

Minnesota Cement Masons
Health and Welfare Fund
SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT
2016 Edition

Minnesota Cement Masons
Health and Welfare Fund
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This booklet has been prepared for Active Employees of the Minnesota Cement Masons Health and Welfare Fund and their Dependents, and serves as the legal document that establishes the Plan. The Trustees have the sole discretion and authority to make final determinations regarding any application for benefits, interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under the Plan will only be paid if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Trustees reserve the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment. A separate booklet describes benefits available to eligible retirees.

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Introduction

The Board of Trustees of the Minnesota Cement Masons Health and Welfare Fund (or “Plan”) is pleased to provide you with this updated Summary Plan Description (SPD), which contains current health and welfare information for Active Employees and their eligible Dependents.

The benefits described in this booklet are effective as of January 1, 2016. This booklet also serves as the Plan's official Plan document, and replaces and supersedes all prior SPDs, Plan documents, and announcements provided before January 1, 2016.

We have tried to describe your benefits as completely as possible and in everyday language. We have also tried to organize this booklet in a way that will be useful to you. Here are some of the sections included in the booklet:

- **Important Contact Information:** Whom to call when you have a question about your benefits.
- **Schedule of Benefits:** An at-a-glance summary of Plan benefits.
- **Life Events:** How your benefits are affected by different events that can occur in your life.
- **Claims and Appeals:** A step-by-step process for filing claims, including what you need to do if a claim is denied.
- **Glossary:** Important terms used throughout the booklet. You can recognize many defined terms within the text because the first letter of the term is capitalized.

This SPD/Plan document also provides in-depth information about the Plan's medical, prescription drug, dental, vision, death, and disability benefits.

BENEFITS PROVIDED BY THE FUND

The Fund offers comprehensive health care coverage to help you and your Dependents stay healthy. The coverage can also help protect you against serious financial loss should you become ill or injured. We recommend that you read this booklet carefully as it is important that you understand your benefits and the protection they provide. If you are married, share it with your spouse.

As an Active Employee, you may qualify for a wide range of benefits including:

- Medical (which also includes chiropractic and hearing benefits);
- Prescription Drug;
- A Physical Exam Program;
- An Employee Assistance Program;
- Dental;
- Vision;
- Death;
- Accidental Death and Dismemberment; and
- Loss of Time Weekly benefits.

The Plan may be amended from time to time—either to revise the benefits or eligibility provisions or to bring the Plan into compliance with various federal laws. If this occurs, you will be sent a written notice explaining the change.

THE PLANS “GRANDFATHERED” STATUS

The Board of Trustees of the Minnesota Cement Masons Health and Welfare Fund believes this is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 651-256-1804. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

YOUR ROLE

It is the Trustees' goal to maintain a financially stable Fund while providing comprehensive health care coverage to you and your family. This becomes more challenging as health care costs rise. The Fund utilizes some cost-saving measures, like contracting with Network Providers, to ensure the Fund can continue to meet a majority of your current and future health care needs.

You can help the Fund manage health care costs by:

- **Visiting Network Providers:** Network Providers, including Hospitals, Physicians and other health care providers, charge negotiated rates that are often less than Out-of-Network Providers' rates. Therefore, when you use Network Providers, both you and the Fund save money because you are sharing in paying the cost of a lower bill.
- **Having your prescriptions filled at contracted network retail pharmacies and/or through the mail order facility:** The Fund has contracted with a Pharmacy Benefit Manager (PBM) to provide you with access to a network of retail pharmacies and a mail order facility that have agreed to charge negotiated rates for prescription medications.
- **Considering emergency treatment alternatives:** In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can receive the same level of care at a Physician's office or at an urgent care facility that you can receive in an emergency room. Keep your Physician's telephone number handy and find an urgent care facility near your home so you will be prepared in case of an emergency.
- **Reviewing receipts and explanations of benefits (EOBs) carefully:** Sometimes providers incorrectly bill for their services. It is important that you review all receipts and EOBs to ensure that charges are correct and that you are receiving Network or preferred rates when appropriate.

Keep this booklet with your important papers so you can refer to it when needed.

If you have questions about your benefits or would like some help understanding how the Plan works, call the Fund Office at 651-256-1804 or toll free at 866-286-8184.

Important Plan Administration Information

The following chart provides contact information for the organizations that service the Plan.

If You Have a Question or Need Information About:	Administered by:	Contact:
<ul style="list-style-type: none"> • Eligibility • Dental Benefits • Weekly Accident and Sickness Benefits • Death Benefits • Accidental Death and Dismemberment Benefits 	Fund Office Minnesota Cement Masons Health and Welfare Fund	2520 Pilot Knob Road, Suite 325 Mendota Heights, Minnesota 55120 651-256-1804 866-286-8184 (Toll Free)
<ul style="list-style-type: none"> • Medical Benefits 	HealthPartners Administrators, Inc.	8170 33 rd Avenue South, P.O. Box 1309 Minneapolis, MN 55440-1309 952-883-5000 800-883-2177 www.healthpartners.com
<ul style="list-style-type: none"> • Vision Benefits 	Vision Services Plan (VSP)	800-877-7195 VSP.com
<ul style="list-style-type: none"> • The Preventive Care (Physical Exam Benefit) Program 	Health Dynamics	377 W. River Woods Parkway Glendale, Wisconsin 53212 414- 443-0200 www.healthdynamics.com
<ul style="list-style-type: none"> • The Employee Assistance Program 	T.E.A.M., Inc.	700 Transfer Road St. Paul, Minnesota 55114 651-642-0182 www.team-mn.com
<ul style="list-style-type: none"> • The Physicians Neck and Back Clinics 	Physicians Neck and Back Clinics	Billing Office P.O. Box 466 Spencer, Iowa 51301 866-333-7622 (PNBC) (Toll Free) www.pnbconline.com
<ul style="list-style-type: none"> • Diagnostic Imaging 	Center for Diagnostic Imaging	910 Sibley Memorial Highway Mendota Heights, Minnesota 55118 800-342-0304 (Toll Free) www.cdiradiology.com
<ul style="list-style-type: none"> • The Prescription Drug Retail Program 	Optum RX	866-795-6816 (Toll Free) www.optumrx.com
<ul style="list-style-type: none"> • The Dental Network 	Delta Dental Delta Dental of Minnesota	P.O. Box 330 Minneapolis, Minnesota 55440-0330 651-406-5916 800-553-9536 (Toll Free) www.deltadental.org
<ul style="list-style-type: none"> • Health Reimbursement Arrangement 	Fund Office Minnesota Cement Masons Health and Welfare Fund	2520 Pilot Knob Road, Suite 325 Mendota Heights, Minnesota 55120 651-256-1804 866-286-8184 (Toll Free)

Schedule of Benefits

The following chart highlights key features of the Plan. These benefits are described in this booklet in further detail.

MEDICAL BASE PLAN BENEFIT		
	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Immunization Benefit	Plan covers 100% of Allowable Charges. Deductible does not apply.	Plan covers 100% of Allowable Charges. Deductible does not apply.
Preventive Care Physical Exam Benefit (For Active Employees and their Spouses Only)	Plan covers 100% of Allowable Charges. Deductible does not apply.	Plan covers 100% of Allowable Charges. Deductible does not apply.
	<i>The Plan covers two routine physical exams per calendar year and one comprehensive physical exam through Health Dynamics per calendar year. Active Employees and their spouses will receive a \$100 gift card following their first use of this benefit and a \$100 gift card the following their first follow-up exam.</i>	
Child Physical Exam Benefit (For Dependent Children Only)	Plan covers 100% of Allowable Charges. Deductible does not apply.	Plan covers 100% of Allowable Charges. Deductible does not apply.
	<p><i>Eight visits are covered from birth through age 12 months per calendar year.</i></p> <p><i>Four visits are covered from age 12 months through age 36 months per calendar year.</i></p> <p><i>Two visits are covered per calendar year from age three and older.</i></p> <p><i>Visit limits are combined for In-Network Benefits and Out-of-Network Benefits.</i></p>	

COMPREHENSIVE MEDICAL EXPENSE BENEFIT
(Active Employees and Their Eligible Dependents)

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Calendar Year Deductible	\$400 per person \$1,200 per family	\$400 per person \$1,200 per family
	<i>The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.</i>	
Calendar Year Out-of-Pocket Maximum	\$7,500 per person \$15,000 per family	\$7,500 per person \$15,000 per family
	<i>The Out-of-Pocket Maximums under the Network Benefits and the Out-of-Network Benefits are combined.</i>	
	<i>Amounts paid toward deductible will not apply to out-of-pocket maximum.</i>	
	<i>Out-of-Network Benefits above the reasonable and customary charge do not apply to the out-of-pocket limit.</i>	
Hospital Expenses <i>Room and board and use of operating room; daily room and board charge may not exceed average semi-private room charge.</i>	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.
Physician Services and Surgery <i>Covers expenses for diagnosis, treatment, and surgery performed by a Physician.</i>	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.
Urgent Care	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.
Emergency Care	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	See Network Benefit.
Ambulance Service	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	See Network Benefit.

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Chiropractic Treatment	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.
	<i>Network Benefits and Out-of-Network Benefits, combined, are limited to 12 visits per calendar year per person.</i>	
Routine Colonoscopy	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.
Radiology Services (including MRIs and CT scans)		
When performed at a Center for Diagnostic Imaging (CDI) Facility	Plan covers 100% of the Allowable charges. Deductible does not apply.	"See Network Benefit below, "When not performed at a Center for Diagnostic Imaging (CDI) Facility".
When not performed at a Center for Diagnostic Imaging (CDI) Facility	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
E-Visits/Electronic Diagnostic Services	Plan covers 80% of Allowable Charges; after the deductible has been satisfied, you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Neck and Back Rehabilitation		
When performed at a Physicians Neck and Back Clinic	Plan covers 100% of the Allowable charges. Deductible does not apply.	"See Network Benefit below, "When not performed at a Physicians Neck and Back Clinic".
When not performed at a Physicians Neck and Back Clinic	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Mental and Nervous Disorders, Alcoholism, Chemical Dependency and Drug Addiction Treatment (Inpatient, Day Treatment or Outpatient Treatment)	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Home Health Care Expenses	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Hearing Aids	Plan covers 100% of Allowable Charges. Deductible does not apply.	Plan covers 100% of Allowable Charges. Deductible does not apply.
	<p><i>Network Benefits and Out-of-Network Benefits are subject to a combined maximum benefit of \$1,500 every five years, which includes the cost of exams.</i></p> <p><i>There is a \$100 maximum benefit every two years for the hearing exam for adults only. This maximum is combined with the maximum benefit of \$1,500 every five years.</i></p> <p><i>The Fund has contracted with Amplifon Hearing Health Care (Amplifon) to offer a hearing discount program. This discount program is an opportunity for participants to purchase hearing aids and related supplies at a discount. These discounts allow participants to maximize their hearing benefits. In addition to discounted hearing supplies, the Amplifon program provides extended warranties on hearing aids, a two-year supply of free batteries and one year of free follow-up care. Amplifon will also extend its discount program to participants' family members who are not covered under the Plan. Participants interested in learning more or who want to get started with the Amplifon program should call Amplifon at 1-877-846-7074 or go to www.Amplifonusa.com.</i></p>	
LASIK Eye Surgery	Plan covers 100% of Allowable Charges. Deductible does not apply.	Plan covers 100% of Allowable Charges. Deductible does not apply.
	<p><i>There is a \$500 maximum benefit per eye, per person, lifetime for Network Benefits and Out-of-Network Benefits combined.</i></p>	

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Genetic Testing <i>Certain criteria apply. See the Covered Medical Expenses section for details.</i>	Plan covers 80% of Allowable Charges after you have met your deductible; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
<i>Network Benefits and Out-of-Network Benefits, combined, are limited to \$3,000 per lifetime per condition to establish a diagnosis of an inheritable disease.</i>		
Surgical Treatment of Morbid Obesity <i>Certain criteria apply. See the Covered Medical Expenses section for details.</i>	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Weight Loss Program <i>When supervised by a Physician. Coverage includes food products purchased specifically for a physician-based program. Certain criteria apply. See the Covered Medical Expenses section for details.</i>	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Diabetes Education	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Celiac Disease Nutritional Counseling	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Temporomandibular Joint Disorder (TMD) <i>Medically necessary services for the treatment of Temporomandibular Joint Disorder (TMD) are payable as a medical expense benefit.</i>	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
Skilled Nursing Facility	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of the Allowable Charges after the deductible has been satisfied; you pay 20%.
<i>Network Benefits and Out-of-Network Benefits, combined, are limited to a maximum of 120 days per confinement.</i>		
Coinurance for all other Covered Services	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.	Plan covers 80% of Allowable Charges after the deductible has been satisfied; you pay 20%.

PRESCRIPTION DRUG BENEFIT
(Active Employees and Their Eligible Dependents)

Retail Pharmacy (30-Day Supply)	
Generic Drugs Brand Name Drugs	Plan covers 90% of the discounted price, you pay 10%. Plan covers 80% of the discounted price, you pay 20%.
Mail Order (90-Day Supply)	
Generic Drugs Brand Name Drugs	Plan covers 100% of the discounted price. Plan covers 90% of the discounted price, you pay 10%.
	<i>Prescription drugs are not subject to a deductible or out-of-pocket maximum.</i>

DENTAL BENEFIT
(Active Employees and Their Eligible Dependents)

Preventive Care Basic & Major Services Orthodontic Services	Plan covers 100% of Allowable Charges* Plan covers 80% of Allowable Charges Plan covers up to \$1,000 per lifetime**
Maximum Benefits – Adults Only – Pediatric Services * <i>The Plan covers 100% of the Allowable Charges if services are rendered by a provider that participates in the contracted dental network; otherwise, the Plan pays 80% and you pay 20%. See the Dental Benefit section for details.</i> ** <i>Coverage for orthodontia treatment is only for Dependent children up to age 19.</i>	– \$1,500 per person per calendar year – Two routine visits/cleanings per calendar year

VISION PLAN BENEFIT
(Active Employees and Their Eligible Dependents)

<p>Vision Services Plan (VSP)</p> <p><i>The Fund has contracted with Vision Services Plan (VSP) to administer its vision benefits. VSP's discounts on vision examinations, frames and lenses will enable the Fund to provide higher benefits at no additional cost.</i></p>	<p>Covered every calendar year – no copayment:</p> <ul style="list-style-type: none"> • Vision examination • Contact Lens fitting and evaluation • One set of lenses – single vision, lined bifocal, lined trifocal or lenticular • Contact lenses in lieu of eyeglass benefit (\$150 allowance per calendar year) <p>Covered every other calendar year:</p> <p>Eyeglass frames - \$150 allowance, then 20% off amount in excess of allowance</p> <p><i>Participants who wish to use vision providers outside the VSP network will continue to have a calendar year benefit of \$300 every two years. Two calendar year periods are 2015-2016, 2017-2018, etc...</i></p>
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LOSS OF TIME WEEKLY BENEFIT
(Active Employees)

<p>Weekly Benefit</p> <p><i>Weekly benefit amount shown is after withholding of Social Security taxes. The actual amount of weekly benefit is slightly higher.</i></p>	<p>\$300</p>
<p>Benefits Begin (Injury or Illness)</p>	<p>Eighth day</p>
<p>Maximum Benefit Period</p>	<p>13 weeks</p>

DEATH BENEFIT
(Active Employees and Their Beneficiaries)

<p>Benefit</p>	<p>\$6,500</p>
<p>Dependent Spouse Benefit</p>	<p>\$1,500</p>

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT
(Active Employees and Their Spouses)

<p>Principal Benefit</p>	<p>\$1,500</p>
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Eligibility Requirements

INITIAL ELIGIBILITY

Active Employees

You become eligible for coverage under the Plan for the next following Benefit Period if you:

- Perform work under the jurisdiction of the Cement Masons, Plasterers and Shophands Union Local No. 633 of Minnesota, North Dakota and Northwest Wisconsin; and
- If you have:
 - 425 or more work hours for which contributions are received by the Minnesota Cement Masons Health and Welfare Fund on your behalf from one or more of your Contributing Employers during the immediately preceding Qualifying Period; or
 - 500 or more work hours for which contributions are received by the Minnesota Cement Masons Health and Welfare Fund on your behalf from one or more of your Contributing Employers during two or more immediately preceding consecutive Qualifying Periods.

