown in the Schedule of Benefits are your responsibility, and they will not be considered a Covered Expense under any other benefits of this Plan, including the Comprehensive Major Medical Expense Benefit.

I. Hearing Benefit Exclusions and Limitations

Benefits will not be paid for:

A. Replacement batteries, or

B. Repair and maintenance of hearing aids.

Vision Benefits

The Fund has contracted with Vision Service Plan Insurance Company (VSP) to provide vision care benefits to eligible participants. VSP has contracted with various licensed optometrists, ophthalmologists, and dispensing opticians to provide you benefits at a discounted rate and these providers are part of the VSP Choice Network. When you use a provider in the VSP Choice Network, you will be able to take advantage of the discounts offered through this program.

If you choose a Non-VSP Network provider, you may submit your claim to VSP and you will be reimbursed in accordance with the schedule provided below. If you reside more than 50 miles from the nearest VSP Network Provider, out-of-network benefits will be paid according to in-network costs sharing amounts.

The vision benefit is a separate benefit and is not subject to the out-of-pocket maximum.

I. Adult Vision Benefit (Participants and Dependents over age 19)

A. **Eye exams**. Available once every Calendar Year. If you go to a VSP Network provider, you will be charged a $20 copay. If you go to a non-VSP Network provider, you will only be reimbursed up to $45 for the exam.

B. **Frames**. Available once every other calendar year. If you go to a VSP Network provider, you will be provided a $160 allowance and an additional 20% discount over your allowance. For frames purchased from a Non-VSP Network provider, including Costco, you will be reimbursed $70.

C. **Lenses**. Available every calendar year. If you go to a VSP Network provider single vision, lined bifocal, and lined trifocal lenses are covered at 100%. If you go to a Non-VSP Network Provider, you will only be reimbursed a portion of the cost of the lenses: single vision – up to $30; lined bifocal – up to $50; lined trifocal – up to $65.

D. **Lens Enhancements**. Available every calendar year. If you go to a VSP Network provider, you will have the following co-pays:

1. Standard progressive lenses: $55
2. Premium progressive lenses: $95-105
3. Custom progressive lenses: $150-175
4. Average savings of 20-25% on other lens enhancements

5. Non-VSP Network providers you will only be allowed up to $50 reimbursement for progressive lens

E. **Contacts**. Available every calendar year in lieu of eyeglasses. If you go to a VSP Network provider, you have a $150 allowance for contacts and contact lens exam (fitting and evaluation) plus a 15% discount on contact lens exam. For a Non-VSP Network provider, you will only be reimbursed up to $105.

II. Pediatric Vision Benefit (Participants and Dependents 19 and under)

A. **Eye exams**. Available once every Calendar Year. If your Dependent age 19 and under goes to a VSP Network provider, there is no charge to you. If you go to a non-VSP Network provider, you will only be reimbursed up to 50% for the exam.

B. **Frames**. Covered in full once every Calendar Year if purchased from the Pediatric Exchange Collection if you go to a VSP Network provider. For frames purchased from a Non-VSP Network provider you will only be reimbursed up to 50% of the cost.

C. **Lenses**. Available every calendar year. If you go to a VSP Network provider single vision, lined bifocal, lined trifocal, and lenticular lenses are covered at 100%. If you go to a Non-VSP Network Provider, you will only be reimbursed up to 50% of the cost.

D. **Lens Enhancements**. Available every calendar year. If you go to a VSP Network provider, all lenses come with polycarbonate, scratch coating, and ultraviolet protection with no additional charge. If you go to a Non-VSP Network provider, you will only be reimbursed up to 50%.

E. **Contacts**. Available every calendar year. If you go to a VSP Network Provider, the contact lens exam (fitting and evaluation) is covered at 100%. Contact lens purchased from a VSP Network provider are covered as follows: Standard Lens – 100% (one pair per year); Monthly Contact lens – six-month supply is covered at 100%; Bi-weekly Contact Lens – three-month supply is covered at 100%; and Daily Contact Lens – three-month supply is covered at 100%. If you go to a Non-VSP Network provider, you will only be reimbursed up to 50% of the cost. Contact lenses are provided in lieu of eyeglasses benefits.

F. **Low Vision Benefit**. Available every Calendar Year. The low vision benefit is available for those who have severe visual problems that are not correctable with regular lenses. Supplementary testing is covered at 100% if you go to a VSP Network Provider. If you go to a Non-VSP Network provider, the testing is reimbursed up to $125. Supplementary Care is covered at 75% of the cost for both VSP Network providers and Non-VSP Network providers. The Low Vision Benefit is capped at $1,000 every two years.

III. Vision Benefit Exclusions and Limitations

The Plan will not pay benefits for Expenses incurred for the following:

A. Special supplies or services not listed as Covered Expenses.

B. Any eye examination required by an employer as a condition of employment.

C. Medical or surgical treatment.

Prescription Drug Benefit

I. Summary of the Benefit

The Fund has contracted with a Pharmacy Benefit Manager (PBM), OptumRx, to provide you access to a national network of conveniently located retail pharmacies and a mail order facility. When you or your eligible Dependents incur Covered Expenses for prescription medications, you may be responsible to pay a percentage of the cost, as specified in the Schedule of Benefits.

The Plan generally only covers medications (including over-the-counter medications) that are prescribed by a Physician or dentist. Over-the-counter insulin and related diabetic supplies are exempt from this restriction and are covered without a written prescription.

A licensed pharmacist must dispense medications to be covered. In addition:

- Certain medications are covered under the Preventive Care Benefit; and
- Certain tobacco cessation pharmacological devices are covered under the Preventive Care Benefit.

To find a pharmacy near you, contact OptumRx, as set out in the **Important Contact Information**.

II. Specialty Medications

Specialty medications are limited to a 30-day supply, for both the initial prescription and refills. Some of these medications require prior authorization before the prescription will be filled. Contact OptumRx for a current list of medications requiring prior authorization.

Specialty medications are complex drugs used to treat chronic conditions and usually require special handling and distribution, as well as a high level of patient management and counseling. Examples of Specialty Medications include, but are not limited to, injectable and/or oral drugs used to treat multiple sclerosis, cancer, rheumatoid arthritis, and other autoimmune disorders.

Certain specialty medications require prior authorization before they will be eligible for coverage. Contact OptumRx for a listing of medications requiring prior authorizations.

III. The Retail Pharmacy (Drug Card) Program

The retail pharmacy program is designed to manage your short-term prescriptions needs. You can only obtain up to a 90-day supply of a particular medication at one time.

If you purchase your prescription at a non-participating pharmacy, you will have to pay the full cost of your medication up front when you pick it up. You will then need to submit a claim to the PBM for reimbursement. You will be reimbursed based on the medication's full retail cost, minus your coinsurance amount.

If the pharmacy you use does not accept your prescription drug card, call the PBM at the phone number shown on the **Important Contact Information** or on your ID card to locate a participating retail pharmacy near you. If you prefer, you can pay the full cost of the prescription and submit a claim for direct reimbursement to the PBM.

IV. The Mail Order Program

The mail order program is designed for longer-term prescription needs. You may order up to a 90-day supply of any covered medication that a Physician or dentist prescribes, including maintenance medications used on an ongoing basis.

When you need to order medication through the mail order program, you should:

- Ask your Physician to prescribe a 90-day supply of medication with refills (if applicable) for up to 1 year;
- Mail your original prescription, along with the applicable copayment for each prescription and refill, and a completed order form to the mail order center; and
- Allow 14 days from the time you mail in your order to receive your prescription.

Call the PBM for order forms and pre-addressed envelopes.

You can enroll for mail order service via telephone by calling the PBM at the phone number shown on the **Important Contact Information**, or online via the PBM's website using the member ID number printed on your member ID card and your date of birth.

Once you have your first prescription filled, you can order refills by mail, over the phone, or via the PBM's website.

Because the price of prescription drugs changes frequently, the price of your prescription may change from the time you mail in your copayment until the time your prescription is dispensed. If the price of your prescription changes, the PBM will send you a bill for any balance due.

V. Under the Prescription Drug Program, Prescription Drug Expenses NOT Covered

In addition to any limitations mentioned above, the Plan does not cover any services or medications listed in the General Plan Exclusions and Limitations.

VI. Medicare Prescription Drug Coverage

If you are eligible for Medicare but you are still working for a Contributing Employer, the Plan will send you a notice about your prescription drug coverage each year to let you know whether the coverage is creditable or whether you should sign up for prescription drug coverage under Medicare. Unless you are actively working for a Contributing Employer, when you become Medicare eligible, you are no longer allowed to participate in the Fund.

Medicare Prescription Drug Coverage is insurance provided by private companies that have been approved by Medicare. It is available through Medicare Advantage Plans (like an HMO or PPO) and Medicare Prescription Drug Plans. All Medicare plans provide at least a standard level of coverage as set by Medicare and some Medicare plans offer better coverage for a higher monthly premium.

Note to Medicare-Eligible Individuals: If you lose your coverage under the Plan and do not enroll for Medicare Prescription Drug Coverage after your current coverage ends, you may pay more for Medicare Prescription Drug Coverage at a later date. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Prescription Drug Coverage, your monthly premium for Medicare Prescription Drug Coverage will increase. The increase will be at least 1% per month for every month after you are eligible for but did not have Medicare coverage. For example, if you go 19 months without coverage, your monthly premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare Prescription Drug Coverage. In addition, you may have to wait until Medicare's next open enrollment period to enroll.

VII. For More Information About Medicare Prescription Drug Coverage

When you become eligible for Medicare, you will receive a Medicare & You handbook in the mail from Medicare. More detailed information about Medicare Prescription Drug Coverage will be included in this handbook.

To get more information:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (the telephone number will be included in the Medicare & You handbook).

- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.
- If you have limited resources, you may be able to receive extra help to pay for Medicare Prescription Drug Coverage. To get more information about this extra help:
- Visit www.socialsecurity.gov.
- Call 800-772-1213. TTY users should call 800-325-0778.

Employee Assistance Program

The Plan has an Employee Assistance Program to provide you and your dependents a variety of services, involving issues such as:

- Stress
- Legal Issues
- Relationships
- Workplace
- Chemical Abuse
- Depression
- Anger Management
- Financial
- Parenting Issues

Your employee assistance program is offered through TEAM. When you call TEAM with an issue, they may be able to help you or they will refer you to the appropriate professional in their network. A**ll** sessions with a TEAM member are provided at no cost to you and are completely confidential. Once you go to a referred professional, if necessary, all services will be covered on the same basis as any other medical condition. Treatment will be limited to services provided by:

- For mental health counseling: LPCC, LPC, LICSW, LMFT, LP, or similarly qualified provider.
- For medication management: MD/DO, CNS/NP.
- For substance abuse treatment: LADC or licensed therapist who can show competence in substance abuse.

The following services are also covered under the Plan:

- Family counseling;
- Family counseling without client;

- Marital counseling;
- Anger Management Treatment;
- Testing for learning disabilities; and
- Treatment for learning disabilities.

The following diagnoses are not covered under the Plan:

- Behavioral issues;
- Conduct disorder;
- Oppositional defiant disorder;
- Developmental disorders;
- Impulse control disorders;
- V codes found in the ICD-10; and
- Sexual disorders.

General Exclusions and Limitations

I. The Plan does not cover:

A. Injury or illness that arises out of or occurs in the course of any occupation or employment for wage or profit.

B. Injury or illness that arises out of declared or undeclared war, or any act thereof, or military or naval service of any country.

C. Treatment or surgical procedures of an elective nature, or any non-emergency plastic or cosmetic surgery on the body, including but not limited to areas such as the eyelids, nose, face, breasts, or abdominal tissue.

Work Injuries and Illnesses Not Covered by the Plan

The Plan does not provide benefits for injuries or illnesses that arise out of your employment.

1. Exception**:** This exclusion will not apply to:

   (a) Corrective surgery which is performed for the correction of defects incurred through traumatic injuries, infection, or other diseases of the involved part sustained by the covered individual;

   (b) The correction of congenital defects;

   (c) Corrective surgical procedures on organs of the body which perform or function improperly;

   (d) Vasectomies and tubal ligation procedures; or

   (e) Surgery and other treatment as required by the Women's Health and Cancer Rights Act of 1998.

D. Dental treatment, except dental treatment made necessary by an Injury to sound natural teeth, and except as specifically provided under the Dental Expense Benefit or the Plan's Comprehensive Major Medical Expense Benefit.