Upon meeting the requirements, you will be eligible for:

- Medical;
- Prescription Drug;
- Dental;
- Vision;
- Death;
- Accidental Death and Dismemberment; and
- Loss of Time Weekly benefits.

One-Time Self-Payment Option

The Plan will allow you a one-time opportunity to make a self-payment (up to 425 hours) after being credited with 240 hours during the initial eligibility period. For example, if you have 240 hours credited during October through December, you can make a self-payment (at the rate in effect) for coverage for February through April of the following year.

This option is a “once in a lifetime option” and does **not** apply to continue eligibility after you have failed to make a self-payment or to re-qualify under the initial eligibility rules. Your coverage will begin on the first day of the Benefit Period following the Qualifying Period in which you meet the above requirements. For example:

Benefit Period	Qualifying Period	Qualifying Period
<i>To become eligible as of the first day of the benefit period...</i>	<i>425 or more work hours of contributions must have been received on your behalf for the qualifying period of ... OR</i>	<i>500 or more work hours of contributions must have been received on your behalf for at least the qualifying period of...</i>
May through July	January through March	October through March
August through October	April through June	January through June
November through January	July through September	April through September
February through April	October through December	July through December

Self-Employed Contractors and Other Non-Collectively Bargained Employees

Coverage may be available for self-employed contractors and other non-collectively bargained Employees under separate rules prescribed by the Board of Trustees.

Apprentices

Apprentices are credited with 100% of the hours spent in apprenticeship classes, not to exceed 144 hours per year.

Dependents

Your eligible Dependent's coverage begins on the same day your eligibility begins, or if applicable, the date you acquire a Dependent or a Dependent is designated for you in a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a court order or administrative order that complies with federal law, requires an Employee to provide health care coverage for a Dependent child, and requires that benefits payable on account of that Dependent child be paid directly to the health care provider who renders services or to the custodial parent of the Dependent child. The Fund Office has the authority to determine if a National Medical Support Notice issued by a state agency is a QMCSO. QMCSOs, other than National Medical Support Notices, must contain specific information and be submitted to the Plan Administrator.

Generally, your eligible Dependents include your spouse and children. Refer to the Glossary for a complete description of who qualifies as a Dependent under the Plan.

If you and your spouse are both eligible Employees under the Plan:

- Your children may be covered as Dependents of both of you; and
- Your spouse may be considered an eligible Dependent.

CONTINUING ELIGIBILITY

Active Employees

Eligibility continues for a Benefit Period as long as the combination of your work hours for which contributions are made and your reserve hour bank hours in the preceding Qualifying Period equal at least 350 hours. You **must** be working in covered employment or available for work in covered employment to be eligible (COBRA Continuation Coverage excluded).

To use bank hours or to make a self-payment, you must be working in covered employment or available for work in covered employment.

The Qualifying Schedule is as follows:

Qualifying Period	Prescribed Hours	Benefit Period
January through March	350	May through July
April through June	350	August through October
July through September	350	November through January
October through December	350	February through April

You will be allowed to accumulate any hours contributed on your behalf in excess of 350 hours per Qualifying Period in an individual reserve hours bank. A maximum of 1,500 hours may be accumulated at any time. If you do not have sufficient contributions made on your behalf during a Qualifying Period to continue your eligibility for benefits, the number of hours required to continue eligibility are withdrawn from your individual reserve hours bank. When your individual reserve hours bank is depleted, you may continue in the Plan according to the self-payment rules explained below.

Each time the rate of hourly employer contribution increases, the number of hours in your individual reserve hours bank are reduced in proportion to the percent of increase in the rate of contribution.

TERMINATION OF ELIGIBILITY

Active Employees

Your eligibility ends on the last day of the Benefit Period for which the combination of your contributed hours and reserve hours bank hours does not equal at least 350 hours.

Self-Payment Rules—If Your Employment Ends

If your employment with a Contributing Employer ends and you:

- Are currently eligible for benefits;
- Work in the territorial and trade jurisdiction of Local No. 633;
- Are immediately available for work in the territorial and trade jurisdiction of Local No. 633; and
- Have used up all your contributed work hours and reserve hours bank hours so that your eligibility is due to terminate,

You may elect to continue Plan benefits for yourself (excluding the Loss of Time Benefit) and your Dependents who were eligible under the Plan on the date of termination by making self-payments. The self-payment amount is determined and adjusted regularly by the Board of Trustees.

Your eligibility to make self-payments will end on the first to occur of:

- The date you become reemployed and covered under this or any other group health plan;
- The end of 12 consecutive months (four quarters) of self-payments following your termination; or
- The end of 24 consecutive months of self-payments following your termination due to disability.

Instead of electing the Plan's "self-payment coverage," you can elect COBRA Continuation Coverage. If you elect COBRA Continuation Coverage, you waive any right to make self-payments. Similarly, when you elect the Plan's self-payment coverage, you waive any right to COBRA Continuation Coverage. Refer to the **COBRA Continuation Coverage** section for more information.

Dependents

Coverage for your children stops at the end of the calendar month in which they turn age 26. The eligibility of your Dependent will terminate on whichever of the following dates occurs first:

- The date the Dependent is no longer your Dependent;
- The date your Plan coverage terminates; or
- The date the Plan is discontinued.

However, if you have a child who is incapable of self-sustaining employment because of mental or physical handicap, whose incapacity began before reaching age 26, and who is dependent on you for support and maintenance, you can continue health coverage for the child after he or she reaches age 26, provided you remain eligible and the incapacity continues. Proof of incapacity must be submitted to the Trustees within 31 days of the date the Dependent's coverage would otherwise terminate. An update on the Dependent's incapacitated status will be requested annually.

REINSTATEMENT OF ELIGIBILITY

If you have not continued your eligibility by using your individual reserve hours bank or by making self-payments, your eligibility may be reinstated on the first day of the Benefit Period following:

- The completion of 350 hours during the immediately preceding Qualifying Period; or
- 500 hours during the two consecutive immediately preceding Qualifying Periods.

However, if you are ineligible for four consecutive quarters, then you must re-qualify under the initial eligibility requirements.

To use the hour bank or to make a self-payment, you must be working in covered employment or be available for work in covered employment.

SPECIAL ENROLLMENT

In compliance with federal legislation under the State Children's Health Insurance Program (SCHIP) Reauthorization Act of 2009, special enrollment is allowed and the following rules apply:

- Special enrollment is allowed under the Plan for a newly acquired eligible Dependent if you acquire the new Dependent through marriage, birth, adoption, or placement for adoption.
- You are eligible to enroll in the Plan within 30 days after you acquire a new Dependent.
- You and/or your Dependent are eligible to enroll in the Plan within 60 days of the date that you and/or your Dependent lose Medicaid or SCHIP coverage, or become eligible to participate in a financial assistance program through Medicaid or SCHIP that allows coverage under the Plan.

RESCISSION OF COVERAGE

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission.

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

The following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to pay required premiums or contributions for your coverage in a timely manner.
- The Plan retroactively terminates your former spouse's coverage back to the end of the month in which the divorce occurred.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

COBRA Continuation Coverage

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your eligible Dependents (“Qualified Beneficiaries”) have the right to make self-payments to extend coverage temporarily after coverage would otherwise end due to certain reasons, called “qualifying events.” This extension is called COBRA Continuation Coverage.

You must notify the Fund Office of any qualifying event. Failure to provide notice within 60 days of a qualifying event may prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

Qualified Beneficiaries include you, your spouse, and your Dependent child(ren) who were covered by the Plan on the day before the qualifying event. Children born, adopted or placed for adoption during the period of COBRA coverage have the same COBRA rights as a spouse or Dependents who were covered by the Plan on the day of the event that triggered COBRA Continuation Coverage.

Evidence of good health is not required to obtain COBRA Continuation Coverage. Self-payments are required for COBRA Continuation Coverage; contact the Fund Office for information about the self-payment rates.

COBRA BENEFITS

Primarily, COBRA Continuation Coverage will be identical to the coverage you had under the Plan on the day before the qualifying event occurred that caused your loss of Plan coverage. This includes your medical, dental and vision benefits. However, coverage for Death, Accidental Death and Dismemberment, and Loss of Time Weekly benefits are not included under COBRA Continuation Coverage.

If your coverage terminates under your HRA account because of a COBRA qualifying event, you will continue to be able to receive reimbursement through your HRA for the COBRA periods of coverage described herein. Refer to the HRA Appendix for details.

PERIODS OF COVERAGE

18-Month COBRA Continuation Coverage

You and/or your Dependents are entitled to elect COBRA Continuation Coverage and to make self-payments for the coverage for up to 18 months if your coverage terminates because of one of the following qualifying events:

- A reduction in your hours; or
- Your loss of employment (which includes retirement), unless your termination of employment is due to your gross misconduct.

When the qualifying event is the end of your employment or reduction of your hours of employment, and you become entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for your qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. However, your maximum coverage period will be 18 months. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

29-Month COBRA Continuation Coverage for Disabled Individuals

A special extension to the initial 18-month continuation period is available for disabled individuals under COBRA Continuation Coverage. If you or your Dependent is determined to be disabled by the Social Security Administration within 60 days of when COBRA Continuation Coverage begins, the maximum period of COBRA Continuation Coverage will be extended from 18 months to 29 months for any eligible family members electing COBRA Continuation Coverage.

To be eligible for this 11-month extension, you must provide the Fund Office with proof of the Social Security Administration's determination within 60 days of the date the disabled person is determined to be disabled and before the expiration of the initial 18-month COBRA Continuation Coverage period. The Plan may charge a higher self-payment rate for the extra 11 months of coverage.

If the Social Security Administration later determines that you are no longer disabled or that your Dependent is no longer disabled, you or your Dependent must notify the Fund Office in writing within 30 days of the date such notice is received from the Social Security Administration.

36-Month COBRA Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, your spouse and Dependent children can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly supplied to the Fund Office. This extension may be available to your spouse and any Dependent children receiving COBRA Continuation Coverage if:

- You die;
- You become entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both);
- You get divorced or legally separated; or
- A child stops being eligible under the Plan as a Dependent.

The extension is available only if the event would have caused your spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

NOTIFICATION RESPONSIBILITIES

Employers

Your employer must give written notice to the Fund Office of the following qualifying events within 45 days of the event:

- Your employment ends;
- Your hours of employment are reduced;
- You die; or
- You enroll in Medicare (Part A, Part B, or both).

You, your spouse or your child must give written notice to the Fund Office of the following qualifying events within 60 days of the event:

- Your divorce or legal separation;
- Your child's loss of Dependent status; or
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA Continuation Coverage with a maximum of 18 or 29 months. This second qualifying event could include your death, enrollment in Medicare (Part A, Part B, or both), divorce, legal separation, or a child losing Dependent status.

In addition to these qualifying events, there are two other situations where you, your spouse, or your Dependent must provide the Fund Office with notice within the timeframe noted in this section:

- You, your spouse or Dependent who is receiving COBRA Continuation Coverage with a maximum of 18 months is determined by the Social Security Administration to be disabled. If the qualified beneficiary is determined to be disabled at any time during the first 60 days of COBRA Continuation Coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18-month maximum coverage period, for a total of 29 months of COBRA Continuation Coverage.
- The Social Security Administration determines that you, your spouse, or Dependent is no longer disabled while you are on extended COBRA Continuation Coverage. In this case, you must notify the Plan within 30 days of receiving the determination letter from the Social Security Administration.

You must provide written notice of any of the five situations listed above. You must send a letter to the Fund Office containing:

- Your name;
- The event for which you are providing notice;
- The date of the event; and
- The date on which you, your spouse or Dependent will lose coverage.

You should send your written notice to:

Minnesota Cement Masons Health and Welfare Fund

c/o Zenith American Solutions
2520 Pilot Knob Road, Suite 325
Mendota Heights, Minnesota 55120

The required notice may be sent by you, a qualified beneficiary with respect to the qualifying event or any representative acting on your behalf or on behalf of the qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

If you do not notify the Fund Office of a qualifying event within the timeframe noted, you will lose your right to elect or extend COBRA Continuation Coverage.

You should keep a copy of your records of any notices you send to the Fund Office.

To make sure that you are sent notification of your election rights as soon as possible, you or a Dependent should also notify the Fund Office any time any type of qualifying event occurs.

The Fund Office

When the Fund Office is notified of a qualifying event, an election (self-payment) notice and self-payment election form will be sent to you and/or your Dependents that would lose coverage due to the qualifying event. The notice will inform you of your right to elect COBRA Continuation Coverage, the due dates for returning the election form and the amount of the self-payment, as well as other necessary information.

To protect your family's rights, you should keep the Fund Office informed of any change in your address or in the addresses of family members.

ELECTING COVERAGE

You or your Dependents must complete the form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

- If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents.
- If you do not elect COBRA Continuation Coverage for yourself and/or your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any children who were covered by the Plan on the date of the qualifying event.
- The person electing COBRA Continuation Coverage has 60 days after the election notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed form. An election of COBRA Continuation Coverage is considered to be made on the date the election form is mailed back to the Fund Office. A person also has the right to waive a previous election and make a new election within the 60-day period.
- If the election form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

Self-Payments for Coverage

Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Board of Trustees on a yearly basis and will not exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

The following rules apply to your self-payments for COBRA Continuation Coverage:

- COBRA Continuation Coverage self-payments must be made monthly.
- The amounts of the monthly self-payments are determined by the Trustees based on federal regulations. The amounts are subject to change, but not more often than once a year, unless substantial changes are made in the benefits.
- You and/or your Dependents who are electing COBRA Continuation Coverage must make the initial self-payment for coverage within 45 days of your timely submission of the signed election form to the Fund Office.
- The due date for each following monthly payment is the first day of the month for which payment is due. A payment will be considered on time if it is received within 30 days of the due date.
- If you do not make a self-payment within the time allowed, COBRA Continuation Coverage for all family members for whom the payment is being made will end. You may not make up the payment or reinstate coverage by making up missed payments.

TERMINATION OF COVERAGE

COBRA Continuation Coverage may end before the end of the applicable 18-, 29- or 36-month coverage period as of the first of any of the following events:

- A correct and on-time self-payment is not made to the Plan;
- The Plan no longer provides group health coverage to any Employee;
- You (or your Dependent) become entitled to Medicare coverage;
- You are receiving extended coverage due to disability and the Social Security Administration determines that you are no longer disabled; or
- The person electing COBRA Continuation Coverage becomes covered under another group health plan (as an Employee or Dependent) that does not limit or exclude benefits that would otherwise be provided by this Plan.

If your COBRA Continuation Coverage ends before the end of the maximum COBRA Continuation Coverage period, the Fund Office will send you a written notice as soon as practicable after the Fund Office determines that your COBRA Continuation Coverage will end. The notice will state the reason why your COBRA Continuation Coverage will end early, the date of termination, and your rights, if any, to alternative individual or group coverage.

TRADE ACT COBRA PROVISIONS

This provision applies primarily if your employment is adversely affected by international trade. If the U.S. Department of Labor (DOL) certifies that you are eligible for benefits under the Trade Act of 2002, you may be eligible for both a new opportunity to choose COBRA Continuation Coverage and an individual Health Insurance Tax Credit. If you did not choose COBRA Continuation Coverage during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA Continuation Coverage election period beginning on the first day of the month in which you were certified. However, in no event will this benefit allow you to choose COBRA Continuation Coverage later than six months after your coverage ended under the Plan.

Also under the Trade Act, you can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. You can find more information about the Trade Act at www.doleta.gov/tradeact/. The Plan Administrator may also be able to assist you with your questions.

Life Events

Your benefits are designed to meet your needs at different stages of your life. Therefore, if you experience a life-changing event, you should notify the Fund Office within 60 days of the occurrence to help avoid gaps in your eligibility or delays in your receipt of benefits.

IF YOU MOVE

Most information about your Plan is sent to you by mail. When you buy a new home or move, it is important that you contact the Fund Office to update your address. You should provide a written, signed notice to the Fund Office indicating your address. This will help ensure you receive important benefit information in a timely manner.

IF YOU GET MARRIED

If you get married, your spouse is eligible for medical, dental and vision benefits. Once you provide any required information, coverage for your spouse begins on the date of your marriage.

If your spouse is covered under another group medical plan, you **must** report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage. This means that benefits for your spouse under this Plan will be paid after any benefits are payable from your spouse's plan.

IF YOU ADD A DEPENDENT CHILD

Your natural born child will be eligible for coverage on his or her date of birth. If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible to provide health care coverage. You may cover stepchildren under the Plan as of your date of marriage. You may also cover other children if they meet the definition of Dependent (refer to the Glossary for the definition). Once you provide any required information, coverage for your child will be effective retroactively to the date he/she became your Dependent, as defined under the Plan.

Qualified Medical Child Support Orders (QMCSOs)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for eligible Dependents, as determined by the order. A copy of the Plan's QMCSO qualification procedures is available free of charge from the Fund Office. Please notify the Fund Office if a change in your situation involves a QMCSO.

When you add a child, provide the Fund Office with:

- The birth date, effective date of adoption or placement for adoption or the date of your marriage (for stepchildren).
- A copy of the state-issued birth certificate, adoption papers, court order or marriage certificate (for stepchildren).
- A copy of your child's other medical insurance information, if your child is covered under another plan.

IF YOU LEGALLY SEPARATE OR DIVORCE

In the event of a legal separation or divorce, your ex-spouse will no longer be eligible for coverage as a Dependent under the Plan. Your stepchildren will no longer be eligible for coverage under the Plan once they no longer meet the definition of a Dependent.

If your ex-spouse was covered under the Plan and wants to continue coverage under COBRA, you or your ex-spouse must contact the Fund Office within 60 days from the date of the divorce or legal separation to request COBRA information. At that time, you may also want to review your beneficiary designation for your Death and AD&D Benefits, if eligible.

Refer to the **COBRA Continuation Coverage** section for more information about COBRA.

- If you legally separate, provide the Fund Office with a copy of the "Legal Decree."
- If you legally divorce, provide the Fund Office with a copy of the "Final Divorce Decree." Your ex-spouse may elect to continue coverage under COBRA for up to 36 months.

IF YOUR CHILD LOSES ELIGIBILITY

In general, your child is no longer eligible for coverage when he or she reaches age 26. However, if your child is not capable of self-supporting employment due to a physical or mental handicap, you may continue coverage for that child for as long as your own coverage continues and the child depends on you for financial support and maintenance.

You should notify the Fund Office at least 31 days before the date your Dependent child reaches age 26.

Your child may elect COBRA Continuation Coverage for up to 36 months after losing eligibility as an eligible Dependent. Refer to the **COBRA Continuation Coverage** section for more information about COBRA.

IF YOU TAKE FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you and your Dependents if you are eligible for and have been granted unpaid leave by your employer, pursuant to FMLA, and your employer makes the required contributions to the Fund.

FMLA Provisions

If you qualify, FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- The birth, adoption, or placement with you for adoption of a child;
- To care for a seriously ill spouse, parent or child;
- You are unable to work because of a serious illness; or
- If you have a qualifying urgent need for leave because your spouse, son, daughter or parent is on active duty in the armed services in support of a military operation.

If the need for qualifying exigency leave is foreseeable, you must provide your Employer with notice that is "reasonable and practicable."

You may also take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who is your spouse, son, daughter, parent, or next of kin. The service member must be undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a serious illness or injury incurred in the line of duty while in military service. A service member for the purposes of this leave means a member of the U.S. Armed Forces, including the National Guard or Reserves.

Spouses employed by the same employer are jointly entitled to a *combined* total of 12 weeks of family leave for the birth or placement of a child for adoption or foster care and to care for a child or parent (but not parent-in-law) that has a serious health condition.

Under some circumstances, you may take FMLA leave intermittently—which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Intermittent FMLA leave for birth or adoption or foster care placement requires your employer’s approval. FMLA leave may be taken intermittently whenever it is Medically Necessary to care for a family member’s serious health condition, or because you have a serious health condition and are unable to work.

Leave for birth or adoption (including foster care placement) must conclude within 12 months of the birth or placement.

Eligibility for FMLA

Your eligibility for FMLA leave and benefits will be determined by your employer. You are eligible for a leave under FMLA if you:

- Have worked for a Contributing Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the employer within a 75-mile radius.

When leave is needed to care for an immediate family member or your own illness, and is for planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your employer’s operation. You and your employer must certify to the Trustees, in writing, that you have been granted leave under the Family and Medical Leave Act.

Maintenance of Health Benefits

The Fund will maintain your prior eligible status until the end of the leave, provided your Contributing Employer properly grants the leave under the federal law and the Contributing Employer makes the required notification and payment to the Fund.

If you and your Contributing Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Trustees will have no direct role in resolving such a dispute. Coverage under this Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Your use of FMLA leave cannot result in the loss of benefits that you earned or were entitled to before using FMLA leave.

You will not accrue additional benefits or seniority during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Welfare benefits other than health care must be reinstated when you return to work without any new conditions or need to meet eligibility requirements.

How FMLA Works with COBRA

Taking a family or medical leave is not itself considered a COBRA qualifying event. If you return from leave within 12 weeks, there will not be a loss of coverage.

If you do not return from leave, that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks (or 26 weeks, if applicable) of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

IF YOU BECOME DISABLED

A certified disability is one for which you are receiving the Loss of Time Benefit from this Fund. If, after you become eligible, you are unable to perform covered work because of a certified disability, you will be credited, for purposes of maintaining your eligibility, with 32 Disability Hours for each full week of disability, up to a maximum of 750 hours in a 12-consecutive-month period.

Be sure to report your Medicare status to the Fund.

If you become Totally Disabled (as defined in the Glossary) while eligible and while employed by a Contributing Employer, you will continue to be eligible for all benefits (except Accidental Death and Dismemberment and Loss of Time Benefits) for up to 24 months, provided you make the appropriate self-payments to maintain your eligibility. If you are eligible for Medicare, you will be eligible for only the Medicare Supplement Benefit under the Plan, regardless of whether you have applied for Medicare Benefits.

Loss of Time Benefits

If you are out of work due to a non-work related disability, you may receive weekly Loss of Time Benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first.

For more information about **Loss of Time Benefits**, see the “Loss of Time Weekly Benefit” section.

Workers’ Compensation

If you are out of work due to a work-related disability, you may be eligible for workers’ compensation benefits. Contact your local or state workers’ compensation office. The Fund does not provide coverage for work-related disabilities.

IF YOU TAKE MILITARY LEAVE

If you are in active service with the Uniformed Services for up to 31 days, your medical coverage will be continued at no cost to you for up to 31 days. If your military service lasts more than 31 days, you may continue your coverage by making any required self-payments for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, full-time National Guard duty, inactive duty training, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

You must give advance notice of your military service to your Employer and the Fund Office, unless you are unable to do so because of military necessity, or when advance notice is impossible or unreasonable under the circumstances. Dependents do not have a separate right, as they do under COBRA Continuation Coverage, to elect Continuation Coverage under USERRA.

Uniformed services include service in the:

- United States Armed Forces;
- Army National Guard;
- Air National Guard;
- National Guard;
- Commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

Continuation Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described for COBRA in the Continuation of Coverage section, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her Dependents, and coverage may continue for up to 24 months. You also have the choice of using your reserve hours to pay for your coverage, or freezing your hour bank for use upon your return from service.

Your coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former Contributing Employer ceases to provide any group health plan to any Employee;
- You lose your rights under USERRA (for instance, for a dishonorable discharge);
- Your self-payment contribution is due and unpaid; or
- You again become covered under the Plan.

Following your discharge from service, you may be eligible to apply for reemployment with your former Contributing Employer in accordance with USERRA. Such reemployment includes your right to reinstatement in any existing health care coverage provided by the Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military services.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a Contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a Contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a Contributing Employer.

When you are discharged, if you are Hospitalized or recovering from an Illness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a Contributing Employer. The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

When you enter the uniformed services and when you return to covered employment, notify the Fund Office to ensure you receive all benefits under this Plan to which you are entitled.

If you do not elect to continue coverage under USERRA, your coverage will end 31 days after the date on which you enter active military service. Your eligible Dependents will have the opportunity to elect COBRA Continuation Coverage.

IF YOU RETIRE

If you retire, you become eligible for Retired Employee Benefits if you:

- Are receiving a pension from Social Security;
- Were eligible under this Plan immediately prior to your retirement;
- Had coverage as an Active Employee for the most recent five-year period; and
- Are not eligible for Medicare.

In order to be eligible, you must make self-payments to the Fund, the amount of which are determined by the Board of Trustees. You will need to begin making self-payments when you have used up your reserve hours bank.

Once you become eligible for Retired Employee Benefits, you cannot again be eligible for Active Employee benefits unless you resume employment and meet the initial eligibility requirements for Active Employee benefits. In no event can you be eligible for both Active Employee benefits and Retiree benefits at the same time.

Instead of Retired Employee Benefits, you may elect to continue your Active coverage by electing COBRA Continuation Coverage. However, Retired Employee Benefits will not be available to you after your COBRA Continuation Coverage ends. Refer to the **COBRA Continuation Coverage** section for more information.

Retired Employee Benefits, as well as information on the Early Retiree Benefit Plan, are described in more detail in a separate Summary Plan Description booklet.

IN THE EVENT OF YOUR DEATH

If you die while you are an Active Employee, any remaining hours in your hours bank will be converted to a dollar bank based on the contribution rate in effect at the time of death. The dollar bank may be used to pay for your Dependents' COBRA Continuation Coverage or the Fund's self-payment coverage.

Earned eligibility will continue through the end of the quarter in which you die. Your Dependents' COBRA Continuation Coverage will start at the beginning of the next quarter. As required by federal law, the appropriate COBRA notices will be sent to your qualified beneficiaries when the Fund is notified of a death.

If you are eligible for coverage on the date of your death, your beneficiary will receive a Death Benefit (and the Accidental Death and Dismemberment Benefit if the death is caused by an accident). Refer to the **Death Benefits** and **Accidental Death and Dismemberment Benefits** sections for more information.

Base Plan Benefit

Your medical coverage is a benefit you may not think about—until you need it. However, peace of mind comes in knowing that your health plan is there, offering you benefits that will pay a substantial portion of any covered medical expenses that may arise.

The Fund offers a Base Plan Benefit to you and your Dependents that provides coverage for certain preventive care. The Base Plan Benefit is administered by HealthPartners Administrators, Inc., except as specified.

HOW THE PROGRAM WORKS

Under the Base Plan Benefit, the Plan covers costs associated with certain Covered Expenses, up to any applicable calendar year maximum amount, as shown in the Schedule of Benefits. During any one calendar year, the Plan will not cover expenses that exceed the applicable calendar year maximum amounts. You will be responsible to pay any excess amounts.

The Fund also provides coverage for medical services under the Comprehensive Medical Expense Benefit.

COVERED MEDICAL EXPENSES

Each calendar year, the Plan covers 100% of the costs associated with the following services, up to any applicable calendar year maximum amount and/or Plan limitation:

- Immunizations for you and your eligible Dependents;
- Two ***routine*** physical exams (including cancer screenings) for you and your spouse, if you are married;
- One ***comprehensive*** physical exam for you and your spouse, if you are married, performed by Health Dynamics; and
- Physical exams for your Dependent children.

Refer to the Preventive Care (Physical Exam Benefit) Program for more information about Health Dynamics' comprehensive health assessment.

Comprehensive Medical Expense Benefit

Benefits are payable under the Comprehensive Medical Expense Benefit when you incur covered medical expenses as the result of an Injury or Illness that is not employment-related. The Fund does not provide coverage for work-related disabilities.

The Comprehensive Medical Expense Benefit is administered by HealthPartners Administrators, Inc.

HOW THE PLAN WORKS

Under the Comprehensive Medical Expense Benefit, the Plan covers Allowable Charges for necessary medical care and treatment ordered by a legally qualified Physician, up to the maximum benefit shown in the **Schedule of Benefits**. The decisions about how and when you receive medical care are up to you and your Physician—not the Fund. The Fund determines how much it will pay. You and your Physician must decide what medical care is best for you.

The Fund also provides coverage for certain medical services under the Base Plan Benefit.

There are program components that determine what the Plan will cover and your out-of-pocket expenses, which are explained later in this section. They include:

- A calendar year deductible;
- A coinsurance amount;
- A calendar year out-of-pocket maximum;
- A calendar year maximum; and
- Network Provider Reimbursement Arrangements.

Allowable Charges

Allowable Charges are the reasonable and customary charges for necessary medical care, services and supplies, 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 discounted rates charged by Network providers are considered reasonable and customary charges by the Plan.

Medically Necessary Services

The Plan only covers services and supplies that are Medically Necessary. In general, “Medically Necessary” means a service or supply which the Fund’s medical staff and/or an independent review panel believes:

- Is appropriate and consistent with the diagnosis in accordance with accepted standards of community practice; and
- Could not have been omitted without adversely affecting the person’s condition or the quality of medical care.

The fact that a Physician prescribes a service or supply does not automatically mean the service or supply is Medically Necessary and covered by the Plan.

Your Responsibility

It is important to remember that the medical Plan is not designed to cover every health care expense. The Plan covers Allowable Charges for Covered Expenses, up to the limits and under the conditions established under the rules of the Plan.

You are responsible for paying the following:

- A calendar year deductible;
- Any applicable coinsurance, up to the out-of-pocket maximum;
- All expenses for medical services or supplies that are not covered by the Plan;
- All charges that are not covered by the Plan or are in excess of the Plan's Allowable Charge; and
- All charges in excess of any other Plan limitations.

Calendar Year Deductible

The deductible is the amount of Covered Expenses you pay each calendar year before the Plan begins to cover Allowable Charges. The Plan has an individual deductible (per person) and a family deductible (per family) as shown in the **Schedule of Benefits**.

The **per person deductible** applies to each covered person each calendar year. However, if you have several family members covered under the Plan, the **per family deductible** will help limit the amount you and your Dependents will have to pay out-of-pocket.

The per family deductible is met once any combination of covered members of your family reach the per family deductible amount shown in the **Schedule of Benefits**. Once the per person deductible and/or per family deductible is met during a calendar year, no further deductibles are required for that year for that individual or family. Deductibles cannot be carried over from one calendar year to the next.

Here is an example of how deductibles work, assuming a per person deductible of \$400 and a per family deductible of \$1,200:

Even though no individual met the \$400 per person calendar year deductible, as a family, Covered Medical Expenses reached the family maximum of \$1,200 during the calendar year. Therefore, the Plan will begin covering any additional Covered Expenses incurred by any family member during the same calendar year.	
Individual Family Member	Covered Medical Expenses Applied to the Per Family Deductible
John	\$ 375
Mary	350
Linda	300
Joe	175
Total	\$1,200

If two or more eligible members of your family are injured in the same accident, the medical expenses covered under the Plan, which resulted from the accident, will be combined and only one deductible will apply to all expenses incurred as a result of that accident.

Coinsurance

Once you or your family meet the deductible, you and the Fund share expenses. Coinsurance, generally expressed as a percentage, is the amount you pay for covered services under the Plan after you meet the deductible, where applicable.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you or your Dependents pay out-of-pocket in a calendar year for Covered Expenses. If your coinsurance payments toward Covered Expenses reach the out-of-pocket maximum (excluding the deductible), the Plan covers 100% for most additional Covered Expenses for the rest of the calendar year, as shown in the ***Schedule of Benefits***. Your coinsurance amounts toward the out-of-pocket maximum do not include amounts you pay toward meeting your calendar year deductible.

Network Providers

The Plan provides Network Benefits and Out-of-Network Benefits from which you may choose to receive covered services. Coverage may vary according to your network or provider selection. Network Providers are Hospitals, Physicians and other health care providers that deliver a range of health care services who have entered into an agreement to provide health care services.

Please keep in mind that when you visit a Network Hospital, the Physicians and other health care providers in the Hospital may not belong to the Network.

It is your decision whether or not to use a Network provider. You always have the final say about the Physicians and Hospitals you and your family use. 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 provider will submit a claim for you.

To see what physicians and other health care providers are in your network, log onto your “myHealthPartners” 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).

COVERED MEDICAL EXPENSES

The Plan’s medical benefits pay for a wide range of services and supplies needed to treat Illness and/or Injury, including Physician charges, diagnostic testing, Hospital charges, and surgery. However, keep in mind that charges relating to Covered Expenses will be paid according to the Plan’s benefit maximums and limitations as shown in the ***Schedule of Benefits***.

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

- (a) Hospital Expenses for room and board and use of an operating room, except that the daily room and board charge may not exceed the average semi private room charge in the Hospital where the eligible person is confined. Prior authorization for Hospital admissions, including maternity admissions, is not required.

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

- (b) Expenses for diagnosis, treatment, and surgery by a Physician.