E. Vision Therapy.

F. Hearing aids, except as specifically provided under the Hearing Benefit.

G. Expenses incurred during confinement in a Hospital owned or operated by the United States or any agency thereof, or for service, treatments or supplies furnished by or at the direction of the United States or any agency thereof, unless there is a charge made by the Hospital or agency that you are legally required to pay.

H. Expenses incurred during confinement in a Hospital owned or operated by a state, province, or political subdivision, unless you are legally required to pay for those expenses.

I. Expenses for services or supplies which are:

i. Not provided in accordance with generally accepted professional medical standards,

ii. Not proved to be safe and effective, or

iii. Experimental /Investigative in nature.

J. Services provided by a family member or a person who ordinarily lives in the Employee's or Retiree's home or in the home of the Dependent who is receiving care.

K. In-Hospital items such as telephone, televisions, cosmetics, magazines, newspapers, guest trays, laundry or other personal comfort items or items that are not Medically Necessary.

L. Medical or surgical treatment for weight-related disorders including, but not limited to, surgical interventions, dietary programs, and prescription drugs.

M. Any expense or charge for orthopedic shoes and orthotics for Dependents.

N. Hypnosis or biofeedback.

O. Nutritional counseling or nutritional supplements, including vitamins, even if prescribed by a Physician, except as specifically provided under the Nutritional Counseling and Diabetic Education Benefit. However, nutritional supplements for special formulas to treat inherited amino acid and enzyme diseases such as Phenylketonuria and Maple Syrup Urine Disease are covered if recommended by a Physician.

P. LASIK, radial keratotomy, or other surgery to correct refractive errors and related charges.

Q. Reversal of cosmetic surgery and related charges.

R. Sterilization reversals and related charges or charges from complication of a reversal.

S. Drugs or procedures attempting to promote artificially assisted conception or the establishment of surrogate pregnancy including, but not limited to, those related to in-vitro fertilization, gamete intrafallopian transfer, artificial insemination or fertility, surrogacy fees, or other related charges.

T. Any loss, expense or charge for sex transformation or complications.

U. Supplies or equipment that do not meet the Plan's definition of Durable Medical Equipment including, but not limited to, those for personal hygiene, comfort, or convenience such as air conditioning, humidifiers, physical fitness and exercise equipment or programs, waterbeds, tanning beds, home traction units and home lifts.

V. Wigs, except wigs for hair loss due to illness or treatment of an illness (see the Schedule of Benefits for limitations).

W. Charges incurred for Custodial Care or any care that is designed primarily to assist an individual in meeting the activities of daily living.

X. Charges incurred for confinement and services at a halfway house or group home.

Y. Charges that the Eligible person is not required to pay, including those that would not have been made if this Plan did not exist.

Z. Hospital charges incurred in connection with dental treatment, except under special circumstances as described in this SPD.

AA. Any expense or charge for failure to appear for an appointment as scheduled, completion of forms, attorney fees, pre-natal risk assessment forms or late discharge fees.

BB. Court-ordered treatment or confinement of any kind, except as specified as a Covered Expense under the Mental and Nervous Treatment Disorder Benefit.

CC. Services, supplies, treatments, and procedures that are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily Injury or Sickness unless the charges are specifically identified as Covered Expenses under the Plan.

DD. Physical or Occupational therapy that is custodial or maintenance in nature.

EE. Speech therapy services, to the extent such services are not covered under the coverage criteria of HealthPartners Administrators, Inc.

FF. Home construction and automobile modification.

GG. Educational service and/or materials, except as specifically provided under the Nutritional Counseling and Diabetic Education Benefit.

HH. Any treatment or service not prescribed by a Physician, or not recommended or approved by the attending Physician.

II. Any services or supplies received from a Physician who does not meet this Plan's definition of a Physician or from a Hospital that does not meet this Plan's definition of a Hospital.

JJ. Any loss, expense, or charge for which a third party may be liable and for which the Participant on whose behalf the claim was filed did not submit the required acknowledgement of the Fund's first priority right of subrogation and reimbursement to the Fund. The term third party means any individual, insurer, entity, or federal, state or local government agency, which is or may be in any way legally obligated to reimburse, compensate, or pay for a Participant's loss, damages, injuries, or claims relating in any way to the Injury, occurrence, condition, or circumstance giving rise to the Fund's provision of medical, dental, or disability benefits, including but not limited to, insurers providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverages.

KK. Any loss, expense, or charge arising out of or related to an Injury, occurrence, condition, or circumstance for which the Participant has received a recovery or the Fund deems it likely a recovery will be received. This means that claims submitted after the Participant receives a recovery that are related to the recovery will be excluded from coverage. The amount of future related claims that will be excluded from coverage is the full amount of the recovery. This exclusion applies to any recovery received by a Participant regardless of how it is characterized, including, but not limited to any apportionment to a spouse for loss of consortium.

LL. Any loss, expense, charge incurred by, or benefits payments made on behalf of the Participant, which are made in reliance of misleading or fraudulent information provided by the Participant.

MM. Any loss, expense or charge arising from the maintenance or use of an automobile where (a) the Participant fails to maintain the statutory minimum level of applicable automobile medical and/or disability insurance protection in the jurisdiction in which the Participant resides (this exclusion will apply only up to the amount of the amount of automobile medical and/or disability insurance so required); (b) the Participant fails to apply for any available automobile medical and/or disability insurance; (c) the automobile insurer has determined that charges are not Medically Necessary, Reasonable or Customary; or (d) the Participant does not first exhaust any medical payment and/or disability coverage on the vehicle(s) involved in the accident.

NN. Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. However, if an Injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor it will not be excluded from coverage. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts of involved.

OO. Any loss, expense, or charge for any Injury or Illness that results from an event occurring on any property where a lessee, lessor, or owner of the property is responsible for the Injury or Illness or where the loss, expense, or charge is otherwise covered under homeowner's insurance on the property. The Fund may pay the loss, expense, or charge (a) only if no insurance or other form of compensation is available to the victim, and (b) only if the Participant (or other individual legally responsible for payment of expenses) signs an acknowledgement of the Fund's first priority right to subrogation and reimbursement.

PP. Acupuncture.

QQ. Massage therapy, except as provided by a Licensed Physical Therapist.

RR. Shipping charges and sales tax, except for MinnCare tax, which is paid on allowable charges.

SS. Medical-related services provided by a school district (e.g., physical therapy, speech therapy, aides, etc.).

TT. Magnetic devices or magnet therapy.

UU. Allergy food drops, sublingual drops, or oral immunotherapy.

VV. Dental treatment, including but not limited to dental implants and orthodontics, except as specified in the Dental Expense Benefit.

WW. Chelation therapy, except in documented cases of heavy metal poisoning.

XX. Non-emergency care when traveling outside the United States.

YY. Any expense incurred for in-patient services provided by an Out-of-Network facility, except in an emergency. For purposes of this exclusion, "emergency" means an Injury or illness requiring immediate medical attention such that any delay in obtaining treatment places the individual's health in serious jeopardy. A condition will not be considered an emergency if the first treatment is provided more than 24 hours after the onset of symptoms. A condition will cease to be an emergency once it is not medically inappropriate to transfer the individual to the care of a Network Provider.

Benefit Claims and Appeals

This section describes the procedure for filing claims for Fund benefits. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the denial.

I. Filing Benefit Claims

A claim for benefits is a request for Fund benefits that you make in accordance with the Fund's claims procedures. To file a claim for benefits offered under this Fund, you, or the provider of the service, must complete and submit a claim to the Fund Office. No other form of communication (for instance, a phone call or a letter that does not include a claim) will be treated as a claim for benefits. The process that is required for submitting a claim depends upon the type of benefit you are requesting.

Under this Plan, there are several different types of benefits available to you: medical benefits, prescription drug benefits, vision benefits, dental benefits, weekly accident and sickness benefits and a death benefit. In addition, you may also be a Participant in the HRA. Information on filing claims under the HRA is set forth in the Addendum.

A. **Medical benefits**: In many cases, your healthcare provider will file a claim on your behalf, and the Fund will pay the healthcare provider directly. In such cases, you will not need to file a claim with the Fund c/o HealthPartners. For further information regarding payment of your benefits directly to a healthcare provider, contact the HealthPartners Member Services. If your provider does not file a claim, contact HealthPartners Member Services.

B. **Prescription drug, vision, and dental benefits:** For these benefits, if you utilize a provider participating in the network, the provider will submit claims on your behalf. If you do not use a network provider, you will need to contact the preferred network vendor and obtain appropriate claim forms.

C. **Weekly Accident and sickness benefits and Death benefit:** To make a claim for these benefits, contact the Fund office for a claim form.

The Fund Office must have sufficient information to process your claim and for your request for benefits to be considered a claim. If there is not sufficient information, the Fund Office will request more information from you. If you do not provide the requested information, your claim may be denied.

II. When You Must File Your Claim

You must provide written notice of any Injury or Illness upon which claim may be based to the Fund Office. A claim should be filed with the Fund Office as soon as possible after the charge was incurred. However, a claim for covered services must be filed within the time specified in the PPO network contract or 12 months, whichever is earlier, to be eligible for payment or reimbursement. If no time is specified in such network contract or there is no applicable network contract, a claim for covered services must be received by the Fund Office within 12 months of the date of service to be eligible for payment or reimbursement.

III. Where Claims Must Be Filed

To the extent your provider does not file a claim, you should file your claims as follows (See Contact Information at the front of the SPD for details):

A. Medical – HealthPartners Administrators, Inc.

B. Prescription drug – OptumRx

C. Vision – VSP

D. Dental – Delta Dental

E. Weekly Accident and Sickness – Fund Office

F. Death – Fund Office

If you have any questions about your medical claim, please call HealthPartners at:

Telephone: 952-883-5000; Toll free: 800-883-2177 or visit www.healthpartners.com

If you have any questions about all other claims, please call the Fund Office at:

Telephone: 651-256-1801; Toll free: 800-879-4412

IV. Payment of Benefit Claims

Benefit claims will usually be paid directly to the provider with respect to medical, prescription, vision and dental. Under certain circumstances, reimbursement payments may be made directly to you. Weekly accident and sickness benefits will be paid to you. The death benefit will be paid to your designated beneficiary.

If payments that should have been made under this Plan, have been made under any other plan or plans, then the Fund may, at its sole discretion, pay any organizations making other payments the amount that the Fund determines will satisfy the intent of this provision. Payments are considered benefits paid under this Plan and, to the extent

of these payments, the Fund will be fully discharged from liability.

Any payment made by the Fund in good faith and pursuant to this section will fully discharge the Plan to the extent of payment.

V. Medical Examination

The Fund has the right and opportunity to examine the Covered Person, whose Injury or Sickness is the basis of a claim. An examination may be required as often during the pendency of the claim as may be reasonable.

VI. Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and you have designated the individual to act on your behalf. You can obtain a form from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

VII. Claim Decisions

Ordinarily, you will be notified of the decision on your claims within 30 days from the Fund's receipt of the claim. If there is not sufficient information included with the claim, the Fund will contact you and request the information. If you do not respond to the request for additional information, your claim will be processed based upon the information available and may be denied.

For Weekly Accident and Sickness (Loss of Time) claims, the Fund will process your claims within 10 days of receipt of your completed claim form. The Fund may request additional information from you to process your claim. If you do not provide the information, your claim will be processed based upon the information available and your claim may be denied.

Before your Weekly Accident and Sickness (Loss of Time) claim has been denied, the plan administrator will, as soon as possible and free of charge, provide you with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Fund, the insurer, or any other person making the benefit determination. If the denial of your claim is based on a new or additional rationale, then the plan administrator will provide you with that rationale as soon as possible and free of charge.

VIII. Notice of Denial of Claim

The Trustees must provide you with a notice of their initial determination about your claim within certain periods after they receive your claim. The notice will be culturally and linguistically appropriate and provide you with the following information:

A. The date of service, the health care provider, the claim amount (if applicable), the

diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason or reasons for the denial of benefits or other adverse benefit determination, including (if applicable) the denial code and its corresponding meaning;

C. A specific reference to the pertinent provisions of the Plan upon which the decision is based;

D. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;

E. A copy of the Fund's appeal and review procedures and time periods to appeal your claim, including the date on which the contractual limitations period expires for the claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;

F. A copy of any internal rule, guideline, protocol, or similar criteria that was relied on in denying your claim or a statement that a copy is available to you at no cost upon request with a description of the internal rule;

G. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for medical and weekly accident and sickness (loss of time) claims that are denied due to:

1. Medical necessity;

2. Experimental/Investigative treatment; or

3. Similar exclusion or limit.

H. Contact information for the appropriate office of health insurance consumer assistance or ombudsman established under the Affordable Care Act (Public Health Service Act Section 2793).