- (c) Expenses for a registered graduate nurse for private duty nursing service in a Hospital. Such expenses outside of a Hospital will only be covered under Home Health Care.
- (d) Obstetrical and gynecological services provided by a Certified Nurse Midwife (C.N.M.). The C.N.M. must be practicing under the supervision of a Physician, and services must be provided in a covered health care facility.
- (e) Routine nursery Expenses (including nursery care, circumcision and pediatric visits) incurred for a newborn Dependent child, provided the Expenses are incurred during the first seven days after birth and while the child is Hospital confined.
- (f) Back or neck rehabilitation performed at an out-of-network clinic, or one of the clinics available through the Fund's contracted network provider. Refer to the **Important Contact Information** listing for the name of the network provider and contact information. If services are provided by a contracted network provider and you meet the network provider's patient selection criteria, charges for back or neck rehabilitation are covered at 100%, and will not be subject to the calendar year deductible. This preferred benefit structure includes a Modified Roman Chair, which is part of the network provider's follow-up self-care program.
- (g) Expenses for radiology or diagnostic imaging services performed at a contracted or non-contracted facility. If diagnostic imaging services are provided at a contracted facility, the services are covered at 100%. Refer to the **Important Contact Information** listing for the name of the contracted diagnostic imaging network provider and contact information.
- (h) Expenses for annual low-dose CT scan screening for participants aged 55-80, with a 30 pack/year history, who are current smokers or who quit within the past 15 years. A 30 pack/year history means one pack per day for 30 years or two packs per day for 15 years, etc. If imaging services are provided at a contract site, the services are covered at 100%.
- (i) Expenses for e-visits /electronic diagnostic services, which can be used to treat common conditions such as bronchitis, ear infections, certain skin conditions and urinary infections. Examples of covered electronic diagnostic services include, but are not limited to Virtuwel and Zipnosis.
- (j) Expenses for treatment of mental health and substance abuse will be limited to services provided by individuals licensed as follows:
 - i. For mental health counseling: LPCC, LPC, LICSW, LMFT, LP, or summarily qualified provider.
 - ii. For medication management: MD/DO, CNS/NP.
 - iii. For substance abuse treatment: LADC or licensed therapist who can show competence in substance abuse.

The following services are also covered under the Plan:

- i. Family counseling and
- ii. Family counseling without client.

The following diagnoses are NOT covered under the Plan:

- i. Behavioral issues;
- ii. Conduct disorders;
- iii. Oppositional defiant disorders;
- iv. Developmental disorders;
- v. Testing and/or treatment for learning disabilities;
- vi. Anger management treatment;

- viii. Impulse control disorders;
 - ix. V codes found in the ICD-10; and
 - x. Sexual disorders.
- (k) Expenses for treatment of an emotionally handicapped child in a licensed residential treatment facility. Payment will be made only for Expenses incurred prior to the child's 26th birthday.
- (l) Expenses for treatment of alcoholism, chemical dependency, and drug addiction.
- (m) Expenses for treatment provided by a Home Health Care Agency according to a Home Health Care Plan. The following are covered Home Health Care Expenses:
- i. Part-time or intermittent nursing care provided by a registered nurse or a licensed practical nurse supervised by a registered nurse;
 - ii. Part-time or intermittent home health aide services which consist primarily of medical care or therapy for the patient;
 - iii. Physical, occupational or speech therapy; or
 - iv. Medical supplies, drugs and medicines, and related pharmacy and laboratory services, which are prescribed by a Physician.

The following are NOT Covered Expenses under Home Health Care:

- i. Services which consist primarily of the duties of a housekeeper, companion or sitter;
 - ii. Services and supplies not included in the Home Health Care Plan;
 - iii. Services of a person who is a family member or lives in the home of the patient; or
 - iv. Services provided outside the patient's home.
- (n) Expenses for the following:
- i. Local ambulance service;
 - ii. Appliances;
 - iii. X ray services;
 - iv. Laboratory tests;
 - v. Anesthesia and the administration thereof;
 - vi. The use of radium and radioactive isotopes;
 - vii. Oxygen, physiotherapy, and similar services, supplies and treatment;
 - viii. Rental (up to the purchase price) or purchase and repair of durable medical equipment;
 - ix. Vision training to correct amblyopia (lazy eye); and
 - x. Routine foot care.
- (o) Drugs and medicines legally obtained only upon prescription of a Physician (specifically excluding those drugs or any other form of medication that may be obtained without such a prescription, even though they may be so prescribed). The following drugs and medicines are also specifically **excluded**:
- i. Rogaine; and
 - ii. Drugs for sexual dysfunction, except for organic conditions.

Refer to **Prescription Drug Benefit** for details regarding Plan coverage for prescription drugs.

- (p) Anti-viral medication, including Tamiflu (oseltamivir) and Relenza (zanamivir) for the treatment of influenza, or the prevention of influenza in high-risk patients. High-risk patients include:
 - i. Adults and children who have chronic disorders of the pulmonary or cardiovascular system, including asthma;
 - ii. 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;
 - iii. Children and adolescents aged six months to 18 years who are receiving long-term aspirin therapy;
 - iv. A participant with any other condition that poses a serious complication if the participant contracts influenza.

Antiviral medication for any other indication is excluded.

- (q) Chiropractic treatment, except for related x-rays, laboratory work, nutritional or food supplements, or pillows, supports and similar devices.
- (r) Vasectomies and tubal ligation procedures.
- (s) Expenses for home traction devices prescribed by a Physician.
- (t) Dental services rendered by a Physician or dentist for treatment within six months of an Injury to the jaw or natural teeth, including the initial replacement of these teeth and any necessary dental x rays, provided such Injury is the result of an accident.
- (u) Expenses for LASIK eye surgery, including the examination and follow-up care, up to the lifetime maximum shown in the **Schedule of Benefits**.
- (v) Expenses for hearing aids and examinations, up to the maximum limits shown in the **Schedule of Benefits**. Replacement batteries are not covered.
- (w) Medical and surgical expenses for mastectomies as required by the Women's Health and Cancer Rights Act of 1998, including:
 - i. Reconstruction of the breast on which the mastectomy has been performed;
 - ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - iii. Prostheses; and
 - iv. Physical complications of all stages of the mastectomy, including lymphedemas.
- (x) Educational programs designed to improve patient knowledge of diabetes and techniques for self-management of diabetes.

This benefit will be paid only when ordered by a Physician and when all of the following conditions are met:

- i. The Employee submits a receipt showing the:
 - 1. name of the patient;
 - 2. cost of the program;
 - 3. name, address and telephone number of the program sponsor;
 - 4. dates and times classes were held; and
 - 5. classes actually attended by the Employee or Dependent.
 - ii. The Employee or Dependent attends 80% or more of the scheduled classes.
- (y) Expenses for an annual routine colonoscopy.

- (z) Expenses for surgical treatment of morbid obesity (such as bariatric surgery), subject to the following criteria:
 - i. Body Mass Index (BMI)^{*} of 40 or higher; or
 - ii. BMI greater than 35 in addition to any of the following co-morbidities:
 - 1. Coronary heart disease
 - 2. Type 2 Diabetes
 - 3. Clinically significant obstructive sleep apnea
 - 4. Hypertension (Blood pressure >140 systolic and/or 90 diastolic)
 - and:
 - iii. The patient has participated in a Physician-supervised nutrition and exercise program of at least six months duration, occurring within the two years prior to the surgery. Participation in the program must be documented in the medical record by an attending Physician who does not perform weight loss surgery.
 - (aa) Expenses for physician-supervised weight loss programs, such as Optifast, and special foods used in such programs. Coverage for food is subject to the same criteria as food recommended after bariatric surgery (refer to (y) above).
 - (bb) Genetic testing to establish a diagnosis of an inheritable disease, up to the lifetime maximum per condition shown in the **Schedule of Benefits**. Benefits will be subject to the annual deductible and coinsurance, and are contingent upon meeting the following criteria:
 - i. The patient displays clinical features, or is at direct risk of inheriting the genetic mutation in question;
 - ii. The result of the test will directly impact that treatment being delivered to the patient; and
 - iii. 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.
- The Plan will not:
- i. 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;
 - ii. Ask for the results of a genetic test when the claim is for the payment of a genetic test; or
 - iii. Use or disclose genetic information for underwriting purposes as defined under the terms of the Genetic Information Nondiscrimination Act (GINA).
- (cc) Nutritional counseling, designed to improve patient knowledge of Celiac Disease and techniques for self-management of Celiac Disease for patients with a documented diagnosis of Celiac Disease.
 - (dd) Medically necessary services for the treatment of Temporomandibular Joint Disorder (TMD) are payable as a medical expense benefit.

* BMI is calculated by dividing weight in pounds, divided by height in inches squared, multiplied by 704.5. BMI between 18.5 and 24.99 is considered to be within normal range.

- (ff) Room and board, daily skilled nursing and related ancillary services for post-acute treatment and rehabilitative care of an illness or injury, following a hospital confinement.
- (gg) Lasik eye surgery.

Other Covered Charges

The Plan covers the Allowable Charges or network contracted charges incurred for the following Medically Necessary services and supplies when they are recommended by the attending Physician for the treatment of an Injury or Sickness:

- (a) Inpatient and outpatient Hospital expenses, including:
 - i. Hospital room and board, up to the average semi-private room rate charged by the Hospital. (If the Hospital has no semi-private accommodations, 80% of the Hospital's minimum daily private room and board rate will be the Covered Charge.)
 - ii. 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—cutting, suturing, correction of a fracture, reduction of dislocation, electro cauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means or injection of sclerosing solution, including pre-and post-operative care. The Plan also covers up to 80% of the surgical reimbursement for anesthesia, after the deductible is met, when it is not billed as part of the Hospital charges.

MEDICAL EXPENSES NOT COVERED

You should be aware that not every medical Expense is covered by the Plan under the Comprehensive Medical Expense Benefit. For a list of Expenses not covered by the Plan, refer to the ***General Plan Exclusions and Limitations***.

Wellness and Managed Care benefits

The Fund offers several wellness programs and managed care services to you and your eligible Dependents at no additional cost.

PREVENTIVE CARE (PHYSICAL EXAM BENEFIT) PROGRAM

For Active Employees and their Spouses Only

Each calendar year, the Plan covers 100% of the cost of two **routine** physical exams (including cancer screenings) for you and your spouse, if you are married. This means there are no copays or deductibles for you to pay.

In addition, the Fund contracts with Health Dynamics so that you can receive a more **comprehensive** physical exam each calendar year, as well, free of charge. The Plan covers 100% of the cost. You do not have to pay a copay or a deductible.

The preventive care program provided by Health Dynamics includes health-screening tools designed to thoroughly assess your individual health status and health risks, and strives to achieve one basic objective: to work with you to improve your health status.

The comprehensive physical exam will include the following:

- Complete blood chemistry analysis, including glucose and cholesterol;
- Urinalysis;
- Body fat composition measurements;
- Resting blood pressure;
- Height and weight measurements;
- Pulmonary function test (lungs);
- Strength evaluation;
- Flexibility testing;
- 12 lead EKG;
- Cardiovascular fitness test—bike or treadmill;
- Physician-directed exam;
- Pap smear for women, upon request;
- Colorectal cancer screening;
- Breast screening mammography, according to American Cancer Society guidelines;
- Chest x-ray, according to American Cancer Society guidelines;
- PSA test for prostate cancer, according to American Cancer Society guidelines; and
- One-hour wellness coaching/consultation session.

To schedule an appointment, contact Health Dynamics at the phone number shown on the **Important Contact Information** listing. When you call, it is important that you tell the receptionist that you want to schedule your physical exam and that you are a participant in the Minnesota Cement Masons Health and Welfare Fund. The receptionist will ask you for information, including your (or your spouse's) name, address, email, telephone number, date of birth and Social Security number or unique identifying number, as well as the Fund's name.

Once the physical exam is scheduled, a questionnaire and additional information will be mailed to you. Please fill out the questionnaire before your appointment and bring it with you on the day of your exam. You can expect your exam to last from two to three hours.

After your physical exam, you will be provided with a confidential individual report that will contain your health risk scores, explanations of how your scores were derived, recommendations for improvement, and educational material based on your specific needs. The information that is obtained through the physical exam will be retained by Health Dynamics, but treated as confidential.

You will also be scheduled for a wellness coaching consultation session to take place a few weeks after your physical exam. You (and your spouse, if applicable) will each receive a confidential individual report booklet at the personal consultation session and a Health Dynamics health educator will review the results and discuss with you the ways in which you can improve your health and fitness levels to achieve better results the following year. All follow-up work will be provided by your Physician and billed directly to the Fund.

The Fund contracts with Health Dynamics to provide comprehensive physical exam services at no cost to the participant. The Fund covers these services at 100%, with no deductible or co-payment. The preventive care program provided by Health Dynamics includes health-screening tools designed to thoroughly assess participants' individual health status and health risks, and strives to work with participants to improve their health status.

The Board of Trustees is committed to promoting wellness services in the Minnesota Cement Masons Health and Welfare Fund. In order to incent participants to use the Health Dynamics program, participants will receive a \$100 gift card upon completion of their initial Health Dynamics physical, and a second \$100 gift card upon completion of their first follow up Health Dynamics physical (usually performed one year following the first consultation). Health Dynamics will issue the gift cards once they have certified that the participant has completed their program.

For more information about the preventive care program, refer to the Health Dynamics website via the site address shown on the ***Important Contact Information*** listing.

EMPLOYEE ASSISTANCE PROGRAM

The Plan has an Employee Assistant Program (EAP), which is designed to help participants resolve different types of personal concerns, including:

- Stress;
- Legal Issues;
- Relationship Difficulties;
- Job-related Matters;
- Chemical Abuse;
- Depression;
- Anger Management;
- Financial Needs; and
- Parenting Issues.

The Plan will cover services in the same manner as any other Illness. All treatment must be clinically appropriate, as determined by the EAP.

When you call the EAP with an issue, a caseworker will help you directly or, if it is deemed necessary, refer you to the appropriate professional in the EAP network. Sessions with an EAP staff member are provided at no cost to you and are completely confidential.

For more information about the EAP, refer to the ***Important Contact Information*** listing.

Mental Health and Substance Abuse Case Management

Treatment for mental health and substance abuse is covered under the Plan's Comprehensive Medical Expense Benefit. Certain limitations apply, as shown under the **Covered Medical Expenses** section. The Fund strongly encourages you and your Dependents to contact the EAP before starting any mental health or substance abuse treatment. The EAP can refer you to the health care provider or facility best suited to your individual treatment needs.

For more information about the EAP, refer to the **Important Contact Information** listing.

TOBACCO CESSATION SERVICES

The Plan covers 100% of the costs associated with any over-the-counter tobacco cessation aid you purchase, including, but not limited to, transdermal patches and nicotine gum and lozenges. Coverage will not be subject to the deductible. You must pay for these aids and submit receipts to HealthPartners for reimbursement.

You can use HealthPartners' Partners in Quitting tobacco cessation program by calling 952-883-7800 or 800-311-1052. A telephone program coach will work with you to create a customized plan to help you stop smoking. You will also receive tips to help you stay on track.

FREQUENT FITNESS PROGRAM

HealthPartners' Frequent Fitness Program provides up to two \$20 credits per household for the employee and a dependent that is 18 years old or older toward your monthly dues when you and/or you dependent work out at least eight days per month at any participating fitness center. Present your medical ID card when you enroll at a participating fitness center. You are responsible for paying any enrollment fees and your monthly membership fee. However, most participating clubs offer the program members a discount on their enrollment fees. To find participating fitness centers contact HealthPartners Member Services at 952-883-5000 or 800-883-2177 or visit www.healthpartners.com.

Prescription Drug Benefit

To help you and your Dependents meet your prescription drug needs, the Plan covers the cost associated with your medications if they are legally obtained and prescribed by a Physician or dentist. How the Program Work

The Fund has contracted with a Pharmacy Benefit Manager (PBM), which offers 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 shown in the ***Schedule of Benefits***.

When you have your prescriptions filled at a retail pharmacy that participates in the network or at the PBM's mail order facility, your prescriptions will be filled at discounted rates. The discounts offer a savings opportunity for you and the Fund. You pay less for your medications because your coinsurance amount, if any, is based on a lower negotiated prescription drug price instead of a higher full price.