I. For Weekly Accident and Sickness (Loss of Time) claims, the notice will include an explanation of agreement or disagreement with the views of healthcare or other medical experts who treated or evaluated you or whose advice was obtained by the Fund in connection with the benefit determination.

J. For Weekly Accident and Sickness (Loss of Time) claims, the notice will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

IX. Request for Review of Denied Claim

You must file your request for review of the denial of your claim within 180 days of receiving notice of the denial.

You have the right to a full and fair review if your claim for benefits is denied by the Fund. You must make your request to the Fund Office to appeal the Fund's decision within 180 days (60 days for a Death Benefit claim) after you receive notice of denial.

Medical Benefit Claims:

Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund
c/o Health Partners, Inc. - Member Rights and Benefits
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

All Other Claims:

Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund
c/o Zenith American Solutions
2520 Pilot Knob Road, Suite 325
Mendota Heights, Minnesota 55120

Your request for review must be in writing and it must include the specific reasons why you feel denial was improper. You may submit any document you feel appropriate, as well as your written issues and comments. In requesting a review of your claim, the following procedures will apply:

A. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:

1. It was relied upon by the Fund in making the decision,

2. It was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon,

3. It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making, or

4. It constitutes a statement of Fund policy regarding the denied treatment or service.

B. Upon request, the Fund will provide you with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard as to whether their advice was relied upon in deciding your claim.

C. If an expert was used to provide advice on your initial claim, a different person will review your claim than the one who originally reviewed the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including any additional documents and comments that you may submit.

D. If your claim was denied based on a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental/Investigative), the Fund will consult a health care professional who has appropriate training and experience in a relevant field of medicine.

E. If the Plan considers, relies on, or generates new or additional evidence in connection with the claim, or additional rationale for denying the claim (beyond the evidence and rationale involved in the initial denial), the Plan will provide you (free of charge) the new or additional evidence or rationale and a reasonable opportunity to respond before the appeal decision.

F. Before your appealed Weekly Accident and Sickness (Loss of Time) claim has been denied, the plan administrator will, as soon as possible and free of charge, provide you with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Fund, the insurer, or any other person making the determination on your appeal. If the denial of you claim on appeal is based on a new or additional rationale, then the plan administrator will provide you with that rationale as soon as possible and free of charge.

Ordinarily, decisions on appeals of that are heard by the Board of Trustees will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once the Board of Trustees reaches a decision on your claim, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

You will be notified of a decision on an appeal over which the Board of Trustees has delegated discretionary authority to a third-party within the following time-periods: 24 hours (urgent medical/drug claims); 15 days (pre-service medical/drug claims if there are two levels of review); 30 days (pre-service medical/drug claims if there is one level of review); 45 days (disability claims); and 60 days (all other claims). For medical (but not prescription drug) benefits, there are currently two levels of review. For all other benefits, there is one level of review.

X. No Surprises Act

Under the No Surprises Act, you will not be subject to surprise or balance billing when you receive the following types of care:

- Emergency care; or
- Treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center.

Balance Billing (sometimes called "surprise billing")

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in the Plan's HealthPartners network.

"Out-of-network" describes providers and facilities that have not signed a provider agreement with HealthPartners. Out-of-network providers may be permitted to bill you for the difference between what the Plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who engages in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

- If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

- When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is the Plan's in-network cost-sharing amount. This applies

to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

- If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

- You are never required to give up your protections from balance billing. You also are not required to get care out-of-network and the Plan would strongly encourage you to seek care from providers in the HealthPartners Network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility were in-network). The Plan will pay out-of-network providers and facilities directly.

- The Plan will:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what the Plan would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit under the Plan.

No Surprises Act Claims – Appeal Rights

Should you have a claim be denied for coverage or payment in the manner described above for emergency services or non-emergency services performed at an in-network facility by an out-of-network provider, you may appeal the matter to the Board of Trustees. Further, should the Board of Trustees deny the appeal, the above noted claims are subject to an External Third-Party Review as further provided below.

External Claim Appeals for No Surprises Act Claims Only

If the Board of Trustees denies your claim appeal involving a claim covered by the No Surprises Act, you may elect to have that adverse appeal determination reviewed by an

External Third-Party Review.

Standard External Review for Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

A. Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:
   1. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   2. The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;
   3. You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and
   4. You have provided all the information and forms required to process an external review.

B. Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

C. If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.
   1. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.
   2. The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.
   3. The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the

following in reaching a decision:

a. Your medical records;
b. The attending health care professional's recommendation;
c. Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;
d. The terms of the Plan;
e. Evidence-based practice guidelines;
f. Any applicable clinical review criteria developed and used by the Plan Administrator; and
g. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

4. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

A. You may request an expedited external review when you receive:

1. An adverse benefit determination that involves a medical condition for which the time for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
2. A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

B. Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

C. When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

D. The IRO must consider the information or documents provided and is not bound by

the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

XI. Notice of Decision of Appeal

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on appeal will state:

A. A discussion of the decision, including the specific reason(s) for the determination.

B. Reference to the specific Fund provision(s) on which the determination is based.

C. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

D. A statement that you have the right to have an external, third-party review of your denied appeal by an independent review organization (IRO).

E. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

F. If an internal rule, guideline, or protocol was relied upon by the Fund, then you may receive either a copy of the rule, or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was Experimental/Investigative or another similar exclusion, then you may receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

The Board of Trustees has broad discretion to interpret the terms of the Plan in making decisions on your claims and appeals. If the decision of the Board of Trustees is challenged in court or in an administrative proceeding, the decision is to receive judicial deference to the extent it does not constitute an abuse of discretion.

XII. External Review

If your appeal for medical or prescription drug benefits is denied, you may further elect to have the adverse appeal determination reviewed by an Independent Review Organization ("IRO") if an IRO determines that the claim involved a medical judgment or rescission of coverage.

If you elect to do so, you must file a request for an external review of an adverse internal appeal decision within four (4) months after the date of receipt of a notice of an adverse

benefit determination on internal appeal.

Within five (5) business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

A. You, or your Dependent, was covered under the Plan at the time the health care item or service was provided;

B. The adverse benefit determination on appeal does not relate to you, or your Dependent's, failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

C. You, or your Dependent, exhausted the Plan's internal appeal process; and

D. You, or your Dependent, has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan shall issue a notification in writing to you regarding whether your claim is eligible for external review. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Plan must allow you 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. If the request is complete and eligible for review, the Plan shall assign the matter for external review as described below.

The Plan shall assign an IRO to conduct the external review. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

The Plan will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

The IRO will review all the information and documents timely received and is not bound by the Plan's prior determination. The IRO may consider the following in reaching a decision:

1. your medical records;

2. the attending health care professional's recommendation;

3. reports from appropriate health care professionals and other documents submitted by the Fund Administrator, you, or your treating provider;

4. the terms of the Plan;

5. evidence-based practice guidelines;

6. any applicable clinical review criteria developed and used by the Fund Administrator; and

7. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

If there is a reversal of the Plan's decision, upon receipt of the notice of final external review decision reversing the adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. If the Plan disagrees with the IRO's determination, it may sue you or your representative to recover the benefits paid after the IRO's determination.

XIII. Legal Actions

You may not start a lawsuit until after:

A. You have requested all applicable levels of internal review and a final decision has been reached in each of those reviews, or

B. You have not received a final decision or notice that an extension will be necessary to reach a final decision in the appropriate time described above.

Any lawsuit based on the denial of your appeal by the Fund's Board of Trustees must be brought within one year after you have exhausted the Plan's internal claims and appeals procedures,

Note: You are not required to elect an external review before commencing a lawsuit.

XIV. Authority to Make Benefit Determinations

The Board of Trustees has the authority to determine whether benefits are payable by the Plan, including, without limitations, the authority to make findings of fact and to interpret the Plan. A determination pursuant to this authority is final and binding and may not be overturned unless a court of competent jurisdiction finds that the decision is arbitrary and capricious. The Board's authority over benefit determinations is exclusive, except to the extent the Board expressly delegates its authority to another party. The Board has delegated non-discretionary authority over initial benefit determinations to various third-party administrators. The Board retains discretionary

authority to decide appeals of all claims except, with respect to claims for medical benefits, the Board has delegated final and exclusive discretionary authority to HealthPartners Administrators, Inc.

XV. Non-Assignability

You may not assign your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any rights to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign shall be void and unenforceable under all circumstances.

Medical Data Privacy

Under the Federal Health Insurance Portability and Accountability Act ("HIPAA"), the Plan is required to keep an individual's health plan information private except in certain circumstances. Individual health plan information generally may be used:

A. To provide an individual's health care treatment; or

B. To pay for health care; or

C. To operate the health plan providing the care.

A copy of the Plan's Notice of Privacy Practices with a complete description of your privacy rights is enclosed with this Plan as Exhibit B.

Coordination of Benefits

The total benefits payable to you or your eligible Dependent under this Plan of Benefits in a Calendar Year will be reduced so that the sum of the benefits payable by this Plan and any other plan will not exceed what this Plan would normally pay for Covered Expenses.

The term “other plan” includes:

1. Group, blanket or franchise insurance coverage;

2. Group Blue Cross, group Blue Shield coverage, group practice or any other group prepayment plans or other coverage, whether group or individual, resulting from employment;

3. Automobile “no fault” contract as mandated by state;

4. Group automobile “fault” contract if medical benefits are included;

5. Any coverage under labor-management trust plans, union welfare plans, employer organization plans or any other arrangement of benefits for individuals of a group;

6. Any coverage under governmental program, and any coverage required or provided by any statute;

7. Medicare, Title XVIII of the Social Security Act of 1965, as amended to the extent permitted by law; and

8. This Plan of Benefits when the Covered Person is both an Employee and an eligible Dependent spouse or the eligible Dependent of two Employees under this Plan of Benefits.

Order of Payment

The Plan which makes payment first is called the primary plan and the plan which pays second is called the secondary plan.

The first of the following rules which applies will determine which plan’s benefits are payable first:

1. A plan which does not have a coordination of benefits rule or claims to provide excess coverage only is always primary and pays benefits first.

2. A plan that covers an individual as an employee is primary and pays benefits first.

3. The plan covering a person as a laid-off or retired employee, or as a dependent of a laid-off or retired employee, will be secondary to the benefits of any other plan covering the person. This rule does not apply if the other plan does not have this rule.

4. When this Plan covers an individual as a Dependent child, and another plan covers that individual as a Dependent spouse, the benefits of the plan covering the individual as a Dependent spouse will be primary to this Plan. When this Plan covers an individual as a Dependent spouse, and another plan covers that individual as a Dependent child, the benefits of this Plan will be primary.

The rules below determine which plan's benefits are payable first if a dependent child is covered under two (2) or more plans:

1. If the parents are not divorced or separated, the plan that covers the parent whose date of birth occurs earlier in the Calendar Year, excluding the year of birth, is primary and pays benefits first. If the birthday of both parents occurs on the same date, the plan which has covered the parent for the longer period of time pays benefits first. This does not apply if either plan does not have the rules of this paragraph. In such a case, the rules of the plan which does not have the rules of this paragraph will determine the order of benefit payments.

2. If the individual is a dependent child of separated or divorced parents and:

   (a) A court order makes one parent financially responsible for the health care expenses of the child (including health care coverage), that parent's plan will pay benefits first.

   (b) There is no court order, the "order of payment" used to determine the primary plan is as follows:

      i. The plan of the natural parent with custody of the child is primary and pays benefits first;

      ii. The plan of the step-parent with custody of the child pays benefits second; and

      iii. The plan of the parent not having custody of the child pays benefits third.

3. A plan which covers an individual as a dependent of an active employee pays before a plan which covers the individual as a dependent of a laid-off or retired employee. This rule does not apply if the other plan does not have this rule.

If the above rules do not determine which plan's benefits are payable first, the plan which has covered the Person for the longest time will pay benefits first.

When this Plan of Benefits pays reduced benefits due to these rules, only the reduced amount will be charged against the payment limits of the Plan of Benefits.

If the other plan pays benefits that should have been reduced because of coordination of benefits, the amount by which the benefits should have been reduced may be paid to the other plan. Amounts so paid will be considered benefits under this Plan of Benefits.

If a payment of any amount has been made that is in excess of that permitted by coordination of benefits, this Plan of Benefits has the right to recover such amount from any party that has received such payment.

How Benefits Are Paid

If the rules above determine that this Plan is primary, then this Plan will pay benefits first and without consideration of the other plans.

If this Plan is secondary, the benefits payable under this Plan will be reduced to the extent that the total amount of benefits payable under all plans does not exceed the Reasonable and Customary Charges for medical care or treatment covered in whole or in part, by any of the plans.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service will be considered both a Covered Expense and a benefit paid. The Plan of Benefits also considers benefits payable by another plan as a benefit paid, whether or not a claim is made for the benefit.

Right to Receive and Release Necessary Information

The Fund Office may, without the consent of or notice to any Person, release to or obtain from any insurance company or other organization or person any information, with respect to any Person, which they deem to be necessary for such purposes of implementing these coordination of benefit rules. Any Person claiming benefits under this Plan of Benefits must furnish to the Fund Office such information as may be necessary to implement these rules.

Coordination of Benefits with Other Types of Insurance

Coverage under this Plan is deemed to be secondary coverage to any plan or policy of insurance which may pay medical and/or disability expenses for a specific risk, including but not limited to, workers compensation, homeowner's, or premises insurance policy.

The Plan may require that you show that you have made a reasonable effort to determine if there is an applicable other insurance policy. Benefits that might otherwise be payable under another insurance policy will not be paid by the Plan merely because you have not made a claim under the other insurance policy or failed to investigate possible sources.

Coordination of Benefits with Automobile Insurance

This Plan will coordinate benefits with automobile insurance carriers as described in the following provisions:

1. Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides. That

type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile.

2. For any expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. The amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed one hundred percent (100%) of the expenses incurred.

3. Benefits that otherwise might be payable under no-fault automobile insurance will not be payable by the Plan merely because a claim for no-fault benefits was not filed. If you or an eligible dependent fail to maintain the legally required no-fault automobile insurance within the jurisdiction in which an individual resides, Plan benefits will not be payable for amounts which the legally required minimum amount of no-fault automobile insurance otherwise would have paid.

4. An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must arbitrate any notice of discontinuance of no-fault automobile insurance or benefits for said injuries will not be payable under this Plan.

5. In states without a no-fault statute, the above provisions will then apply to the priority of payment of any applicable automobile medical payments and/or disability benefits policy.

Subrogation And Reimbursement

Introduction

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an injury, occurrence, or condition for which the Subrogee has a right of redress against any third-party. For purposes of this Subrogation and Reimbursement section, Subrogee means the participant, employee, dependent, beneficiary, representative (including a trustee in a wrongful death action), an administrator of an estate or any other person asserting a claim related to the injury, claim, action, or occurrence under this section.

What does first priority right of subrogation and reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a third-party, such as an insurance company, the Subrogee agrees that when a recovery is made from that third-party, the Plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If the Subrogee does not agree to the Plan's subrogation and reimbursement rules, benefits will not be paid.

For example, the subrogation and reimbursement right may apply if a Subrogee is injured at work, in an automobile accident, at a home or business, in an assault, as a result of medical or other negligence or in any other way for which a third-party has or may have responsibility. If a recovery is obtained from a third-party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Subrogee receives payment only after the Plan is fully reimbursed.

The rights of subrogation and reimbursement are incorporated into this Plan for the benefit of each Subrogee in recognition of the fact that the value of benefits provided to each employee or dependent will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement – Rules for the Plan

The following rules apply to the Plan's right of subrogation and reimbursement:

1. Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the Subrogee agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Subrogee and their attorney will sign a Subrogation Agreement with the Plan acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the Subrogee and/or their attorney refuses to sign the Subrogation Agreement. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right are not impacted if the Subrogee and (if represented) their attorney refuses to sign the Subrogation Agreement. Should the Subrogee and/or their attorney fail to sign the required Subrogation Agreement, the Plan will take any and all action necessary to protect its subrogation and reimbursement rights including denying the payment of benefits, offsetting any

future benefits payable under the Plan, recouping any benefits previously paid, suspending, and/or terminating coverage under the Plan.

2. Plan Granted Constructive Trust or Equitable Lien: The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Subrogee from a third-party, whether by settlement, judgment or otherwise and in consideration for the payment of benefits, the aforementioned individual(s) agree to the same. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Subrogee fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, and at the discretion of the Trustees, pursue all available equitable remedies, pursue all available legal remedies, offset any benefits payable under the Plan, recoup any benefits previously paid, suspend all benefits available under the Plan, deny all claims related to the incident in which a recovery was received in addition to non-related claims submitted by the Subrogee, or terminate coverage of the Subrogee or Subrogees.

3. Subrogee Constructive Trust and/or Equitable Lien Duties: The Subrogee is required to use his or her best efforts to preserve the Plan's right of subrogation and reimbursement. This will include, but not be limited to, the Subrogee's causing of the Plan's subrogation or reimbursement interest to be paid to the Plan, advising their legal counsel to segregate the Plan's subrogation or reimbursement interest to be held in such legal counsel's trust account until the Plan's interest is agreed to or completely adjudicated, and not allowing any other disbursement from any settlement or judgment proceeds to Subrogee, Subrogee's attorney, or any other third-party, prior to complete disbursement to the Plan. Should Subrogee fail to use their best efforts to preserve the Plan's right of subrogation and reimbursement, including but not limited to, the actions set-forth in paragraph (b) above as well as the entirety of these subrogation provisions and the terms of the Plan as a whole, Subrogee's coverage under the Plan will terminate until such time as the Plan is made whole, including the reimbursement of all interest, attorney's fees and costs reasonably incurred. Only upon the Plan's being made whole may the Subrogee make application to the Board of Trustees of the Plan for reinstatement of their coverage.

4. Plan Paid First: Amounts recovered or recoverable by or on the Subrogee's behalf are paid to the Plan first, to the full extent of its subrogation and reimbursement rights, and the remaining balance, if any, to the Subrogee. The Plan's subrogation and reimbursement right comes first even if the Subrogee is not paid for all of their claims for damages. If the Plan's subrogation and reimbursement rights are not fully satisfied directly by a third-party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the Subrogee may have received or may be entitled to receive from the third-party.

5. Right to Take Action: The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan can bring an action (including in the Subrogee's name) for, breach of contract, specific performance, injunction, or any other equitable

action necessary to protect its rights in the cause of action, right of recovery or recovery by a Subrogee. The Plan will commence any action it deems appropriate against a Subrogee, an attorney or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of eligible dependents covered by the Plan regardless of whether such dependent is legally obligated for expenses of treatment.

6. Applies to All Rights of Recovery or Causes of Action: The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Subrogee has or may have against any third-party, regardless of whether such person or entity has the right, legal or otherwise, to recover the medical expenses paid by the Plan.

7. No Assignment: The Subrogee cannot assign any rights or causes of action they may have against a third-party to recover medical expenses without the express written consent of the Plan.

8. Full Cooperation: The Subrogee will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied or recouped if the Subrogee does not cooperate with the Plan. This includes, but is not limited to, responding to any Plan request for information and updates.

9. Notification to the Plan: The Subrogee must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the Subrogee for their injuries, sickness, or death. Further, the Subrogee must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims. The Subrogee must promptly notify the Plan Administrator, in writing, with the name, address and telephone number of their attorney in the event a claim is pursued.

10. Third-Party: Third-party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate, pay or are liable for a Subrogee's losses, damages, injuries or claims relating in any way to the injury, occurrence, conditions or circumstances leading to the Plan's payment of benefits. This right of subrogation and reimbursement exists regardless of whether the policy of insurance is owned by the Subrogee.

11. Apportionment, Comparative Fault, Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply: The Plan's subrogation and reimbursement rights include all portions of the Subrogee's claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines, or any other equitable defenses.

12. Attorney's Fees: The Plan will not be responsible for any attorney's fees or costs incurred by the Subrogee in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorney's fees or costs.

13. Course and Scope of Employment: If the Plan has paid benefits for any injury which may have arisen out of and in the course and scope of employment, the Plan's right of subrogation and reimbursement will apply to all awards or settlements received by the Subrogee regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorney's fees are awarded to the Subrogee's attorney from the Plan's recovery, the Subrogee will reimburse the Plan for the attorney's fees.

Important Information about the Plan

This section of the Summary Plan Description contains information required by the Employee Retirement Income Security Act of 1974 (ERISA). This information is provided to help identify this Welfare Plan and the people who are involved in its operation as required under ERISA.

(1) The Plan is known as the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund. This Summary Plan Description booklet is meant to be an easy-to-understand description of your Plan benefits. This booklet also serves as the Plan Document, which constitutes the Plan's official Rules and Regulations. The Plan is governed by this document and by the Trust Agreement establishing the Plan. The Trust Agreement may be inspected by you at any time during business hours at the Fund Office.

(2) A Board of Trustees is responsible for the operation of this Welfare Fund. The Board of Trustees has the responsibility of determining the eligibility rules for participation by Covered Employees in the benefit Plan and for determining the benefits to be offered to Covered Employees and their Covered Dependents. The Board of Trustees is also responsible for seeing that information regarding the Plan is reported to the government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of ERISA.

(3) The Board of Trustees is both the Plan Sponsor and Plan Administrator of the Health Fund and has delegated day-to-day operations of the Fund to various third-party administrators. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund
Zenith American Solutions, Inc.
P.O. Box 257
Minneapolis, Minnesota 55440-0257
Telephone: (651) 256-1801
Toll free: (800) 879-4412

The list of Trustees, as of October 1, 2025, is located at the beginning of this SPD.

(4) This Plan is a Health and Welfare Plan that provides medical, chiropractic, home health care, physical exam and cancer screening, organ transplant, dental, hearing, vision, death and weekly accident and Sickness benefits. The Fund is self-funded, which means that the benefits provided by the Fund are paid out of the Fund's assets and are not insured.

(5) This booklet describes the requirements and eligibility for participation, the types of benefits available and the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits.

(6) All assets are held in trust by the Board of Trustees.

(7) In accordance with Collective Bargaining Agreements in effect with the Union, the Health Fund receives money from Contributing Employers on an hourly basis for each hour worked by all persons covered by the agreement. The terms of the collective bargaining agreement also indicate the effective dates of the Collective Bargaining Agreement and specify the contribution rate required from the Contributing Employer to be paid to the Welfare Fund. Copies of the Collective Bargaining Agreement are available at the Union and the Fund Office upon request and at no charge.

(8) The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 41-6023461. The Number assigned to this Plan by the Board of Trustees pursuant to the instructions of IRS is 501. The Department of Labor Number issued to the Board of Trustees is WP-156206.

(9) The Fund's fiscal year for the purpose of maintaining records and filing various governmental records and filing various governmental reports is the calendar year that begins on January 1 and runs through December 31.

(10) The person designated as Agent for Service of legal process is:

Scott Crossman, Esq.
Shumaker Loop & Kendrick, LLP
8400 Normandale Lake Blvd, Suite 920
Bloomington, MN 55437

Service of process may also be made on any member of the Board of Trustees at the address of the Fund Office listed in item (3) above.

(11) The Board of Trustees intends to continue the Welfare Plan indefinitely. However, the Board of Trustees retains the right to amend the Plan at any time. Any amendment to the Plan will be made pursuant to the terms of the Trust Agreement and will be binding on all Covered Persons covered under the Plan prior to, or on or after the effective date of the amendment. Participants will be notified in writing of any amendment to the Plan.

(12) The Board of Trustees also retains the right to terminate the Welfare Plan and Welfare Trust Fund if all Contributing Employers are no longer obligated through written agreement to make required contributions. Termination of the Plan will be binding on all Covered Persons who were covered under the Plan prior to termination.

In the event of termination, the monies of the Trust Fund will be applied to all existing benefit obligations in effect on the date of termination of the Welfare Plan and Trust. Any balance in the Welfare Trust Fund that cannot be so applied, will be applied to other uses as, in the opinion of the Board of Trustees, will best serve the intentions of the Welfare Plan. Upon the disbursement of the entire Trust, the Trust will then terminate.

(13) The Plan Administrator has broad discretion to determine eligibility for benefits, interpret Plan language and amend or terminate the Plan. If the decision of the Plan Administrator is challenged in court or in an administrative proceeding, the Plan Administrator's decisions are to receive judicial deference to the extent they do not constitute an abuse of discretion. The Plan Administrator may delegate its authority to determine eligibility for benefits and interpret Plan language to another person or entity. Decisions rendered under delegated authority are to be given the same deference as decisions rendered by the Plan Administrator.