When you need a medication for a short time—an antibiotic for example—it is best to have it filled at a retail pharmacy. If you are taking a medication on a long-term basis (a maintenance medication), it is usually best to have it filled through mail order. Maintenance medications include those used to treat chronic illnesses such as arthritis, diabetes, depression, heart disorders, high blood pressure and ulcers.

The PBM's network includes regional and national retail pharmacy chains, as well as community independent locations. To find a pharmacy near you, log on to the PBM's website and access the online Pharmacy Locator. The tool enables you to search for local pharmacies and print a map with driving directions. Refer to the ***Important Contact Information*** listing for the PBM's website address.

Generic Equivalents and Brand Name Medications

Many prescription medications have more than one name: a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

In general, use of generic medications can be a significant source of savings for you and the Fund. Typically, generic medications cost less than brand name medications. Since your retail pharmacy copayment is a percentage of the cost of your medication, you can save money by taking generic medications because you will be paying a percentage of a smaller amount. The Plan covers 100% of the discounted cost of generic medications when they are purchased through mail order.

When you or your Dependent needs a prescription, you should ask your Physician whether a generic medication can be substituted for a brand name medication. Your pharmacist can also assist you in substituting generic medications when appropriate.

The Retail Pharmacy (Drug Card) Program

The retail pharmacy program is designed to handle your short-term prescriptions needs. You can only obtain up to a 30-day supply of a particular medication at one time. The Prescription Drug Retail Program is administered by Catamaran.

When you go to a participating network retail pharmacy, you need to show the pharmacist your prescription drug card and pay your coinsurance amount for each medication purchased. You do not have to file a claim. Your coinsurance amount will depend on whether a brand name or generic medication is dispensed, as shown in the ***Schedule of Benefits***. When you purchase your medication at a participating network retail pharmacy, the medication will be available at a discounted price, thereby reducing your out-of-pocket costs.

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** listing 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.

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. You will not be required to pay any coinsurance when you purchase generic medications through the mail order, as shown in the **Schedule of Benefits**. The Plan will cover 100% of the discounted cost.

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions: a short-term supply, which you can have filled right away and a 90-day supply for the mail order program.

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** listing, 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.

Prior Authorization

Certain prescription drugs will require Prior Authorization in order to be covered.

If a drug requires prior authorization, your pharmacist will let you know when you pick up your prescription. Contact the Plan's pharmacy benefits manager for a list of drugs for which prior authorization is required.

If you were using a drug on the prior authorization list prior to September 15, 2015, no prior authorization is required. If you are filling a new prescription with one of these drugs on or after September 15, 2015, please have your physician contact the pharmacy benefits manager to initiate the prior authorization process.

COVERED PRESCRIPTION DRUG EXPENSES

Under the Prescription Drug Program, 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.

All medications must be dispensed by a licensed pharmacist in order to be covered. In addition:

- If you need help to quit smoking, prescription medications, including, but not limited to Wellbutrin, Chantix and Bupropion are covered under the Prescription Drug Benefit; and

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***.

MEDICARE PRESCRIPTION DRUG COVERAGE

If you are eligible for Medicare but you are still working, 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.

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 Minnesota Cement Masons Health and Welfare Fund 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.

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.

Dental Benefit

Your Dental Benefits help cover the cost of dental services for you and your Dependents.

The Dental Benefit is administered by Delta Dental.

HOW THE PROGRAM WORKS

The Fund has contracted with a dental PPO provider, which offers access to a network of dental professionals that offer discounted rates for their services.

When you receive preventive care services from a dentist who participates in the dental PPO network, you do not pay any coinsurance. In addition, the Plan shares in paying the costs associated with other covered dental Expenses, to the extent that they are reasonable and customary, up to the maximum amounts shown in the **Schedule of Benefits**.

You can seek care from any dentist. However, the Plan will cover 100% of the costs associated with preventive dental care when you receive services from a dental PPO provider.

When you seek care from a PPO network dentist, the provider should file a claim for you. When you use a non-network dentist, you will need to send your receipts to the Fund Office for reimbursement. Call the dental PPO network provider or visit its website to locate a network dentist in your area. Refer to the **Important Contact Information** listing for information.

Calendar Year Maximum

All payments made under the Dental Benefit are limited to the calendar year maximum shown in the **Schedule of Benefits**. The maximum benefit applies to you and each of your eligible Dependents separately.

Coinsurance

The Plan covers a percentage (also called “coinsurance”) of your dental Covered Expenses. The amount the Plan covers depends on the type of dental service you receive and/or whether such service is rendered by a dental PPO network provider, as shown in the **Schedule of Benefits**. Your coinsurance payment is the remaining percentage of Covered Expenses.

COVERED DENTAL EXPENSES

Covered dental Expenses are those charges for services, supplies and treatment performed or supplied by a legally qualified dentist for oral examinations, treatment of accidentally injured or diseased teeth, or treatment of supporting bone or tissue.

The services, supplies and treatment must be reasonably necessary and must not be unreasonably priced or of a luxury nature, as determined by the charges generally incurred for cases of a comparable nature and severity in the particular geographical area concerned. Covered dental Expenses are incurred on the date the dental service is performed.

Covered Expenses include the reasonable and customary charges for the following dental services:

- (a) Two oral examinations per calendar year, including scaling and cleaning of teeth;
- (b) Topical application of sodium or stannous fluoride, once in each period of 12 consecutive months, but only if the covered family member has not yet reached age 16;
- (c) Application of dental sealants, but only if the covered family member has not yet reached age 16;
- (d) Dental x-rays;
- (e) Extractions;

- (f) Oral surgery, including excision of impacted teeth;
- (g) Fillings;
- (h) General anesthetics administered in connection with oral surgery or other covered dental services;
- (i) Injections of antibiotic drugs by the attending dentist;
- (j) Drugs for treatment of dental disease, which can be dispensed by a licensed pharmacist only upon a prescription by a legally qualified dentist or Physician operating within the scope of his or her license;
- (k) Space maintainers;
- (l) Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- (m) Endodontic treatment, including root canal therapy;
- (n) The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework, provided that such installation is required as a result of the extraction, of one or more natural teeth, accidentally injured or diseased, and that such denture or bridgework includes the replacement of teeth so extracted;
- (o) The replacement or alteration of full or partial dentures, or fixed bridgework, which is necessary because of:
 - i. Oral surgery resulting from an accident; or
 - ii. Oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue;
 but only if the replacement or alteration is completed within 12 months after such surgery;
- (p) The replacement of a full denture, which is necessary because of:
 - i. Structural change within the mouth, but only if more than five years has elapsed since the initial placement;
 - ii. The initial payment of an opposing full denture, but only after you or your Dependent have been eligible under this provision for at least two years; or
 - iii. The prior installation of a temporary denture, but only within 12 months of the installation of the temporary;
- (q) Replacement of or addition of teeth to an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if:
 - i. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this provision and after the existing denture or bridgework was installed; or
 - ii. 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;
- (r) The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement;
- (s) Inlays, gold fillings, crowns, including precision attachments for dentures;
- (t) Repairs or recementing of crowns, inlays, bridgework or dentures, or relining of dentures;
- (u) Orthodontia treatment for Dependent children up to age 19; and
- (v) Implants.

DENTAL EXPENSES NOT COVERED

The Plan does not cover:

- (a) Treatment on or to the teeth or gums for cosmetic purposes (including realignment of teeth), except for orthodontia;
- (b) Expense incurred after termination of eligibility, except for prosthetic devices which were fitted and ordered prior to termination and which were delivered to you or your Dependent within 30 days after the date of termination;
- (c) Rebase or reline of dentures in 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 a preceding placement, except as provided in (n), (o) and (p) listed as Covered Dental Expenses;
- (f) Treatment of temporomandibular joint disorders (TMJ), other than splints; and
- (g) Any of the exclusions and limitations outlined in the ***General Plan Exclusions and Limitations***.

VSP Vision Benefit

The Fund has contracted with Vision Services Plan (VSP) to administer its vision benefits. VSP's discounts on vision examinations, frames and lenses will enable the Fund to provide higher benefits at no additional cost.

Covered every calendar year – no copayment:

- Vision examination
- Contact Lens fitting and evaluation
- One set of lenses – single vision, lined bifocal, lined trifocal or lenticular
- Contact lenses in lieu of eyeglasses benefit (\$150 allowance per calendar year)

Covered every other calendar year:

- Eye glass frames - \$150 allowance, then 20% off amount in excess of allowance.

PARTICIPANTS WHO WISH TO USE VISION PROVIDERS OUTSIDE THE VSP NETWORK WILL CONTINUE TO HAVE A CALENDAR YEAR BENEFIT OF \$300 EVERY TWO CALENDAR YEARS (2015-2016, 2017-2018, ETC...).

The allowance you receive can be used to pay for the following Covered Expenses:

- (a) Professional eye examinations by an ophthalmologist (M.D.) or a licensed optometrist;
- (b) Lenses prescribed by an ophthalmologist (M.D.) or a licensed optometrist; and
- (c) Frames.

Coverage for LASIK Eye Surgery is provided under the Plan's Comprehensive Medical Expense Benefit. Refer to the *Schedule of Benefits* for details.

VISION EXPENSES NOT COVERED

In addition to the exclusions and limitations outlined in the **General Plan Exclusions and Limitations**, the following expenses are not covered under the Plan's Vision Benefit:

- (a) Routine yearly examinations required by an employer in connection with the occupation of the eligible person; and
- (b) Surgical procedures on the eyes, including pre- and post-surgical treatment.

Death Benefit

The Death Benefit is designed to help protect your family against the sudden loss of your income in the event of your death, even if the cause of your death is work-related.

HOW THE PROGRAM WORKS

The amount of your Death Benefit is shown in the **Schedule of Benefits** and is paid directly from the Fund. For your Death Benefit to be paid, written notice of your death, along with a copy of your death certificate, must be received by the Fund Office within 12 months after your date of death. Upon receipt, benefits will be paid to your beneficiary(ies).

In the event of your death, your beneficiary should contact the Fund Office.

Your beneficiary or beneficiaries may request one of the following forms of payment by notifying the Fund Office:

- (a) A lump sum;
- (b) A series of monthly installments; or
- (c) A partial lump sum with the balance in a series of monthly installments.

If there is no specified form of payment, payment is made in a lump sum.

Your Responsibility/Designating a Beneficiary

You must inform the Fund Office of the name of the individual(s) that you designate as your beneficiary.

You may designate anyone you wish as your beneficiary for the Death Benefit (and for the death portion of the Accidental Death and Dismemberment Benefit). To change or designate a beneficiary, you need to file a form with the Fund Office.

You can change your beneficiary at any time, without the consent of your previous beneficiary. The designation will take effect, after the Fund Office receives your completed and signed form, as of the date you signed the form, provided the Fund Office receives it prior to your death.

If you name more than one beneficiary and you do not identify how much each beneficiary receives, the beneficiaries will share the benefit equally. If you do not designate a beneficiary, your Death Benefit (and Accidental Death and Dismemberment Benefit, if applicable) will be paid as follows:

- (a) To your surviving spouse; or if none,
- (b) To your surviving children in equal shares; or if none,
- (c) To your surviving parent(s) in equal shares; or if none,
- (d) To your estate.

DEPENDENT SPOUSE BENEFIT

The Fund will pay you a benefit in the event your Dependent spouse dies while covered under this benefit. Your spouse may only be covered while you are covered under the Death Benefit. The amount of coverage is shown in the **Schedule of Benefits**. The Dependent spouse Death benefit is not assignable.

Accidental Death and Dismemberment Benefit

In addition to the Death Benefit, the Plan also provides an Accidental Death and Dismemberment Benefit. This benefit is payable if you lose your life, limb(s) or sight in one or both eyes.

HOW THE PROGRAM WORKS

If you suffer any of the following losses within 90 days of an accident that occurs while you are eligible for coverage (on or off the job), you will be eligible for the amount shown the **Schedule of Benefits**, in addition to any other benefits payable under the Plan:

The total paid for all injuries from any one accident will not exceed the principal sum.

Type of Loss	Benefit
Life	\$1,500 (Principal Sum)
Both hands	\$1,500 (Principal Sum)
Both feet	\$1,500 (Principal Sum)
Loss of sight in both eyes	\$1,500 (Principal Sum)
One hand and one foot	\$1,500 (Principal Sum)
One eye and one foot	\$1,500 (Principal Sum)
One hand	\$750 (One half of the Principal Sum)
One foot	\$750 (One half of the Principal Sum)
Loss of sight in one eye	\$750 (One half of the Principal Sum)

Benefits are paid directly to you for an Injury or to your beneficiary in the event of your death (refer to the Death Benefit section for information about **Designating a Beneficiary**). The Accidental Death and Dismemberment Benefit is in addition to the Death Benefit.

COVERED AD&D BENEFITS

Benefits will be paid for any losses shown in the prior table, which:

- (a) Result solely from accidental Injury;
- (b) Occur while your coverage under this Accidental Death and Dismemberment Benefit is in force; and
- (c) Occur within 90 days from the day of the accident.

EXPENSES NOT COVERED

Benefits are not paid for the following:

- (a) Bodily or mental infirmity, disease, hernia or bacterial infections, except infections caused by pyogenic organisms that occur with and through an accidental cut or wound; or
- (b) Medical or surgical treatment, except loss from surgery performed solely due to, and within 90 days of, a covered accidental Injury.

Loss of Time Weekly Benefit

The Plan provides a Loss of Time Weekly Benefit in the event you cannot work because of a non-work related Injury or Illness. The amount of the Loss of Time Weekly Benefit is shown in the **Schedule of Benefits**.

HOW THE PROGRAM WORKS

Benefits will be payable if you, while eligible, become Totally Disabled because of:

- Any Injury not arising out of or in the course of your employment; or
- Any Illness not entitling you to benefits under any workers' compensation or occupational disease law.

You must be under the regular care of a legally qualified Physician who is a licensed Medical Doctor (M.D.) in order to receive benefits.

Benefits will begin on the 8th day of disability due to Injury or Illness.

The weekly benefit and maximum number of weeks payable, both of which are shown in the **Schedule of Benefits**, are payable during each continuous period of disability due to one or more causes.

Two or more periods of disability are considered one unless you have returned to active full-time work for at least two weeks between periods of disability; or unless you have returned to active full-time work for at least one full working day and the second period of disability is due to causes entirely unrelated to the prior disability.

It is not necessary that you be confined to your home to collect benefits, but you must be under the regular care of a legally qualified Physician who is a licensed Medical Doctor (M.D.). No disability will be considered as beginning more than three days prior to the first visit of a Physician.

The law imposes FICA Tax (Social Security Tax) on certain weekly loss of time benefits. Any applicable FICA tax will be paid by the Fund. The actual amount of the Loss of Time Weekly benefit to you is shown in the **Schedule of Benefits**. At year-end, you will receive a Form 1099 from the Fund that shows the amounts paid and withheld. If you have questions about including your benefits in your gross income or about exclusions in the law, you should consult your tax advisor or legal counsel.

LOSS OF TIME WEEKLY BENEFIT LIMITATIONS

Loss of Time Weekly Benefits will not be payable if you are not employed by a Contributing Employer on the beginning date of eligibility. In addition, you cannot collect Loss of Time Weekly Benefits while you are collecting unemployment benefits.

General Plan Exclusions and Limitations

The Plan does not cover any health benefits (including the Loss of Time Weekly Benefit) for:

- (a) Any Injury, Illness, or dental treatment which arises out of or occurs in the course of any occupation or employment for wage or profit, and/or for which the covered individual has received, or is reasonably entitled to receive, benefits under a workers' compensation or occupational disease law.
- (b) Any Expense incurred after your eligibility ends.
- (c) Injury or Illness, which arises out of declared or undeclared war, or any act thereof.
- (d) Any Expense, which is incurred while you or your Dependent is on active duty or training in the armed forces, national guard or reserves of any state or country, and for which any governmental body and its agencies are liable.
- (e) Treatment or surgical procedures of an elective nature (including elective abortions), or any non-emergency plastic or cosmetic surgery on the body, including, but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue.