(14) Your coverage by the Plan does not confer any right to continue benefits. The welfare benefits provided by the Plan are not vested benefits.

(15) Your coverage by the Fund does not constitute a guarantee of your continued employment.

Statement of ERISA Rights

As a participant of this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). Although these rights and protections first became a part of the federal law with the passage of ERISA, the Trustees have always considered the fair management of this Plan as their primary objective. Therefore, the Trustees intend to fully comply with all aspects of the law and encourage you to seek assistance by contacting the Fund Office when questions or problems that involve the Plan arise first.

I. ERISA provides that all Plan participants will be entitled to:

A. Receive Information about Your Plan and Benefits

You have the right to:

1. 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 (EBSA).

2. 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.

3. 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.

B. Continue Group Health Plan Coverage

Under ERISA, you have the right to:

1. Continue health care coverage for yourself, your spouse, and/or your 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 this coverage. Review this summary plan description and the documents governing the Plan on the rules regarding your COBRA continuation coverage rights.

II. 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 welfare benefit or exercising your rights under ERISA.

III. 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 the reason for the denial, 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 the requested materials within 30 days, you may file suit in a Federal court. In this 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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decisions or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

IV. Assistance with Your Questions

If you have any questions about the 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.

V. Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Fund Office at the address or phone number at the front of this booklet. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

Definitions

ACTIVE EMPLOYEE: An individual who meets the definition of Employee (below), and is employed in, available for, or would be available for (except for being disabled) bargained or non-bargained work where contributions are required to be made to this Fund. An Active Employee includes an individual Employee who is making self-payments.

ACTIVE WORK: The Covered Employee is employed in, available for, or would be available for (except for being disabled) bargained or non-bargained work where contributions are required to be made to this Fund.

ALLOWABLE CHARGE: The reasonable and customary charges for Medically Necessary care, treatment, supplies, and services which are recommended and approved by a legally qualified Physician. If a charge is more than the reasonable and customary amount, only the Allowable Charge will be considered a Covered Expense. The participating Network Provider's discounted charges are considered reasonable and customary charges by the Plan.

COINSURANCE: The portion of your Covered Expenses that the Plan pays after you have paid your Deductible. The Coinsurance amounts are set forth in the Schedule of Benefits, as percentages of your Covered Expenses.

CONTRIBUTING EMPLOYER: Any employer that, pursuant to the terms of a collective bargaining agreement or a participation agreement, agrees to contribute to the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund for hours worked by individuals employed by a Contributing Employer.

COPAYMENT: A payment you must make to the provider upon incurring certain Covered Expenses. The Plan may pay the entire balance of a Covered Expense that is subject to a Copayment, or the balance may be subject to Coinsurance. Copayment amounts are set forth in the Schedule of Benefits

COVERED DEPENDENT: Any of the following persons who are eligible for coverage under this Plan as a Covered Dependent, provided they are not also eligible as a Covered Employee:

1. The Employee's spouse or surviving spouse from whom you are not divorced or legally separated; if both spouses are Employees, then both will be covered as Employees and one can cover other dependents; or

2. Each child who is under age 26 including:

    a. A natural child, a lawfully adopted child, or a child placed for adoption (unless placement is disrupted prior to legal adoption and the child is removed from placement). Health evidence for an adopted child is not required.

b. Any of the following who live with the Employee in a regular parent-child relationship:

   i. A stepchild, and

   ii. Any other child for whom the Employee is a legal guardian.

c. A child incapable of self-sustaining employment because of disability, which means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more, provided:

   i. The child's disability began before the child reached the age limit shown above of 26; and/or

      (1) Proof of the Dependent's disability is furnished to the Fund Office no later than 31 days after the child reaches the appropriate age limit. Proof of the continued existence of a disability must be submitted annually at the expense of the Covered Employee.

d. An unmarried child who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO) entered by a court of proper jurisdiction or administrative agency. The QMCSO must be approved by the Fund.

   i. The Plan has adopted procedures for Qualified Medical Child Support Orders. These procedures are available upon request from the Fund Office.

e. If the Employee's child does not have his or her principal place of residence with the Employee, the child will be a dependent child, provided that the child meets the other (non-residence-related) requirements of section (b) above and satisfies either of the following conditions:

   i. In the divorce/separation context:

      (1) The child's parents are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times during the last six months of the calendar year;

(2) The child's parents provide over one-half of the child's support; and

(3) The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; or

(4) The Employee provides over half the child's support and the child is not a "qualifying child" (within the meaning of Code section 152) of any other person.

COVERED EMPLOYEE: Any employee who is covered according to the rules explained under Rules of Eligibility.

COVERED EXPENSE: The charge incurred for a covered service or supply. A Physician, as described in this Plan, must order or prescribe the service or supply. An expense is considered incurred on the date the service or supply is received. An expense does not include any charge for a service or supply that is:

1. Not Medically Necessary, or

2. In excess of the Reasonable and Customary Charge or negotiated network charge for services or supplies.

COVERED PERSON: Either a Covered Employee or a Covered Dependent.

DEDUCTIBLE: the amount of Covered Expenses you must pay each calendar year before the Comprehensive Major Medical Expenses Benefit will be paid. After you pay the Deductible amount for your Plan option and coverage level, benefits are payable at the percentage shown in the Schedule of Benefits. The calendar year Deductible amounts are shown in the Plan options table. The calendar year Deductible amount has these special provisions:

1. Family Deductible: When Covered Persons in the same family satisfy the family deductible, no other deductible amount will be assessed against Covered Persons in that family for the remainder of the calendar year.

2. Three-Month Carryover: Any Covered Expenses incurred in the last three months of a Calendar Year that are used to satisfy the Calendar Year deductible amount, in part or in full, are also applied to the Calendar Year deductible amount for the following year.

3. Common Disaster: If two or more Covered Persons in the same family are injured in the same accident, only one calendar year deductible amount for one person will be applied against the combined total Covered Expenses resulting from the accident. This combined calendar year deductible amount will also apply to future calendar year deductible amounts.

DURABLE MEDICAL EQUIPMENT: Equipment that can withstand repeated use, is primarily and customarily used for a medical purpose, is not generally useful in the absence of an Injury, is not disposable or non-durable, and is appropriate for use in the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

The Plan will provide benefits for the replacement of Durable Medical Equipment only when the replacement is needed due to a change in the member's physical condition or when the original equipment is inoperative and cannot be repaired at a cost that is less than rental or replacement cost. Replacement due to loss or for patient convenience will not be covered.

EMPLOYEE means an individual that the Contributing Employer classifies as a common-law employee and who is on the Contributing Employer's W-2 payroll, but does not include the following: (a) any leased employee including but not limited to those individuals defined as leased employees in Code Section 414(n); (b) any individual who performs services for the Contributing Employer but who is paid by such agency, whether or not the individual is determined by the IRS or others to be a common-law employee of the Contributing Employer; (c) any employee covered under a Collective Bargaining Agreement, unless the agreement provides for contributions to the Fund; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more than 2% shareholder in a Subchapter S corporation, including those deemed to be more than a 2% shareholder by virtue of Code Section 318 ownership attribution rules.

ESSENTIAL HEALTH BENEFITS: The items and services described in Section 1302 of the Affordable Care Act, which provides that the Plan may identify Essential Health Benefits by reference to any state benchmark plan. Currently, the Plan refers to the Utah benchmark plan. The Plan's selection of state benchmark plan may change. For a current list of Essential Health Benefits, contact the Fund Administrator. No annual or lifetime limit on the dollar value of a benefit applies to an Essential Health Benefit.

EXPERIMENTAL/INVESTIGATIVE: A service, procedure, drug, device, or treatment modality for a specific diagnosis:

1. That has failed to obtain final approval for use of a specific service, procedure, drug, device, or treatment modality for a specific diagnosis from the appropriate governmental regulatory board;

2. For which reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, or treatment modality on health outcomes for a specific diagnosis;

3. For which reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study, or investigational arm of on-going phase III clinical

trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

4. For which reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

   Reliable evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

5. For which the Trustees have retained the authority to determine, in their discretion, whether a service, procedure, drug, device, or treatment modality is experimental or investigative, regardless of whether a Physician has prescribed, ordered, recommended, or approved it.

   Except, the Plan will not deny or limit, or impose additional conditions on, the coverage of routine patient costs for items or services furnished in connection with participation in an approved clinical trial. The Plan will not discriminate against a Participant on the basis of participation in the approved clinical trial.

   Routine patient costs generally include all items and services consistent with the coverage provided under the Plan for a Participant who is not enrolled in a clinical trial. However, costs associated with the following are excluded from the definition:

   a. The cost of the investigational item, device, or service.

   b. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.

   c. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

   The term approved clinical trial is a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

   a. A federally funded or approved trial.

   b. A clinical trial conducted under an FDA investigational new drug

application.

c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

FUND: The Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund, including Health Funds that have merged into the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund.

FUND ADMINISTRATOR: The person or entity appointed by the Trustees to manage daily operation of the Plan.

HOME HEALTH CARE AGENCY: Any agency or organization that:

1. Is primarily engaged in providing nursing and other therapeutic services;

2. Is federally certified and duly licensed by the state in which the care is given, if licensing is required;

3. Has policies established by a professional group associated with an agency, including at least one Physician and at least one registered nurse, to govern the services provided;

4. Provides for full-time supervision of services by a Physician or by a registered nurse;

5. Has its own administrator; and

6. Maintains a complete medical record on each patient.

HOME HEALTH CARE PLAN: A plan for continued care and treatment of a Covered Person who:

1. Is under the care of a Physician; and

2. Would need Hospital confinement without home health care.

A Home Health Care Plan must be:

1. Approved in writing and established by the attending Physician with the home health care provider;

2. Provided for a condition that would require a Hospital confinement if the Home Health Care Plan was not implemented and certified by the attending Physician; and

3. Reviewed at least every thirty days by the attending Physician.

HOSPITAL: An institution approved or licensed by an authorized state agency and lawfully operated in the jurisdiction in which it is located, and is included in one of the following descriptions:

1. An institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and surgery and having twenty-four-hour nursing service;

2. A community mental health center or mental health clinic; or

3. A residential primary treatment facility, for treatment of Mental or Nervous Disorders, alcoholism, chemical dependency, or drug addiction.

However, this does not include institutions operated primarily as rest homes or homes for the aged nor institutions that are primarily custodial in nature. The term Hospital as used by this Plan also includes a free-standing ambulatory surgical center or facilities offering ambulatory medical service twenty-four hours a day, seven days a week, which are not part of a Hospital, but which have been reviewed and approved by an authorized state agency to provide health care treatments or services.

INJURY: Any damage resulting from trauma from an external source. Note: This Plan does not cover injuries that are employment-related.

MEDICALLY NECESSARY: An item or service that is:

1. Provided or prescribed by a Healthcare Provider exercising prudent clinical judgment, acting in accordance with generally accepted standards of medical practice, and acting within the scope of his or her license to practice;

2. Provided or prescribed for the purpose of diagnosing or treating an illness or injury;

3. Clinically appropriate, in terms of types, frequency, extent, site and duration;

4. Considered safe and effective for diagnosis or treatment of the patient's illness or injury;

5. Not primarily for the convenience of the patient or Healthcare Provider, or another Healthcare Provider; and,

6. Not more costly than an alternative that is likely to produce similar therapeutic or diagnostic results.

MENTAL AND NERVOUS DISORDER: A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or as identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

NETWORK: A Hospital, Physician or other health care provider that has entered into an agreement to provide services through a provider reimbursement arrangement.

NETWORK PROVIDER: A network of Hospitals, Physicians and other health care providers that deliver a range of health care services at discounted prices. It is your decision whether to use a Network provider, however you will save money for yourself and the Fund when you use Hospitals, Physicians or other service providers that participate in the Network because you will receive discounts on the services you receive. In addition, when you seek care from a Network Provider, the Network Provider will submit a claim for you. Before seeking care from a provider, you should check to see whether the provider participates in the network. Refer to the Important Contact Information section of this Plan Document for the name of the network and contact information.

To see what physicians and other health care providers are in your network, log onto your "*my*HealthPartners" account at www.healthpartners.com or create one at www.healthpartners.com. If you need assistance locating a physician or other health care providers in your network, please contact Member Services at 952-883-5000 or 800-883-2177 (toll-free).

OUT-OF-NETWORK: A Hospital, Physician or other health care provider that has not entered into an agreement with HealthPartners to provide services through a provider reimbursement arrangement.

NETWORK REFERRALS: There is no referral requirement for services delivered by providers within your network.

OUT-OF-POCKET MAXIMUM: the limit you or Dependents pay out-of-pocket in a calendar year for Network and Out-of-Network Covered Expenses. Medical expenses that are not Covered Medical Expenses do not count toward any Out-of-Pocket Maximum. If your payments toward Covered Expenses reach the Out-of-Pocket Maximum, the Plan generally pays 100% of your remaining Covered Expenses during that calendar year. In addition to the overall annual Out- of-Pocket Maximum, there may be separate Out-of-Pocket Maximums for specific items and services. These apply separately. Any out-of-pocket expense for a product or service that is paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturers coupons, debit cards, or other forms of payment or direct reimbursement to a Covered Person do not could towards your Out-of-Pocket Maximum.

PERMANENTLY AND TOTALLY DISABLED or **TOTAL DISABILITY:** The inability of the Covered Employee to engage in or perform the duties of his/her regular occupation or employment during the first two years of a disability. After the first two years of a disability, Totally Disabled means the inability of the Covered Employee to engage in any paid employment or work for which the Covered Employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

The Board of Trustees will initially require certification of Total Disability by a Medical Doctor (M.D.) and may require proof of continued disability. In addition, the Board of Trustees has the

right, at their expense, to have the Covered Employee submit to a medical examination.

PHYSICIAN: Any individual who is licensed to practice medicine by the governmental authority within the United States having jurisdiction over licensure, and who is acting within the usual scope of his practice. However, for purposes of coverage under the Plan, Physician is interpreted to include a certified nurse midwife, psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and Doctor of Dental Surgery, provided the individual is licensed and acting within the usual scope of the licensed practice.

PLAN DOCUMENT: This Summary Plan Description and Plan Document adopted by the Board of Trustees that describes the benefits to be provided for Covered Persons, eligibility requirements, termination rules and the rules and regulations pertaining to Plan administration. The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

PLAN YEAR: the calendar year (*i.e.*, the 12-month period commencing on January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

PREVENTIVE CARE: Items and services that are defined as "Preventive Care" under the Affordable Care Act (Section 2713 of the Public Health Service Act, see also, 29 C.F.R. 2590.715- 2713). The Affordable Care Act defines Preventive Care by reference to governmental agency recommendations and guidelines. If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Fund will use reasonable medical management techniques to determine appropriate coverage limitations. Contact the Fund Administrator for the current list of coverage limitations. Agencies may add or modify recommendations and guidelines at any time. The Plan will begin covering a newly added item or service as Preventive Care starting on the first day of the Plan Year that begins one year after the date the recommendation or guideline is issued. The Plan will cease covering an item or service as Preventive Care on the day that the recommendation or guideline on which it is based no longer meets the definition of Preventive Care under the Affordable Care Act. If the office visit is coded as a routine preventive care exam, then all testing and treatment during the course of the exam is covered as preventive.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO): A QMCSO is a court order or a document obtained through a special administrative process adopted by the state in which an Employee resides that requires the Plan to continue coverage of the Employee's child. A copy of the QMCSO must be sent to the Plan Administrator before the claims for the child will be considered for payment. The Plan has procedures it follows to determine if a child support order is a Qualified Medical Child Support Order, which are available upon request from the Fund Office, free of charge.

REASONABLE AND CUSTOMARY CHARGES: The usual and customary fee or charge for the services rendered and the supplies furnished in the area where services are rendered, or supplies are furnished, provided these services and supplies are recommended and approved by a legally qualified Physician.

SICKNESS: An illness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. Sickness also includes pregnancy. Note: This Plan does not cover sickness that is employment-related.

SPOUSE: an individual who is legally married to a Participant as determined under the law of the state or foreign jurisdiction in which they were married (and who is treated as a spouse under the Code).

TRUSTEES: The Board of Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund.

UNION: Bricklayers and Allied Craftworkers Union Local #1 of Minnesota and North Dakota, its predecessors and successors, and all its participating chapters and/or sublocals.

Health Reimbursement Account (HRA) Plan Document

Health Reimbursement Arrangement Appendix to the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Plan and Summary Plan Description

I. Introduction

A. Establishment of HRA feature to Plan

The Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund (the "Plan"), as Plan sponsor, established the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Reimbursement Arrangement ("HRA") as a feature of the Plan, effective January 1, 2005 (the "Effective Date"). Capitalized terms used in this Plan not otherwise defined shall have the meanings set forth in Article 2. The HRA is intended to permit an Eligible Employee and Dependents to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

B. Legal Status

This HRA feature is intended to qualify as an employer-provided medical reimbursement arrangement under Code §§105 and 106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45 and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

II. Definitions

A. Definitions Applicable to HRA Feature

BENEFITS means the reimbursement benefits for Medical Care Expenses described under Article 6.

COMPENSATION means the wages or salary paid to an Employee by the Employer.

CONTRIBUTING EMPLOYER means an Employer that has signed a Collective Bargaining Agreement or Participation Agreement requiring contributions to the HRA account, which has been accepted by the Board of Trustees.

COVERED INDIVIDUAL means a Participant, Spouse or Dependent.

DEPENDENT means any individual who is a tax dependent of the Participant as defined in the Internal Revenue Code of 1986, as amended, with the following exception: any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents.

EFFECTIVE DATE of this Plan has the meaning described in Section 1.1, (January 1, 2005).

ELIGIBLE EMPLOYEE means an Employee eligible to participate in this Plan, as provided in Section 3.1.

EMPLOYEE means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee including but not limited to those individuals defined as leased employees in Code §414(n)); (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a Collective Bargaining Agreement, unless the agreement provides for contributions to this Plan; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than 2% shareholder in a Subchapter S corporation, including those deemed to be a more than 2% shareholder by virtue of the Code §318 ownership attribution rules. The term Employee includes former Employees for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

EMPLOYER means any Contributing Employer that has a signed Collective Bargaining Agreement or Participation Agreement required contributions to the HRA account and approved by the Board of Trustees.

EMPLOYMENT COMMENCEMENT DATE means the first regularly scheduled working day on which the Employee first performs an hour of service for a Contributing Employer for Compensation.

ENROLLMENT FORM means the form provided by the Plan's Third-Party Administrator for the purpose of allowing an eligible Employee to participate in this feature of the Plan.

EXCEPTED BENEFITS are those listed in Exhibit D, as may be updated from time to time.

HEALTH FSA means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125.2, Q/A-7(a).

HRA or HEALTH REIMBURSEMENT ARRANGEMENT means a health reimbursement arrangement as defined in IRS Notice 2002-45.

HRA ACCOUNT means the HRA Account described in Section 6.3.

MEDICAL CARE EXPENSES has the meaning defined in Section 6.2.

PARTICIPANT means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article 3.

PERIOD OF COVERAGE means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2.

PLAN means the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Plan as set forth herein and as periodically amended from time to time.

PLAN ADMINISTRATOR means the Board of Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund. The contact person is the Third-Party Administrator for the Plan who has the full discretionary authority to act on behalf of the Board of Trustees, except with respect to appeals, for which the Board of Trustees has the full authority to act.

PLAN YEAR means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

SPOUSE means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

SPD means the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Plan Summary Plan Description, which includes this HRA Plan Document.

THIRD PARTY ADMINISTRATOR is the administrative agent of the Board of Trustees.

III. Eligibility and Participation

A. Eligibility to Participate

An individual is eligible to participate in this feature of the Plan if: 1) the individual is an Employee covered by a Collective Bargaining Agreement or Participation Agreement requiring contributions to the HRA feature of the Plan, which has been approved by the Board of Trustees; and, 2) contributions have been received by the trust on behalf of the individual from a qualified employer. Once an Employee has met the Plan's eligibility requirements and an Enrollment Form has been submitted to the Third-Party Administrator, the Employee's coverage will

commence on the first day of the next calendar month.

If you are not covered by the Plan or another employer-sponsored group health plan that provides minimum value, the expenses which are reimbursable from your HRA account are limited. See Section 6.2 below.

B. Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

1. The termination of this Plan; or

2. The date that is five (5) years from the date on which the Employee ceases to have contributions made on his or her behalf (because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Board of Trustees on a uniform and consistent basis under Section 6.6.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 6.6 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

C. Opt-Out

You may opt-out of and waive future reimbursements from the HRA Plan. Your Employer will continue to make contributions on your behalf, but they will not be allocated to an account for you. If you opt-out, your account balance will be forfeited and you may not submit any additional claims. You may re-enroll in the HRA in the future.

D. FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee.

E. Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2.

IV. Method and Timing of Enrollment

A. Enrollment When First Eligible

An Employee who first becomes eligible to participate in the HRA feature of the Plan will commence participation on the first day of the month after the eligibility requirements have been satisfied, provided that an Enrollment Form is submitted to the Third-Party Administrator before the first day of the month in which participation will commence. Once enrolled, the Employee's participation will continue from month to month and year to year until the Employee's participation ceases pursuant to Section 3.2. The Enrollment Form shall identify the Spouse and Dependents whose medical expenses may be submitted to the HRA. The Employee must promptly notify the Third-Party Administrator if this information changes.

V. Benefits Offered and Method of Funding

A. Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Articles 3 and 4, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article 6. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

B. Employer and Participant Contributions

1. Employer Contributions. The Employer funds the full amount of the HRA Accounts. The Board of Trustees may allocate earnings to the HRA, in their discretion.

2. Participant Contributions. There are no Participant contributions for Benefits under the Plan.

3. No Funding under Cafeteria Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions over which an Employee exercises control (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or such employer contribution be treated as Employer contributions to the HRA feature of the Plan.

C. Funding This Plan Feature

All the amounts payable under this Plan shall be paid from the general assets of the Trust. Nothing herein will be construed to require the Board of Trustees to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Trust from which any payment under this Plan may be made.

VI. Health Reimbursement Benefits

A. Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 6.3.

B. Eligible Medical Care Expenses

Under the HRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

1. Incurred. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the Participant was a Participant in the Plan during both Periods of Coverage.

2. Medical Care Expenses Generally. "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213 (including, for example, amounts for certain Hospital bills, doctor and dental bills and prescription drugs and certain health care premiums), but shall not include expenses that are described in subsection (c). Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account, except as provided below.

   If you do not have qualified coverage under a group health plan, either under the Fund or through your employer, your spouse, etc., expenses reimbursable from your HRA account are limited to Excepted Benefits, set forth in Exhibit D.

3. Medical Care Expenses Exclusions. "Medical Care Expenses" shall not include the expenses listed as exclusions stated in the Plan Document or this Plan. Notwithstanding the foregoing, an HRA account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan.

4. Cannot Be Reimbursed or Reimbursable from Another Source. Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through other insurance, including any other accident or health plan (but see Section 6.9 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article 6.

5. Nondiscrimination. Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Board of Trustees in its sole discretion.

C. Establishment of Account

The Third-Party Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for any individual participant for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Trust.

1. Crediting of Accounts. A Participant's HRA Account will be credited at the end of each month with an amount equal to the applicable rate specified in the Contributing Employers Collective Bargaining Agreement or Participation Agreement with the Plan, which has been actually received by the Plan. The Board of Trustees, in its sole discretion, may credit earnings from the HRA account feature to HRA accounts.

2. Debiting of Accounts. A Participant's HRA Account will be debited during each Period of Coverage for all applicable reimbursements and those plan administrative expenses charged to the account by the Board of Trustees.

3. Available Amount. The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

D. Carryover of Accounts

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements and administrative assessments paid for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Period of Coverage. However, upon loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected as provided in Section 6.6. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

E. Reimbursement Procedure

1. Timing. Within 30 days after receipt by the Third Party Administrator of a reimbursement claim from a Participant, the Plan will reimburse the Participant for the Participant's Medical Care Expenses (if the Third Party Administrator approves the claim), or the Third Party Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Third-Party Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any Extension, including the reasons for the extension, and will allow the Participant forty-five (45) days in which to complete an incomplete reimbursement claim.

2. Claims Substantiation. A Participant who seeks Benefits may apply for reimbursement by applying in writing to the Third-Party Administrator in such form as the Third Party Administrator may prescribe, by no later than the last day of the Plan Year following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

   (a) the person or persons on whose behalf Medical Care Expenses have been incurred;

   (b) the nature and date of the Expenses so incurred;

   (c) the amount of the requested reimbursement; and

(d) a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Third-Party Administrator may request. Except for the final reimbursement claim for a Period of coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.