Exception: This exclusion will not apply to:

- i. 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;
 - ii. The correction of congenital defects;
 - iii. Corrective surgical procedures on organs of the body, which perform or function improperly;
 - iv. Vasectomies and tubal ligation procedures;
 - v. Surgery and other treatment as required by the Women's Health and Cancer Rights Act of 1998; or
 - vi. Complications of abortion.
- (f) Dental treatment, except dental treatment made necessary by an Injury to sound natural teeth, and except as specifically provided under the Dental Benefit.
 - (g) Dental services with respect to congenital malformations, cosmetic surgery, or dentistry purely cosmetic in nature.
 - (h) Expenses for eye exercises or vision training, except to correct amblyopia (lazy eye).
 - (i) Eye refractions, eyeglasses and their fitting, except as specifically provided for in the Vision Care Benefit.
 - (j) Hearing aids, except as specifically shown in the **Schedule of Benefits**.
 - (k) Expenses incurred for well child exams, except for eligible newborns while in the Hospital immediately following their birth.
 - (l) Medical examinations for "check-up" purposes, except as specifically provided under the Immunization Benefit, the Physical Exam Benefit or the Child Physical Exam Benefit as shown in the **Schedule of Benefits**.
 - (m) 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. Exceptions to this exclusion include:
 - i. The Veterans Administration, when services are provided to a veteran for a disability which is not service connected;

- ii. A military Hospital or facility, when services are provided to a retiree (or Dependent of a retiree) from the armed services;
 - iii. A group health plan established by a government for its own civilian Employees and their Dependents.
- (n) 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. Investigational or experimental in nature.
- (o) 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.
- (p) Long-term care;
- (q) 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.
- (r) Transportation, except local ambulance services used for emergency services only.
- (s) Hypnosis or biofeedback.
- (t) Educational services or materials and nutritional counseling or nutritional supplements, including vitamins, even if prescribed by a Physician, except as specifically provided under the Diabetes Education Benefit and Celiac Disease Nutrition Counseling as shown in the **Schedule of Benefits**.
- (u) LASIK, radial keratotomy or other surgery to correct refractive errors and related charges, except as provided under the LASIK Eye Surgery Benefit as shown in the **Schedule of Benefits**.
- (v) Reversal of cosmetic surgery and related charges.
- (w) Sterilization reversals and related charges or charges from complication of a reversal.
- (x) Infertility treatment; drugs or procedures attempting to promote artificially assisted conception, including, but not limited to, in-vitro fertilization, gamete intrafallopian transfer, artificial insemination, and related charges.
- (y) Any loss, expense or charge for sex transformation or complications, or any treatment related to non-organic sexual dysfunction.
- (z) Supplies or equipment other than 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, and home lifts.
- (aa) Wigs, with the exception of one wig per year following chemotherapy or radiation treatment.
- (bb) Charges incurred for Custodial Care or any care that is designed primarily to assist an individual in meeting the activities of daily living.
- (cc) Charges incurred for confinement and services at a halfway house or group home.
- (dd) Charges that the eligible person is not required to pay, including those that would not have been made if this Plan did not exist.
- (ee) Hospital charges incurred in connection with dental treatment.
- (ff) 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.
- (gg) Court-ordered treatment or confinement of any kind, except as shown as a Covered Expense for the treatment of mental and nervous disorders under the **Comprehensive Medical Expense Benefit**.
- (hh) 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 Illness unless the charges are specifically identified as being Covered Expenses under the Plan.

- (ii) Physical, or Occupational therapy if the prognosis or history of the individual receiving the treatment or therapy does not indicate a reasonable chance of improvement; physical and occupational therapy for the treatment of behavioral disorders or developmental delays.
- (jj) Speech therapy services, except services provided to an individual who has lost existing speech function due to an Illness or Injury. Speech therapy that is educational in nature or for the treatment of developmental delays is excluded.
- (kk) Mental and Nervous treatment/counseling for oppositional or behavioral disorders;
- (ll) Marriage counseling.
- (mm) Special home construction and automobile modification.
- (nn) Any treatment or service not prescribed by a Physician, or not recommended or approved by the attending Physician.
- (oo) 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.
- (pp) 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.
- (qq) Any loss, expense, or charge arising out of 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.
- (rr) 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.
- (ss) Any loss, expense or charge arising from the maintenance or use of an automobile in non-no fault states 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.
- (tt) Any loss, expense or charge arising in connection with an Injury or Illness caused by or contributed to by:
 - i. Engaging in an illegal act or occupation, except that an Injury or Illness that is the result of participation in an act of domestic violence will be covered by the Plan; or
 - ii. Committing or attempting to commit any crime, criminal act, or felonious act, except that an Injury or Illness that is the result of participation in an act of domestic violence will be covered by the Plan. The lack of a conviction or issuance of a citation by a law enforcement body is not conclusive as to whether or not the charges for services were caused by or contributed to by engaging in an illegal act.

- (uu) Any loss, expense or charge for any Injury or Illness that results from an event occurring on any property where a lessee or 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.
- (vv) Acupuncture.
- (ww) Massage therapy, except as provided by a licensed Physical Therapist.
- (xx) Shipping charges and sales tax, with the exception of Minncare tax which is paid as an Allowable Charge.
- (yy) Medical-related services provided by a school district (e.g., physical therapy, speech therapy, aides, etc.).
- (zz) Magnetic devices or magnet therapy.
- (aaa) Allergy food drops, sublingual drops or oral immunotherapy.
- (bbb) Dental treatment, including but not limited to dental implants and orthodontics, except as shown in the Dental Expense Benefit.
- (ccc) Chelation therapy, except in documented cases of heavy metal poisoning.
- (ddd) Non-emergency care when traveling outside of the United States.

Claims and Appeals

This section describes the procedures for filing claims for benefits from the Fund. 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 decision.

When Claims Must Be Filed

If you use the services of a medical, prescription drug, or dental network provider, the provider will generally file your claim for you. However, if your provider does not submit your claim for you, or if you receive services from a non-network provider, it is then your responsibility to file the claim.

You must file your claim for benefits as soon as possible following the date you incurred the charges. If you fail to file your claim within the time required, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, in that case, you must submit your claim as soon as reasonably possible and in no event later than 24 months from the date you incurred the charges. The Board of Trustees will determine whether you have proved good cause for filing a late claim.

How to File a Claim (Medical, Rx, Dental, Vision)

Generally, when you file a claim, you have already received the services in your claim. In order to file a claim for benefits, you must submit a completed claim form. Inquiries or phone calls about the Fund's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits.

If you or an eligible Dependent has coverage under more than one health care plan, benefits are coordinated (refer to the Coordination of Benefits section for details).

A claim form may be obtained from the Fund Office by calling 651-256-1804. Also, contact the Fund Office about how to file a claim for Life Insurance and Accidental Death and Dismemberment benefits.

The following information must be completed in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim:

- Participant name;
- Patient name;
- Patient Date of Birth;
- Social Security Number of participant or retiree, or the alternate ID number from the participant's or retiree's ID card;
- Date of Service;
- CPT-4 (the code for Physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to an accident, provide details of the accident and subrogation-related materials.

You should also have your Physician either complete the Attending Physician's Statement section of the claim form, submit a completed CMS health insurance claim form, or submit an HIPAA-compliant electronic claims submission.

Also, attach all itemized Hospital bills or doctor's statements that describe the services rendered.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any medical or Hospital services covered by the Fund to the Fund Office as soon as you receive them.

Where Claims Must Be Filed

Your claim is considered to be filed as soon as it is received at the Fund Office. You should file your claims with the Fund at the following address:

Medical Benefit Claims Claims:

HealthPartners, Inc.
P.O. Box 1289
Minneapolis, MN 55440-1289

All Other Claims:

Minnesota Cement Masons Health and Welfare Fund
c/o Zenith American Solutions
2520 Pilot Knob Road, Suite 325
Mendota Heights, Minnesota 55120

Time of Payment of Claims

Claims payable for any loss other than for the Loss of Time Weekly Benefit will be paid as they accrue upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued claims for loss of time benefits will be paid at the expiration of each two-week period, and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Facility of Payment of Claims

Certain accrued claims unpaid at the time of your death may, at the option of the Trustees, be paid either to your beneficiary or to your estate.

If any claim is payable to your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Trustees may pay the claim to any relative connected to you or the beneficiary by blood or marriage, who the Trustees deem is equitably entitled. Any payment made by the Trustees in good faith according to this provision will fully discharge the Trustees to the extent of the payment.

Any claims for Hospital, nursing, medical or surgical service may, at the Trustees option, be paid directly to the Hospital or person rendering such services.

Physical Examinations and Autopsy

The Board of Trustees, at its own expense, has the right to examine any individual whose Injury or Illness is the basis of a claim and to make an autopsy in case of death where it is not forbidden by law.

In case of an emergency, have the Hospital or a relative call the Fund Office as soon as possible. The person who calls should be able to provide your or your Dependent's:

- Name and address;
- Social Security Number; and
- Group Number or Name.

Discretionary Authority of the Plan Administrator

In carrying out their respective responsibilities under the Fund, the Administrator and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund have been delegated, have discretionary authority to interpret the terms of the Fund and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect and will be accorded judicial deference in any subsequent administrative proceeding or lawsuit, unless it can be shown that the interpretation or determination was arbitrary and capricious.

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 have previously 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. A health care professional with knowledge of your medical condition may act as an authorized representative in connection without your having to complete the special authorization form.

Assignment of Benefits

You may not anticipate, alienate, sell, transfer, pledge, assign or otherwise encumber any interest in benefits to which you may become entitled under the Fund. However, the Trustees may honor your assignment of benefits to the provider of covered services.

Neither you nor your beneficiary may transfer or assign any Life Insurance benefit payments in anticipation of receiving them.

Claim Decisions

Ordinarily, you will be notified of the decision on your claim within 30 days from the Fund's receipt of the claim. This period may be extended one time by the Fund for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

If an extension is required because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on a medical claim and notify you of the determination.

Loss of Time Weekly Claims

For Loss of Time Weekly claims, the Fund will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond the Fund's control, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

Life and Accidental Death and Dismemberment Claims

The Fund Office will make a decision on your Life Insurance or Accidental Death and Dismemberment insurance claims and notify you or your beneficiary of the decision within 60 days from the date the claim is received. If the Fund requires an extension of time due to matters beyond its control, the Fund may extend the time for making a decision by 30 days. The Fund Office will notify you within the 60-day period of the reason for the delay and the time when the decision will be made.

Notice of Denial of Claim or Adverse Benefit Determination

The Trustees must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. The notice must provide you with the following information:

- The specific reason or reasons for the denial of benefits or other adverse benefit determination;
- A specific reference to the pertinent provisions of the Plan upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- A copy of the Fund's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
- A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;
- A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for medical and Loss of Time Weekly claims that are denied due to:
 - Medical necessity;
 - Experimental treatment; or
 - Similar exclusion or limit.

Your Right to Request a Review of a Denied Claim

You have the right to a full and fair review by the Board of Trustees if your claim for benefits is denied. For Life Insurance and Accidental Death and Dismemberment claims, you must make your request for review of an adverse benefit determination within 60 days after you receive notice of the denial. For all other claims, you must make your request within 180 days after you receive notice of denial. Please submit your request for review to the following:

Medical Benefit Claims Benefit Claims:

Minnesota Cement Masons Health and Welfare 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 Cement Masons Health and Welfare Fund
c/o Zenith American Solutions
2520 Pilot Knob Road, Suite 325
Mendota Heights, Minnesota 55120

Your application for review must be in writing, and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

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

- It was relied upon by the Fund in making the decision;
- It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- It constitutes a statement of Fund policy regarding the denied treatment or service.

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

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Ordinarily, decisions on appeals involving medical claims, disability or life insurance will be made by the Board of Trustees at their next regularly scheduled meeting 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 such an extension is necessary.

Once a decision on your claim has been reached by the Board of Trustees, you will be notified of the decision as soon as possible, but no later than five days after the meeting during which the decision was reached.

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:

- The specific reason(s) for the determination.
- Reference to the specific Fund provision(s) on which the determination is based.
- 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.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Fund, you will 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 or investigational, or other similar exclusion, you will 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.

Timing of Notice of Decision on Appeal

Ordinarily, decisions on claims on appeal (non-disability and disability claims) will be made at the next regularly scheduled meeting of the Board of Trustees or Appeal Committee of the Board of Trustees after receiving your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting after receiving your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary.

You will be advised in writing in advance if an extension will be necessary. You will be advised of the specific reason for the delay and the timing of the expected decision on the claim.

Once a decision on the review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Legal Actions

You may not start a lawsuit to obtain benefits until after you have exhausted your remedies by requesting both a review by the Fund Office and an appeal to the Board of Trustees, and a final decision has been reached; or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. Any lawsuit based on the denial of your appeal by the Fund's Board of Trustees will be governed by the applicable statute of limitations.

Coordination of Benefits

If you or a Dependent are entitled to benefits under any other plan (as defined below) that will pay part or all of the Expenses you and/or your Dependents incur for treatment of an Illness or Injury, the Plan will coordinate the amount of benefits payable with the other plan(s) so that the aggregate amount paid will not exceed 100% of the Expense incurred.

In no event will the amount of benefits paid under the Plan exceed the amount that would have been paid if there were no other plan involved.

The term plan includes any plan providing benefits or services as provided by:

- Group blanket or franchise insurance coverage;
- Blue Cross, Blue Shield and other prepayment coverage provided on a group basis;
- Group or individual automobile No-Fault coverage;
- Any coverage under labor management trustee plans, union welfare plans, employer organization plans or employee benefits organization plans or any other arrangement of benefits for individuals of a group;
- Any coverage under governmental programs, and any coverage required or provided by any statute including but not limited to a Special Needs Trust or Supplemental Needs Trust; and
- The net recovery amount awarded by jury verdict, court order or settlement attributable to the accident, Injury, or Illness.

If a person is covered by this Plan and by one or more other plans, the first of the following rules that applies will determine the order of payment. In these rules, the plan that pays first does so without regard to coverage under other plans.

- A plan, which does not provide for coordination of benefits, will pay its benefits first.
- A plan, which covers a person as an Employee or non-Dependent, will pay its benefits before the plan that covers the person as a Dependent.
- A plan, which covers a person as an Active Employee, or as a Dependent of such person, will pay its benefits before the plan that covers the person as a laid-off or retired person or as a Dependent of such person. This item will not apply if the other plan does not have a coordination of benefits provision regarding laid-off or retired persons.
- When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year, regardless of the year of birth, will pay first. However, if the other plan's coordination of benefits provisions do not use the parents' birthdays to determine which of the parents' plans pay first, the other plan's rules will determine the order of benefit payment.
- If a Dependent child's parents are divorced or separated, then the following rules apply:
 - A plan, which covers a child as a Dependent of a parent who by court decree must provide health coverage, will pay first. If a parent is ordered by the court to provide health benefits and does not, this plan will pay no benefits.
 - When there is no court decree, which requires one parent to provide health coverage to Dependent children, the following rules will apply:
 - If the parent who has custody of the child has not remarried, the custodial parent's plan will pay first.
 - If the parent who has custody of the child has remarried, then benefits will be determined by the custodial parent's plan first, by the custodial stepparent's plan second and by the plan of the non-custodial parent third.
 - With respect to any Participant in the Plan who is covered as a Dependent, any employer-sponsored health coverage that covers that person as an employee will be primary to this Plan.

When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage by one carrier is replaced within one day by another carrier or plan.

COORDINATION OF BENEFITS UNDER NO-FAULT AUTO LAW

The State of Minnesota statutes enable Health and Welfare Plans to coordinate benefit payments under the No-Fault Auto Law. This means that, if you or one of your Dependents are involved in an accident involving a vehicle and medical payments are received from an insurance policy or self-funded plan for the vehicles involved, Plan benefits will be coordinated with those payments.

INFORMATION ABOUT MEDICARE

Medicare is a multi-part program:

- **Medicare Part A:** Officially called “Hospital Insurance Benefits for the Aged and Disabled” primarily covers Hospital benefits, although it also provides other benefits.
- **Medicare Part B:** Officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled” primarily covers Physician’s services, although it, too, covers a number of other items and services.
- **Medicare Part C:** Called “Medicare Advantage” is Medicare’s managed care offering. If you are covered by a managed care program, the Plan will presume that you have complied with the program’s rules necessary for your expenses to be covered by the program.
- **Medicare Part D:** Called “Medicare Prescription Drug Coverage” is Medicare’s prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

Be sure to report your Medicare status to the Fund Office.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, Dependent widow or have chronic End-Stage Renal Disease (ESRD). Special rules may apply if you are eligible for Medicare based solely on ESRD. Contact the Fund Office for more information.