3. Claims Denied. For reimbursement claims that are denied, see the appeals procedure in the Summary Plan Description and Plan Document.

F. Reimbursements After Termination; COBRA Continuation Coverage (COBRA)

You and your Covered Dependents may qualify for continuation of HRA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). While you are a COBRA participant, you may elect two different forms of HRA benefits under the plan. One form of benefits allows you access to your account balance. If you choose to continue to have access to your account balance, your account will be charged for the costs of administration at that same rate as all other plan participants. The second form allows you to contribute to your HRA while you are a COBRA participant. If you are able to contribute to the HRA with funds that are untaxed, then the second form would be of advantage to you.

The HRA is a reimbursement mechanism, which means that only the amounts remaining in your family's account on the day of the COBRA event are available for reimbursement. The exception to this rule is if you establish a new account with the Plan to accept post-COBRA event contributions. The Plan, also, leaves it to you and your family members to decide on how the money in the family account will be used. If a divorce occurs, the divorce decree will need to specify who has access to the account; the Plan will continue to recognize all pre-COBRA event dependents, if claims are submitted. If your child is no longer eligible due to no longer being a dependent, then the Plan will continue to recognize your child as eligible for the 36-month COBRA period. You must make the proper COBRA election. After the COBRA event, contributions for you will go into a new HRA account, with an amended list of participants eligible to receive reimbursements. The subsequent COBRA contributions will be used only for claims of your post-COBRA dependents, and they are not subject to claims of former dependents.

A COBRA qualifying event occurs when you or your Dependent loses eligibility due to one of the following:

1. Your reduction in hours, depletion of your hour bank, or termination of employment.

2. Your death.

3. Your divorce.

4. Your eligible child stops qualifying as a Dependent child under the Plan.

5. Your becoming eligible for Medicare.

You must notify the Fund Office within sixty days of your qualifying event (except for a reduction of hours). If you do not notify the Fund Office within the sixty-day period, then you have lost your right to elect COBRA coverage.

If the qualifying event is your reduction in hours, or termination of employment, then the maximum period of **COBRA Continuation Coverage** for you and your Eligible Dependents is eighteen months, beginning on the day coverage would otherwise end. However, if a second qualifying event occurs during this eighteen-month period, the maximum period of **COBRA Continuation Coverage** for your eligible Dependents extends to thirty-six months. In addition, if you or one of your eligible Dependents is totally disabled at the time of the initial qualifying event or become totally disabled within sixty days of the initial qualifying event, as determined by Social Security, the maximum period of **COBRA Continuation Coverage** will be extended an additional eleven months for a total of twenty-nine months. The Fund Office must be notified within sixty days of the date that Social Security determines the individual is totally disabled.

If the qualifying event is any of the other events, the maximum period of **COBRA Continuation Coverage** for your eligible Dependent is thirty-six months, beginning on the date coverage would otherwise terminate.

Under **COBRA Continuation Coverage**, a qualified beneficiary has the right to continue the same benefits provided to an Active Employee.

COBRA Continuation Coverage terminates on the earliest of the following dates:

1. the date on which the qualified beneficiary becomes entitled to receive benefits under Medicare;

2. the applicable date, which is eighteen, twenty-nine or thirty-six months after the date of the qualifying event, as described in this section; and

3. the date on which the Plan terminates.

If you terminate employment during the period beginning eighteen months prior to your entitlement to Medicare and ending eighteen months after your entitlement to Medicare, the maximum period of COBRA Continuation Coverage for your eligible Dependents will be thirty-six months from the date you become entitled to Medicare.

For more information about COBRA Continuation coverage, please contact the Fund Office.

G. Coordination of Benefits; Health FSA to Reimburse First

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

VII. Appeals Procedure

A. Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Board of Trustees acts on behalf of the Plan with respect to appeals.

VIII. Participant Information

A. Reliance on Participant, Tables, etc.

The Board of Trustees may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Board of Trustees will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

B. Inability to Locate Payee

If the Third Party Administrator is unable to make payment to any Participant or other person to show a payment is due under the Plan because it cannot ascertain he identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

C. Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Third Party Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits of the HRA Account or distributions to which he or she is properly entitled under the Plan. Such action by the Third-Party Administrator may include withholding of any amounts due to the Plan.

IX. General Provisions

A. Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Plan.

B. No Guarantee of Tax Consequences

Neither the Board of Trustees nor the Employers makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participants gross income for federal state or local income tax purposes. It shall be the obligation of the Participant to determine when each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and to notify the Board of Trustees if the Participant has any reason to believe that such payment is not so excludable.

C. Indemnification of Trust and Plan

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Trust for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes form such payments or reimbursements.

D. Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

EXHIBIT A

Active Employees

Plan Option	**Single Coverage**	**Active Employee +Children**	**Active Employee +Spouse**	**Active Employee +Family**
Plan A200	$997	$1,536	$1,667	$2,018
Plan B1000	$820	$1,239	$1,345	$1,672
Plan C2000	$768	$1,140	$1,240	$1,538
Plan D3000	$733	$1,070	$1,164	$1,447
Plan E4350	$659	$973	$1,053	$1,314

Retirees

Plan Option	**Single Coverage**	**Retired Employee +Children**	**Retired Employee +Spouse**	**Retired Employee +Family**
Plan A200	$1,612	$2,851	$3,303	$4,108
Plan B1000	$1,358	$2,403	$2,785	$3,464
Plan C2000	$1,251	$2,215	$2,567	$3,193
Plan D3000	$1,175	$2,079	$2,409	$2,998
Plan E4350	$1,116	$1,974	$2,286	$2,842

EXHIBIT B

MINNESOTA AND NORTH DAKOTA BRICKLAYERS AND ALLIED CRAFTWORKERS HEALTH FUND

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Health Programs Covered By This Notice

This Notice describes the practices of the following group health programs that are part of this Plan and will apply to you to the extent you participate in these programs:

- Medical Plan
- Dental Plan
- Vision Plan

These group health programs are part of the Plan, and the Plan may share protected health information for the treatment, payment, and health care operation's purposes described. If you participate in other programs, you may receive additional notices.

II. Pledge Regarding Your Protected Health Information

This Notice explains how the Plan uses and discloses your protected health information and the rights that you have with respect to accessing that information and keeping it confidential. "Protected health information" means information that individually identifies you, and relates to payment for your health care, your health or condition, or health care you receive, including demographic information. The Plan creates, receives, and maintains eligibility and enrollment information, information about your health care claims paid under the Plan, and other protected health information that is necessary to administer the Plan.

The Plan is required by law to maintain the privacy of your protected health information and to provide this Notice to you. This Notice explains the Plan's legal duties and privacy practices, and your rights regarding your protected health information. The Plan is committed to protecting the privacy of your protected health information by complying with all applicable federal and state laws.

While this Notice is in effect, the Plan must follow the privacy practices described. This Notice takes effect on the date shown at the bottom of this Notice and will remain in effect until it is replaced. The Plan reserves the right to change its privacy practices and

the terms of this Notice at any time, provided that applicable law permits such changes. The Plan reserves the right to make such changes effective for all protected health information that the Plan maintains, including information created or received before the changes were made. The Plan will provide a revised copy of the Notice through the mail.

You may request a copy of the Plan's Privacy Notice at any time. For more information about the Plan's privacy practices, or for additional copies of this Notice, please contact the Plan using the information listed at the end of this Notice.

III. Uses and Disclosures of Your Protected Health Information

The following categories describe the different ways that the Plan uses and discloses your protected health information. Not every use or disclosure within a category is listed, but all uses and disclosures fall into one of the following categories.

A. Payment. The Plan may use and disclose protected health information about you for payment purposes, such as determining your eligibility for Plan benefits, facilitating payment for treatment and health care services you receive, determining benefit responsibility under the Plan, coordinating benefits with other Plans, determining medical necessity, and so on. For example, the Plan may share protected health information with third-party administrators hired to provide claims services and other administrative services to the Plan.

B. Health Care Operations. The Plan may use and disclose protected health information about you for health care operations. These uses and disclosures are necessary to operate the Plan. For example, the Plan uses and discloses protected health information to conduct quality assessment and improvement activities, and for cost management and business management purposes. The Plan may use and disclose protected health information for underwriting, premium rating and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management, and general administration. To the extent the Plan uses or discloses health information for underwriting purposes, under HIPAA the Plan is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

C. Treatment. The Plan may use or disclose protected health information for treatment purposes, including helping providers to coordinate your care. Only the minimum amount of information necessary will be disclosed. For example, an emergency care provider may contact the Plan to find out what other providers you use, so that he or she can contact them to get medical records necessary to your care, if you are unable to provide that information.

D. **Disclosures to the Plan Sponsor**. The Plan may disclose your protected health information to the Trustees, but only to permit the Trustees to perform Plan administration and fiduciary functions.

E. **Disclosures to Other Plans**. This Plan may disclose your protected health information to another health plan sponsored to facilitate claims payments and certain health care operations of the other plan.

F. **Plan Communications with Individuals Involved in Your Care (or Payment for Your Care)**. In general, the Plan will communicate directly with you about your claims and other Plan-related matters that involve your protected health information. In some cases, however, it may be appropriate to communicate about these matters with other individuals involved in your health care or payment for that care, such as your family, relatives, or close personal friends (or anyone else, if you choose to designate them).

If you agree, the Plan may disclose to these persons protected health information about you that is directly relevant to their involvement in these matters. The Plan may also make such disclosures to these persons if you are given the opportunity to object to the disclosures and do not do so, or if the Plan reasonably infers from the circumstances that you do not object to disclosure to these persons. The Plan would not need to obtain your written authorization. For example, if you are an employee and are attempting to resolve a claims dispute with the Plan, and you orally inform the Plan that your spouse will be calling the Plan for additional discussion of these issues, the Plan would be permitted to disclose protected health information directly relevant to that dispute to your spouse.

The Plan also may use or disclose your name, location, and general condition (or death) to notify or help to notify persons involved in your care about your situation. If you are incapacitated or in an emergency, the Plan may disclose your protected health information to persons involved in your care (or payment) if it determines that the disclosure is in your best interest.

G. **Communication about Benefits, Products, and Services**. The Plan may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives, or to tell you about health-related products or services (or payment or coverage for such products or services) that may be of interest to you. The Plan may use your protected health information to contact you with information about benefits under the Plan, including certain communications about health plan networks, health plan changes, and value-added health plan-related products or services. The Plan may communicate with you face-to-face regarding any benefits, products, or services. The Plan may use or disclose protected health information to distribute small promotional gifts.

H. **Required by Law**. The Plan may use or disclose your protected health information when required to do so by law. For example, disclosures to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with federal privacy law.

I. **Disaster Relief**. The Plan may use or disclose your name, location, and general condition (or death) to a public or private organization authorized to assist in disaster relief efforts.

J. **Public Health and Safety**. The Plan may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others (but only to someone in a position to help prevent the threat). The Plan may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. The Plan may disclose your protected health information to appropriate authorities if it reasonably believes that you are a possible victim of abuse, neglect, domestic violence, or other crimes.

K. **Lawsuits and Disputes**. The Plan may disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, in accordance with specified procedural safeguards.

L. **Law Enforcement**. Under circumstances, such as a court order, or court-issued warrant, subpoena or summons, or grand jury subpoena, the Plan may disclose your protected health information to law enforcement officials. The Plan also may disclose limited protected health information to a law enforcement official concerning a suspect, fugitive, material witness, and crime victim or missing person. The Plan may disclose protected health information about the victim of a crime (under limited circumstances); about a death the Plan believes may be the result of criminal conduct; to report a crime on the premises of the Plan; or, in an emergency, information relating to a crime not on the premises. If you are an inmate of a correctional institution, the Plan may disclose protected health information to the institution or to law enforcement.

M. **Research**. The Plan may use or disclose protected health information for research purposes, provided that the researcher follows certain procedures to protect your privacy. To the extent it is required by State law, the Plan will obtain your consent for a disclosure for research purposes.

N. **Decedents (Death, Organ/Tissue Donation)**. The Plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization, for certain limited purposes.

O. **Military and National Security**. The Plan may disclose to military authorities the protected health information of armed forces personnel under certain circumstances. The Plan may disclose to authorized federal officials protected health information required for intelligence, counter-intelligence, and other national security activities authorized by law.

P. **Workers' Compensation**. The Plan may disclose protected health information about you for workers' compensation or similar programs established by law to provide benefits for work-related injuries or illness.

Q. **De-Identified Data**. The Plan may create a collection of information that can no longer be traced back to you (*i.e.*, does not contain individually identifying information).

IV. Specific Disclosures Which Require Authorization Under HIPAA

A. **Uses and Disclosures You Specifically Authorize**. You may give the Plan written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give the Plan an authorization, you may revoke it in writing at any time. If you revoke your permission, the Plan will stop using or disclosing your protected health information in accordance with that authorization, except to the extent the Plan has already relied on it. Without your written authorization, the Plan may not use or disclose your protected health information for any reason except those described in this Notice.

B. **Psychotherapy Notes**. The Plan must obtain an authorization for any use or disclosure of psychotherapy notes, except in limited circumstances as provided in 45 C.F.R. §164.508(a)(2).

C. **Marketing**. The Plan must obtain an authorization for any use or disclosure of protected health information for marketing (as defined under HIPAA), except if the communication is in the form of a face-to-face communication made by the Plan to an individual; or a promotional gift of nominal value provided by the Plan. If the marketing involves financial remuneration, as defined in paragraph (3) of the definition of marketing at 45 C.F.R. §164.501, to the Plan from a third-party, the authorization must state that such remuneration is involved.

D. **Sale of Protected Health Information**. Except in limited circumstances covered by the transition provisions in 45 C.F.R. §164.532, the Plan must obtain an authorization for any disclosure of protected health information which is a sale of protected health information, as defined in 45 C.F.R. §164.501. Such authorization must state that the disclosure will result in remuneration to the covered entity.

V. Your Rights

A. **Access**. You have the right to look at or get copies of protected health information maintained by the Plan that may be used to make decisions about your Plan eligibility and benefits, with limited exceptions. The Plan reserves the right to require you to make this request in writing. If you request copies, you may be charged a fee to cover the costs of copying, mailing, and other supplies. If you prefer, the Plan will prepare a summary or an explanation of your protected health information for a fee.

The Plan may deny your request in very limited circumstances. If the Plan denies your request, you may be entitled to a review of that denial. You will be told how to obtain a review. The Plan will abide by the outcome of that review.

B. **Amendment**. If you feel that your protected health information is incorrect or incomplete, you have the right to request that the Plan amend it. The Plan reserves the right to require that this request be in writing, including a reason to support your request.

The Plan may deny your request if the Plan did not create the information you want amended or for certain other reasons. If the Plan denies your request, the Plan will provide you with a written explanation and the process to be followed for any additional action.

C. **Accounting of Disclosures**. You have the right to receive a list of disclosures the Plan has made of your protected health information. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. Your request for the accounting must be in writing.

You are entitled to such an accounting for the six (6) years prior to your request, though not earlier than April 14, 2003. The Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your protected health information, a description of the protected health information it disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, the Plan may charge you a reasonable, cost-based fee for responding to these additional requests. You will be notified of the cost involved and be given the opportunity to withdraw or change your request before any costs are incurred.

D. **Restriction Requests**. You have the right to request that the Plan place additional restrictions on its use or disclosure of your protected health information for treatment, payment, or health care operations. The Plan is not required to agree

to these restrictions, (except in the case of disclosure protected under 45 C.F.R. §164.522(a)(1)(vi)) but if it does, the Plan will abide by its agreement (except in a medical emergency). Any such agreement by the Plan must be in writing signed by a person authorized to make such an agreement on our behalf; without this written agreement, the Plan will not be bound by the requested restrictions. Please use the contact information at the end of this Notice to get more information about how to make such a request.

E. **Confidential Communication**. You have the right to request that the Plan communicate with you about your protected health information by alternative means or to an alternative location. For example, you may ask that the Plan contact you only at work or by mail. You must make your request in writing and must specify how or where you wish to be contacted. Your request must state that the information could endanger you if it is not communicated in confidence as you request. The Plan will accommodate all reasonable requests. Please use the contact information at the end of this Notice to get more information about how to make such a request.

F. **Copy of this Notice**. You are entitled to receive a printed (paper) copy of this Notice at any time. Please contact the Plan using the information listed at the end of this Notice to obtain a copy of this Notice in printed form.

VI. Obligations of the Plan

The Plan is required to:

A. maintain the privacy and security of protected health information;

B. make available to you this Notice which describes the Plan's legal duties and privacy practices with respect to your health information;

C. abide by the terms of this Notice;

D. notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;

E. notify you of any breach of your unsecured protected health information;

F. accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

G. obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

VII. Questions and Complaints

If you want more information about the Plan's privacy practices, have questions or concerns, or believe that the Plan may have violated your privacy rights, please contact the Fund Administrator.

You also may submit a written complaint to the U.S. Department of Health and Human Services. The Plan will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Plan supports your right to protect the privacy of your health information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

VIII. Conclusion

Uses and disclosures of your protected health information by the Plan are regulated by the federal HIPAA law. This Notice attempts to summarize the Privacy Regulations. The Privacy Regulations will supersede any discrepancy between the information in this Notice and the regulations.

EXHIBIT C

HRA: ESSENTIAL HEALTH BENEFIT ELIGIBILITY FOR REIMBURSEMENT

An essential health benefit eligible for reimburse is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are two lists of eligible expense.

For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses."

Eligible Medical Expenses

- Abdominal supports
- Abortion
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Birth Control Pills (by prescription)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Contraceptive devices (by prescription)
- Convalescent home (for medical treatment only)
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services

- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Special school costs for persons with disabilities
- Spinal fluid test
- Splints
- Sterilization
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Eligible Over-the-Counter Drugs

- Antacids
- Allergy Medications
- Pain Relievers
- Cold medicine
- Anti-diarrhea medicine
- Cough drops and throat lozenges
- Sinus Medications and Nasal sprays
- Nicotine medications and nasal sprays
- Pedialyte
- First aid creams
- Calamine lotion
- Wart removal medication
- Antibiotic ointments
- Suppositories and creams for hemorrhoids
- Sleep aids
- Motion sickness pills

EXHIBIT D

EXCEPTED BENEFITS

Following is a list of items or treatments that you can submit as an expense for reimbursement which constitute excepted benefits:

Baby/Child to Age 13
- Lead based paint removal
- Special education expenses for children with a learning disability

Adult Dental
- Exams and teeth cleaning
- Extractions and fillings
- Dentures and bridges
- Orthodontia
- X-rays
- Accidental dental

Child Dental
- Basic dental care
- Major dental care
- Orthodontia
- Dental anesthesia
- Accidental dental

Adult Vision
- Routine eye exam
- Eyeglasses and contact lenses
- Laser eye surgery
- Prescription sunglasses
- Radial keratotomy

Hearing
- Exams
- Hearing aids for children and adults

Medical Procedures / Treatments
- Acupuncture
- Bariatric surgery
- Chiropractic Services
- Treatment for temporomandibular joint disorders
- Hair loss treatment
- Infertility treatment
- In vitro fertilization
- Modification to the home
- Private duty nursing
- Routine foot care
- Service animals
- Wigs
- Ostomy supplies
- Transplant
- Routine foot care(non-diabetic)

Other
- Premiums for accident-only and disability coverage
- Long-term care benefits
- Weight loss program if prescribed by a physician to treat a medical illness (certain exclusions apply)

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Additionally, some expenses may only qualify for reimbursement if a health care provider has determined they are medically necessary. For additional information, contact the Plan Administrator.

EXHIBIT E

WORKER WELLNESS PROGRAM

Worker Wellness Program Benefit

Effective May 1, 2024, the Fund has established a Worker Wellness Program ("WWP") which provides eligible participants with a wage replacement payment when they take time off from work for Qualifying Leave. This benefit is available only to participants working under a Collective Bargaining Agreement that requires a contribution to the Fund for the WWP benefit. The WWP benefit is taxable.

WWP Benefit Web Portal and WWP Account

Various Collective Bargaining Agreements provide that Contributing Employers will make a WWP contribution for each hour worked by bricklayers and affiliated craftworkers covered by those agreements. Those contributions will be made to Zenith-American Solutions, the third-party administrator (the "Fund Office") and held in the Minnesota & North Dakota Bricklayers & Allied Craftworkers Health Fund.

The Fund Office will establish an individual WWP account for each eligible participant, where contributions and benefit payments will be tracked. This WWP account will be established when the Fund first receives a WWP contribution on behalf of a participant.

The Fund will maintain a self-service WWP benefit portal accessible through Participant Edge at https://edge.zenith-american.com. The portal will provide the following information:

- Eligibility status;
- Current WWP benefit balance;
- Contribution history;
- The process to submit claims for WWP benefit payments; and
- Steps to self-certify that a Qualifying Leave is being taken.

A WWP account balance will show hourly contributions made on behalf of an eligible participant and the amount of any WWP benefits previously paid.

WWP contributions will remain in a WWP account until claimed or forfeited as set forth below. WWP benefits are not affected by transferring between Contributing Employers.

There is no cap on the amount of WWP benefits that may be earned or held in an account. The amounts accrued under the WWP program will rollover from year-to-year if they go unused.

WWP benefit payments will only be made by wire transfer. In order to receive a payment, you will be required to provide bank account information to the Fund. This will also be done on the WWP benefit portal through Participant Edge.

Eligibility for WWP Benefits

To be eligible for a WWP benefit the following requirements must be met:

- You are eligible for coverage under the Fund as an Active participant (through employer contributions, through application of your bank, or through self-payments) or you must be eligible because you have elected and made COBRA contributions;
- You have worked under a Collective Bargaining Agreement requiring WWP hourly contributions to the Fund; and
- You have a balance in your individual WWP benefit account from which to receive reimbursement for a Qualifying Leave.

Retirees and Participants for whom contributions are made to the Health Fund under a Non-Bargaining Participation Agreement are ineligible for the WWP benefit.

Claiming Your WWP Benefits

If you experience a Qualifying Leave, WWP benefits may be claimed in any amount up to your full balance. The amount requested for a Qualifying Leave should be in an amount that replaces the wages that were lost as a result of the Qualifying Leave. As noted below, upon retirement or death, the entire balance must be redeemed, or the balance will be forfeited.

Qualifying Leave Example:

- Paul has $1,000.00 in his WWP account.
- Paul experiences a Qualifying Leave and misses a day of work.
- Paul self-certifies that the value of his lost wages due to the Qualifying Leave is $300.00 and submits a claim to the Fund.
- The Fund will issue Paul a payment in the amount of $300.00, less payroll and income taxes that are required to be withheld and reported.
- After this claim is paid, Paul will have $700.00 remaining in his WWP account.

WWP benefits are taxable. The Plan will issue an IRS Form W-2 detailing the amount of WWP benefits received in a calendar year and the amount of taxes that were withheld from the WWP benefit payments. As with any withholding, you may owe more or less than the amounts withheld when you calculate and file your income tax return for a year.

Qualifying Leave

WWP benefits are only payable for Qualifying Leave. Qualifying Leave is defined as a day (or days) during which you do not work for one of the following reasons:

- Vacation
- Holiday
- Your or another's mental or physical illness, treatment, or preventive care.
- Absence due to domestic abuse, sexual assault, or stalking.
- Closure of your workplace or a Family Member's school due to weather or public emergency.
- Jury duty
- Funeral leave

- Any other reason for which you were unable to otherwise work on a normally scheduled day of work to care for yourself or another.

Termination of Eligibility and Forfeiture

Once eligibility for a WWP benefit is established, eligibility will continue until terminated or forfeited under the provisions below.

Eligibility terminates and any unclaimed WWP benefits will be forfeited upon the earliest to occur of the following dates:

- The date the Minnesota & North Dakota Bricklayers & Allied Craftworkers Health Fund is terminated.
- The date the WWP benefit is terminated.
- The date you begin performing work that would be covered by an applicable bargaining agreement, but the work is performed for a non-signatory employer, so contributions are not payable to the Health Fund.
- The date a WWP account holder becomes self-employed in an industry covered by a Collective Bargaining Agreement and within the jurisdiction of the Union without an obligation to remit contributions to the Fund.
- The date on which the Fund has not received contributions on a WWP account holder's behalf during the preceding (24) months.
- The date a WWP account holder becomes a Retiree.

When eligibility terminates it may only be regained by meeting the requirements for initial eligibility for WWP benefits. The amounts remaining in a WWP account when eligibility terminates are forfeited and those amounts will not be reinstated if eligibility is reestablished.

Payment upon Retirement or Death

If you retire or die and there is a balance in your WWP account, the full balance of your account may be distributed to you or your estate. Depending upon where you resided at that time, the distribution may be subject to mandatory tax withholding.