COORDINATION WITH MEDICARE

When Medicare is the primary coverage (as outlined below), the Plan will not duplicate Medicare Part A and Part B Benefits. Benefits will be reduced by the amount Medicare would have paid even if you had not enrolled for Part A and/or Part B coverage or had filed a claim. Therefore, it is very important that you enroll in Medicare when you retire or become disabled.

This Plan will be primary over Medicare for the claims of you and your Dependents if you maintain your eligibility under this Plan and if you:

- Are at least age 65, eligible for Medicare because of age and actively employed by an ADEA employer who pays all or part of the required contributions for eligibility;
- Are considered disabled by Social Security but are still considered active by an ADEA employer; or
- Have end stage renal disease (ESRD) but have not completed the required waiting period prior to Medicare becoming primary.

Medicare will be primary over the Plan if you:

- Are over age 65 and not actively employed by an ADEA employer who pays all or part of the required premium;
- Are at least age 65 and retired. However, if you become entitled to Medicare due to ESRD prior to becoming eligible for Medicare due to age or another disability, this Plan will be primary for the required waiting period.); or

- Are disabled, have completed the 24-month waiting period and are not actively employed by an ADEA employer who pays all or part of the required premium.

The Coordination of Benefits rules still apply in determining primary coverage for your Dependents.

The following definitions have specific meanings for this section:

Medicare Benefits means benefits for services and supplies, which you receive or are entitled to receive under Medicare Part A and B.

Age 65 means the age attained at 12:01 a.m. on the first day of the month in which your 65th birthday occurs.

ADEA Employer means an Employer who:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- Has 20 or more Employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Subrogation

If a covered individual's Injury or Illness is caused by the action or inaction of another person or party, that person or party may be responsible for your Hospital or medical bills. Automobile accident Injuries or personal Injury suffered on another's property are examples.

The Fund generally does not pay for claims where a third party has liability or for claims that are due to a work-related Injury or Illness. Since collecting payments for these expenses from the third party may take a long time, the Fund will provide covered benefits, but the Fund must be repaid from any settlement, judgment award or claim the covered individual may receive. When the Fund does pay for these claims, the Fund is fully subrogated to any and all claims, rights of recovery and causes of action a participant (covered individual) has against another party for payment of any Medical Expense Benefits and/or Loss of Time Weekly Benefits paid under this Plan.

The Employee and, where applicable, any non-minor Dependent (the covered individual) will be required to sign a form, which acknowledges the Fund's right to reimbursement and verifies that the Employee or Dependent will help the Fund secure its rights. The form must be completed before the Fund will make payments on behalf of the covered individual. If the individual has retained an attorney to recover from the third party or insurer, then the attorney must also acknowledge in writing the Fund's right to reimbursement and subrogation.

If a covered individual brings a liability claim against a third party, benefits payable under the Fund must be included in the claim. By accepting benefits from the Fund, Employees and Dependent specifically acknowledge and agree that, as set out in the Supreme Court's 2006 opinion in *Sereboff v. Mid Atlantic Medical Services*, the Fund is granted an equitable lien in the proceeds of any payment, settlement, judgment or other recoveries from any third party (including any tort feisor or insurer) up to the amounts paid by the Fund. This is a first right of reimbursement and once payment is made to or on behalf of an Employee or Dependent the Fund is granted a lien that can be satisfied from any identifiable funds in the possession or control of the covered individual or the agent or representative thereof. When the claim is resolved, the covered individual and his or her attorney (if the attorney is holding the monetary recovery) must hold any monetary recovery in constructive trust and promptly reimburse the Fund for the benefits provided, up to the amount of the monetary recovery. The covered individual and the attorney (if the attorney is holding the monetary recovery) will be fiduciaries with respect to the monetary recovery and will hold such recovery in trust for the Plan.

In addition, the Fund is granted a specific and first priority right to reimbursement in any recovery regardless of the manner in which the recovery is structured or worded and regardless of whether the covered individual has been "made whole" by the settlement. The Fund's reimbursement will not be reduced by attorney's fees, absent consent of the Board of Trustees. In addition to its right to reimbursement, the Fund is subrogated to the covered individual's claim and may therefore make a claim or bring any action against such third party to recover any benefits paid on behalf of the covered individual by the Fund.

Employees and Dependents are legally obligated to avoid doing anything that would prejudice the Fund's right of reimbursement and subrogation. However, the Fund will be entitled to recover in accordance with these rules, even if the covered individual does not sign or return its forms. Failure to cooperate may result in disqualification from receipt of future benefits from the Fund for the Employee or Retiree and his or her Dependents.

In addition, by accepting benefits from this Fund, Employees and Dependents specifically agree if the covered individual does not reimburse the Fund from the third party recovery then, the Fund may offset any future benefits otherwise payable to that individual with interest of 10% per annum. If the Fund prevails in a lawsuit to enforce its Reimbursement and Subrogation Agreement and/or these rules, the Fund will be entitled to recover benefits paid on your or your Dependent's behalf, together with interest at 10% per annum plus reasonable attorney's fees.

RIGHT OF RECOVERY

The Fund will have a first priority right to recovery against any party or any source for your Injury or Illness, which created the need for the services, and/or benefits for which the Fund paid, to the extent of the payment made by the Fund plus reasonable costs of collection, including reasonable attorney fees. The Fund's claim for reimbursement will be paid in full before, and it will take precedence over, any claim for damage by you. Any state law requiring you to be made whole or fully compensated before the Fund is entitled to reimbursement does not

apply. You must cooperate with the Fund in assisting it to protect its legal rights under this provision, and you must do nothing to prejudice the Fund's subrogation/ reimbursement rights. You agree to assist the Fund in any action it brings to establish a constructive trust on settlement or jury verdict amounts from which the Fund seeks reimbursement. This includes your consent that the Fund may commence an action in the U.S. District Court to pursue equitable remedies under the Employee Retirement Income Security Act (ERISA), including but not limited to the formation of a constructive trust. You agree to pay the amount of the Fund's subrogation/reimbursement claim to the Fund before you pay your attorney fees and costs incurred in any litigation related to the recovery.

The Fund does not agree to pay a share of your attorney fees in recovering the Fund's claim, unless the Board of Trustees otherwise agrees in writing with you and/or your attorney. The Fund may bring suit in your name, and it may recover from you any proceeds of any settlement or judgment obtained from any party or source. In the event that you fail to fully cooperate with the Fund in the process of recovering benefits paid by the Fund, the Fund may offset your future benefit payments to the extent of its costs in obtaining recovery, and/or bring suit against you holding you personally liable for such costs. Costs include attorney's fees, costs and disbursements of any kind, expended or incurred by the Fund for the purposes of effectuating such recovery. Any such proceeds will be held by you in trust for the benefit of the Fund, and the Fund will be entitled to recover reasonable attorney fees it may incur in collecting any proceeds held by you.

You agree to execute documents as the Fund requires facilitating its subrogation / reimbursement rights. You agree the Fund may withhold benefits payable until you execute all of the documents provided by the Fund. The Fund's payments of medical claims and/or disability claims may be conditioned on your agreement in writing to:

- Reimburse the Fund to the extent of benefits paid by the Fund; and/or
- Provide the Fund with a lien to the extent of benefits provided to you by the Fund.

If you recover lost wages benefits from another source, then the Fund has the right to seek repayment from you of any Loss of Time Weekly Benefits that, in addition to the lost wages benefits recovered from the other source, exceed 85% of your weekly income prior to the total disability.

The Fund will provide benefits at the beginning of the total disability, but then you will be asked to execute and deliver such documents or take other action as is necessary to assure the Fund's rights should the lost wages claim prove successful.

Important Plan information

This section provides you with information about how the Minnesota Cement Masons Health and Welfare Fund is administered.

Fund Name

The Fund is known as the Minnesota Cement Masons Health and Welfare Fund.

Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees by the Internal Revenue Service is 41-6187748. The Plan Number is 501.

Plan Type

The Plan is an employee welfare benefits plan that provides Medical, Prescription Drug, Dental and Vision Benefits. This Plan also provides Death, Accidental Death and Dismemberment, and Loss of Time Weekly Benefits.

Plan Fiscal Year

The financial records of this Plan are based on an annual period: January 1 through December 31.

Plan Sponsor and Plan Administrator

The Plan is administered and maintained by the Board of Trustees. The Board of Trustees is the Plan Sponsor and the Plan Administrator.

Board of Trustees

Union Trustees

Mr. Brian Gullickson
Cement Masons Local #633
312 Central Ave., Suite 376
Minneapolis, MN 55414

Mr. Greg Johnson
Cement Masons Local #633
312 Central Ave., Suite 376
Minneapolis, MN 55414

Mr. Greg Massey
Cement Masons Local #633
312 Central Ave., Suite 376
Minneapolis, MN 55414

Mr. Dave Schutta
Cement Masons Local #633
16870 91st Ave. North, #329
Maple Grove, MN 55311

Mr. Mike Syversrud
Cement Masons Local #633
2002 London Road, #112
Duluth, MN 55812

Employer Trustees

Mr. Steve Bulach
Bulach Custom Rock
1870 50th Street East
Inver Grove Heights, MN 55077

Mr. Steve Fritz
Adolfson & Peterson Construction Company
6701 West 23rd St.
Minneapolis, MN 55426

Mr. Dave Joslin
Donald Frantz Concrete Construction
595 Randolph Avenue
St. Paul, MN 55102

Mr. Tim Worke
A.G.C. of Minnesota
525 Park Street, Ste. 525
St. Paul, MN 55103-2186

Third Party Administrator

Zenith American Solutions
2520 Pilot Knob Road, Suite 325
Mendota Heights, MN 55120
651-256-1804

Fund Consultant

The Segal Company
3800 American Boulevard West, Suite 870
Bloomington, MN 55431-4459
952-259-2600

Fund Attorney/Agent for Service of Legal Process

Peter M. Rosene, Esq.
Leonard, O'Brien, Spencer, Gale & Sayre, Ltd.
100 South Fifth Street, Suite 2500
Minneapolis, MN 55402
612-332-1030

If legal disputes involving the Plan arise, any legal documents should be served upon Mr. Rosene. Service of legal process may also be made upon any individual Plan Trustee at the Fund Office address:
2520 Pilot Knob Road, Suite 325
Mendota Heights, MN 55120

Parties to the Collective Bargaining Agreement

The Plan is established and maintained under the terms of a Collective Bargaining Agreement. This Agreement sets forth the conditions under which participating Employers are required to contribute to the Fund.

Upon written request to the Fund Office, you may obtain information as to the address of a particular employer and whether that employer is required to pay contributions to this Plan.

Source of Contributions

The Fund receives money from Contributing Employers in accordance with collective bargaining agreements in effect from time to time with participating local Unions of the Operative Plasterers and Cement Masons International Association. Copies of the collective bargaining agreements are distributed to Employees by the participating local Union. The agreements indicate the expiration date of the collective bargaining agreement, relative provisions and specify the Health and Welfare Fund's contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Employees working under the Collective Bargaining Agreements.

Funding Method

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Employees and their Dependents and defraying reasonable administrative expenses.

All benefits payable under this Fund are self-funded and paid directly from the accumulated assets of the Trust Fund.

Eligibility

The Plan's requirements with respect to Active Employee and Dependent eligibility, as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are described fully in this booklet.

Claim Procedure

The procedures to follow for filing a claim for benefits are detailed in the ***Claims and Appeals*** section of this booklet. If all or any part of a claim is denied, you have the right to request that the Board of Trustees review the matter.

Trustees' Discretionary Authority

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time, in accordance with the Trust Agreement. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Fund and Plan communications and keep them with this booklet.

The Trustees have the exclusive right and sole discretionary authority to make any finding of fact necessary or appropriate for any purpose under the Trust Agreement or any plan or program established there under, including, but not limited to, final determination as to the eligibility of any individual to participate in any plan or program and to receive benefits there under.

The Trustees have the exclusive right and sole discretionary authority to interpret and construe the terms and provisions of the Trust Agreement and any plan or program established thereunder and to determine any and all questions arising with respect to the construction and interpretation of the Trust Agreement and any such plans or programs, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies, or omissions and to construe disputed, doubtful or uncertain terms. All findings of fact, determinations, interpretations and decisions of the Trustees are intended to be conclusive and binding upon all persons having or claiming to have any interest or right under any plan or program established pursuant to the Trust Agreement and will be accorded judicial deference in any administrative or court proceeding. If a decision of the Trustees or those acting for the Trustees is challenged in court or in an administrative proceeding, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

The Trustees reserve the right and have been given the discretion to amend, modify or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant.

Plan Termination

No benefits described in this booklet are vested. The Plan may be terminated under circumstances allowable under ERISA and the terms of the governing Trust Agreement. In the event the Plan is terminated, benefits for Covered Expenses incurred before the termination date will be paid on behalf of eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the Plan's assets available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of the Trust assets.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement. However, any use of such assets will be made only for the benefit of eligible individuals covered under the Plan at the time of the Plan's termination.

Sole Authority on Plan Benefits

Benefits under the Plan will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the Employee or beneficiary is entitled to benefits in accordance with the Plan's terms.

Any interpretation of the Plan's provisions rests with the Board of Trustees. No Employer or Union, nor any representative of any Employer or Union, is authorized to interpret this Plan on behalf of the Board nor can an Employer or Union act as an agent of the Board of Trustees.

However, the Board of Trustees has authorized the Third Party Administrator and the Fund Office staff to handle routine requests from Employees regarding eligibility and benefit and claims procedures. But, if there are any questions involving interpretation of any Plan provisions, the Fund Office will ask the Board of Trustees for a final determination.

Official Plan Document Governs

This SPD/Plan Document is intended to be written in clear, understandable and informal language. It, along with other supplemental documents, such as the Plan's HIPAA's Privacy Policies and Procedures, and COBRA notices, also serve as the Plan's controlling legal documents, which are used by the Plan's Trustees to determine eligibility for benefits and to prescribe the amount, extent, conditions and methods of payment of such benefits.

Your Rights under the Plan

STATEMENT OF ERISA RIGHTS

As a participant in the Minnesota Cement Masons Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- 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, applicable 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).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, applicable Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) and updated Summary plan Description/Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this Summary Annual Report free of charge.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, your spouse or your Dependents if there is a loss of coverage under the Plan due to a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage or when your COBRA Continuation Coverage ends. You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 operate 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.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about 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 (EBSA) or the Division of Technical Assistance and Inquiries at:

National Office

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

Nearest Regional Office

Employee Benefits Security Administration
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
816-285-1800

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their web site at www.dol.gov/ebsa.

Privacy Policy

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended, the Plan protects the confidentiality and security of your private health information. You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations, and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan hires professionals and other companies to assist in providing health care benefits. The Plan requires these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;
- Copy your health information at a cost;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan.

If you need a copy of the Privacy Notice, please contact the Plan Administrator.

Protection and Security of Protected Health Information (PHI)

The Plan Sponsor:

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

Plan's Use and Disclosure of Protected Health Information (PHI)

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to a retirement plan, disability plan, reciprocal benefit plan, and/or workers' compensation insurers for purposes related to administration of these plans.

Payment Defined

Payment includes activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for Plan coverage and provision that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., benefit cost, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of Benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant (and/or authorized representatives) inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including Preauthorization, concurrent review, and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: Name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

Health Care Operations Defined

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration or development or improvement of methods of payment or coverage policies; and

- Business management and general administrative activities of the entity, including, but not limited to:
 - Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;
 - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - Resolution of internal grievances; and
 - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

Plan’s Disclosure of Protected Health Information (PHI) to the Board of Trustees

For purposes of the Plan’s privacy rules, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only as long as this Plan Document incorporates the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as otherwise required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI:

- The Plan Administrative Manager; and
- Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Breach Notification Rights for Unsecured Protected Health Information under HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Administrator to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Administrator is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Administrator to provide notification to the media.

For purposes of this section, a breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under HITECH, which compromises the security or privacy of the protected health information.

If your unsecured PHI is breached, the Fund Administrator will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Administrator or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Administrator has improperly followed the breach notification process.

Glossary

Whenever used in this Plan Booklet, the following terms will have the meanings described below:

Allowable Charge:

- With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.
- With respect to an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees for a particular service or supply. Under no circumstances will the Plan pay an Allowable Charge for out-of-network services or supplies that are determined by any provider, facility, or other person or organization other than the Board of Trustees.

Benefit Period: The period during which an Employee has coverage due to covered employment in the Qualifying Period.

Contributing Employer: An employer who has agreed to submit contributions to the Fund according to a collective bargaining agreement, or any other written agreement, with the Union.

Covered Expense: A charge incurred by a participant for medical care and paid by the Fund, pursuant to this Plan.

Dependent: An eligible Dependent is any one of the following persons:

- Your legal spouse.
- Your natural child, stepchild, legally adopted child, grandchild, or a child who is placed with you for adoption (even if the adoption is not yet final) that is under age 26. A child will be considered placed for adoption if you assume a legal obligation for the total or partial support of a child in anticipation of the adoption of that child.
- A child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO).
- An unmarried child for whom you have been appointed legal guardian, as specified in the order appointing guardianship, if the child lives with you for more than one-half of the calendar year and receives more than one-half of his or her financial support from you during the calendar year.
- Your unmarried child listed above, at any age, who is permanently and totally disabled, due to 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 the child:
 - Sustained such disability before the child reached age 26;
 - Is dependent upon you for more than one-half of his or her support for the calendar year (for the full year for legal guardianship);
 - Resides with you for more than one-half of the calendar year; and
 - Is dependent upon you for lifetime care and supervision.

If the child does not live with you, the child is an eligible Dependent provided that:

- The child's parents are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six months of the calendar year;
- The child's parents provide over one-half of the child's support during the calendar year;
- The child is in the custody of one or both of the child's parents for more than one-half of the calendar year; and
- The child is not the dependent of any other person during the calendar year.

You must provide written proof of incapacity and dependency of such child to the Fund Office within 31 days of the child attaining age 26 and periodically thereafter, upon request. The child will remain covered as long as you remain eligible under the Plan.

For Plan years beginning before January 1, 2014 (until March 31, 2014), a dependent child who is age 19 or older is not eligible for coverage under the Plan if the adult child (defined as an eligible Dependent child who is age 19-26) is eligible for coverage under another employer-sponsored health plan other than a group health plan of a parent. In addition, a spouse of a dependent child is not eligible for coverage under the Plan. However, this provision is waived for any adult children who are full-time students. If your adult child is a full-time student, he or she must provide proof of full-time student status to the Fund Office in order to be eligible for coverage under this exception.

Employee or Active Employee: A person performing covered work that satisfies the conditions for eligibility in the Fund.

Expense: A charge incurred by a participant for medical care and paid by the Fund according to the benefit provisions of this Plan.

Experimental or Investigative: Services or treatment:

- On which the consensus of expert medical opinion, based on reliable evidence (i.e., published reports and/or articles), indicates that further trials or studies are needed to determine the safety, efficiency, and outcomes of such treatment or services compared to standard treatment;
- Are not yet recognized as having proven beneficial outcomes;
- Are primarily confined to a research setting; and
- Are not appropriate based on:
 - Medical circumstances;
 - The advanced stage of an individual's illness; or
 - The likelihood that the service or treatment will measurably improve the individual's illness or medical condition.

The Trustees or their designated representatives have sole authority to determine whether a treatment, service, or supply is Experimental or Investigative.

Home Health Care Agency: Any agency or organization which:

- Is primarily engaged in providing nursing and other therapeutic services,
- Is federally certified and licensed by the state in which the care is given, if such licensing is required;
- Has policies established by a professional group associated with such agency, including at least one Physician and at least one registered nurse, to govern the services provided;
- Provides for full-time supervision of such services by a Physician or by a registered nurse;
- Has its own administrator; and
- Maintains a complete medical record on each patient.

Home Health Care Plan: A plan for your continued care and treatment, if you:

- Are under the care of a Physician; and
- Would need continued Hospital confinement without home health care.

The Home Health Care Plan must:

- Be approved in writing and established by the attending Physician with the home health care provider;

- Be provided for the same or related condition, which required a Hospital confinement of at least three days;
- Begin within 14 days following release from a Hospital; and
- Be reviewed at least every 30 days by the attending Physician and the Board of Trustees.

Hospital: A place which is licensed as a Hospital (if licensing is required by law), which is operated for the care and treatment of resident inpatients and which has a laboratory, registered graduate nurses always on duty and an operating room (or 24 hour access to an operating room and laboratory in an affiliated institution) where major surgical operations are performed by a legally qualified Physician or surgeon. In no event will the term Hospital include an institution or that part of an institution that is used principally as a clinic, convalescent home, rest home, nursing home, or home for drug addicts or alcoholics.

For the purpose of paying benefits for mental and nervous disorders, Hospital also means a place which has accommodations for resident bed patients, facilities for the treatment of mental and nervous disorders and a resident psychiatrist always on duty, and which as a regular practice charges the patient for the Expense of confinement.

For the purpose of paying benefits for alcoholism, chemical dependency or drug addiction, (other than for Non-Residential Alcoholism, Chemical Dependency or Drug Addiction Treatment Benefits), Hospital also means a facility which provides a residential treatment program as licensed by the appropriate State Agency, Department of Human Services pursuant to a diagnosis and upon the recommendation of a legally qualified Physician.

Illness: A disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician.

Injury: Physical damage caused to a person's body that is independent of an Illness and requires treatment by a Physician.

Medically Necessary: A service or supply that the Fund's medical staff and/or an independent review panel believes:

- Is appropriate and consistent with the diagnosis in accordance with accepted standards of community practice; and
- Could not have been omitted without adversely affecting the person's condition or the quality of medical care.

Physician: A person licensed to prescribe and administer all non-narcotic drugs and to perform all surgery or any other licensed practitioner performing services that the practitioner is licensed to perform which would be payable under the Plan if performed by a Physician. The term Physician will also include a licensed chiropractor or optometrist.

Plan: The program of eligibility and termination provisions and benefits as set forth for Active and retired Employees and their Dependents in the Rules and Regulations (Plan Document) of the Health and Welfare Fund adopted by the Trustees.

Qualifying Period: The calendar year period during which a Contributing Employer is required by agreement to make contributions to the Fund for work in covered employment.

Totally Disabled: Your inability to engage in or perform the duties of your regular occupation or employment within the first two years of such disability, and after two years of disability, your inability to engage in any paid employment or work for which you may, by your education and training, including rehabilitative training, be or reasonably become qualified.

The Board of Trustees will require initial proof of total disability and may require subsequent proof of such disability. The Trustees have the right, at their expense, to require you to submit to a medical examination.

Union: The Union refers to Cement Masons, Plasterers and Shophands Union Local No. 633 of Minnesota, North Dakota and Northwest Wisconsin, and its predecessors or successors.

Appendix: Health Reimbursement Arrangement

ARTICLE I. INTRODUCTION

1.1 Establishment of HRA feature to Plan

The Minnesota Cement Masons Health and Welfare Plan (the “Plan”), as plan sponsor, established the Minnesota Cement Masons Health Reimbursement Arrangement (HRA) as a feature of the Plan, effective May 1, 2008 (the “Effective Date”). Capitalized terms used in this Appendix not otherwise defined in this document will have the meanings set forth in the following Article II.

The HRA is intended to permit a Covered Individual to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

1.2 Legal Status

This HRA feature is intended to qualify as an employer-provided medical reimbursement arrangement under Code §§ 105 and 106 and regulations issued there under, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45, and will 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).

ARTICLE II. GLOSSARY

2.1 Definitions Applicable to the HRA

Benefits. The reimbursement benefits for Medical Care Expenses described under Article V.

Compensation. The wages or salary paid to an Employee by the Employer.

Contributing Employer. An employer that has signed a collective bargaining agreement or participation agreement requiring contributions to the HRA account.

Covered Individual. For purposes of Article VIII, a Participant, Spouse or Dependent.

Dependent. The definition in the Glossary section applies for purposes of the HRA.

Effective Date. Has the meaning described in Section 1.1.

Eligible Employee. An Employee eligible to participate in this portion of the Plan, as provided in Section 3.1.

Employee. An individual that the Employer classifies as a common-law Employee and on whose behalf contributions are made to the Minnesota Cement Masons Health and Welfare Fund by a Contributing Employer under the terms of a collective bargaining agreement or participation agreement, but will not include any person that owns any more-than 2% of a Contributing Employer, including those deemed to be a more than 2% shareholders by virtue of the Code § 318 ownership attribution rules. The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

Employer. Any Contributing Employer that has a signed collective bargaining agreement or participation agreement required contributions to the HRA account.

Employment Commencement Date. The first regularly scheduled working day on which the Employee first performs an hour of service for a Contributing Employer for Compensation that require contributions to this feature of the Plan.

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

HRA or Health Reimbursement Arrangement. A health reimbursement arrangement as defined in IRS Notice 2002-45.

HRA Account. The HRA Account described in the following Section 5.3.

Medical Care b Expenses as defined in the following Section 5.2.

Participant. A person who is a Covered Individual and who is participating in this Plan in accordance with the provisions of the following Article III.

Period of Coverage. The Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will 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 will mean the portion of the Plan Year prior to the date participation terminates, as described in the following Section 3.2.

Plan. The Minnesota Cement Masons Health and Welfare Plan, as set forth herein and as amended from time to time, including this HRA Appendix.

Plan Administrator. The Board of Trustees of the Minnesota Cement Masons Health and Welfare Plan. The contact person is the Third-Party Administrator for the Plan who has 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, as described in the SPD.

Plan Year. 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 such case, the Plan Year will be the entire short Plan Year.

Spouse. 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. The Minnesota Cement Masons Health and Welfare Plan Summary Plan Description, which includes this HRA appendix.

Third Party Administrator. The administrative agent of the Board of Trustees.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this feature of the Plan if:

- They are currently a Covered Individual or have been a Covered Individual; and
- They have any funds available in their HRA account .

3.2 Termination of Participation

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

- The termination of this HRA Plan; or
- Ten years from the date on which a former Participant ceases to be a Covered Individual 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 5.6; or
- You request to opt-out and waive future reimbursements from the HRA Plan.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 5.6 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA), except where termination occurs because you exercised your right to opt-out.

If a Participant opts-out, their account balance and any future contributions will be forfeited and they may not submit any additional claims. If a Participant opts-out, the Participant may re-enroll in the HRA.

Participants subject to a Collective Bargaining Agreement that includes a contribution to the Health Reimbursement Arrangement (HRA) may opt out of participation in the HRA on an annual basis by providing written notice to the Fund Office of the election to opt out. The Participant must provide notice within 30 days of becoming eligible or by January 31st of each subsequent Plan Year. When a Participant elects to opt-out of the HRA, the following will occur:

- The opt-out will be effective immediately upon the Fund Office's receipt of the notice;
- After all previously submitted reimbursement claims have been processed for Eligible Medical Care Expenses incurred and submitted prior to the opt-out date, any money in the HRA account will be forfeited and will revert to the general assets of the Plan;
- After the effective date of the opt-out notice, the Participant and his/her Dependents will only be eligible for reimbursements for any Medical Care Expenses for himself / herself or any Dependents, which were incurred prior to the opt-out date and for which a reimbursement claim had been submitted to the Fund Office;
- The election will remain in effect for the remainder of the Plan Year. To continue the opt out in future years, the participant must make an affirmative opt-out election with the Fund Office by January 31st;
- The Employer is required to continue to remit the HRA portion of the hourly Employer contribution while the Participant is in opt-out status, with all contributions going toward the general assets of the Plan.

3.3 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 Plan will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an Active Employee.

ARTICLE IV. BENEFITS OFFERED AND METHOD OF FUNDING

4.1 Benefits Offered

When an Employee becomes a Covered Individual in accordance with the terms of the Plan, an HRA Account will be established for such Covered Individual to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in the following Article VI. In no event will Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. The initial balance in a Covered Individuals HRA account will be all HRA contributions received by the trust on behalf of the Employee for the prior six-month period.

4.2 Employer and Participant Contributions

- *Employer Contributions.* The Employer funds the full amount of the HRA Accounts. The Board of Trustees may allocate earnings to HRA accounts on the last day of the year, based on balances on that date.
- *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.
- *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.

4.3 Funding This Plan Feature

All of the amounts payable under this Plan will 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 will 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, except for benefits properly payable during the existence of the HRA plan feature. The HRA accounts are not vested benefits. HRA accounts are subject to revision or elimination by the Board of Trustees.

ARTICLE V. BENEFITS

5.1 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 5.3.

5.2 Eligible Medical Care Expenses

Section 5.2 titled "Eligible Medical Care Expenses" is amended and reads as follows:

Under the HRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage under the Medical Plan or another qualified employer sponsored group health plan, and also may receive reimbursement for certain other Excepted Benefits incurred outside a Period of Coverage

- *Incurred.* A Medical Care Expense is incurred at the time the medical care or service is rendered. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.
- *Medical Care Expenses Generally.* The Medical Care Expenses available for reimbursement will differ for Participants depending on whether they are eligible in the Plan at the time the claim was incurred, or are enrolled in another employer sponsored group health plan that provides minimum value, or have no health coverage at all. This information will be reported on the new claim forms which will have a question for Participants to indicate which coverage, if any, they had at the time a claim was incurred.
- *Essential Health Benefits.* For participants who are eligible for coverage in the Plan at the time a claim was incurred, or are enrolled in an employer sponsored group health plan that provides minimum value, those Participants will be able to be reimbursed for "Essential Health Benefits." Essential Health Benefits are those expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in § 213(d) (including, for example, amounts for certain Hospital bills, doctor and dental bills and prescription drugs), but will not include expenses that are reimbursed through other insurance, including any other accident or health plan. If only a portion of a Medical Care Expenses 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 V.
- *Excepted Benefits.* For participants who are not eligible for coverage in the Plan at the time a claim was incurred, or are not enrolled in an employer sponsored group health plan that provides minimum value, those participants will only be able to be reimbursed for "Excepted Benefits." Excepted Benefits are those expenses incurred by a Participant or his or her Spouse or Dependents for medical care which do not constitute Essential Health Benefits. These may be revised from time to time, but in general do not include copays or coinsurance.

Examples of Excepted Benefits include:

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**

Adult Vision

- **Eyeglasses and contact lenses**
- **Laser eye surgery**
- **Prescription sunglasses**
- **Radial keratotomy**

Hearing

- **Exams**

Medical Procedures / Treatments

- **Acupuncture**
- **Bariatric surgery**
- **Hair loss treatment**
- **Infertility treatment**
- **In vitro fertilization**
- **Modification to the home**
- **Private duty nursing**
- **Routine foot care**
- **Service animals**

Therapy

- **Exercise programs**
- **Weight loss programs**

Other

- **Premiums for accident-only and disability coverage**
- **Long-term care benefits**

5.3 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 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.

- (a) **Crediting of Accounts.** Your HRA Account will be credited at the end of each month that you are Eligible to Participate in the Plan 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.
- (b) **Debiting of Accounts.** Your 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.
- (c) **Available Amount.** The amount available for reimbursement of Medical Care Expenses is the amount credited to your HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

5.4 Carryover of Accounts

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements and administrative assessments are paid for the Period of Coverage, such balance will 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 the following Section 5.6.

5.5 Reimbursement Procedure

- *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 (See SPD regarding procedures for claim denials and appeals procedures). 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 45 days in which to complete an incomplete reimbursement claim.
- *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Third Party Administrator in such form as the Third Party Administrator may prescribe, before the later of twelve (12) months following the date the Medical Care Expense was incurred, or March 31 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:
 - The person or persons on whose behalf Medical Care Expenses have been incurred;
 - The nature and date of the Expenses so incurred;
 - The amount of the requested reimbursement; and
 - A statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application will 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.

- *Claims Denied.* Refer to the appeals procedures described in this Summary Plan Description (Claims and Appeals section) for information about reimbursement of claims that are denied.

5.6 Reimbursements after Termination; COBRA

When a Participant ceases to be a Participant under the prior Section 3.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by end of the close of the following Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event, will be given the opportunity to continue to receive reimbursement the same as if he or she had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries will be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants.

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 in the

family account. If you chose to continue to have access to your account balance, your account is charged for the costs of administration at that same rate as similarly situated plan participants. The second form allows you to contribute to your HRA while you are a COBRA participant.

The contributions would go into a separate account, with only your post-COBRA event Dependents being eligible for benefits. If you were able to contribute to the HRA with funds that are untaxed, then the second form would be to your advantage. If you are only able to contribute funds that have already been taxed, it is doubtful that you will have any financial advantage in making continued contributions.

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. Subsequent to the COBRA event, contributions for the Employee/participant will also go in to 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:

- Your reduction in hours, depletion of your hour bank, or termination of employment.
- Your death.
- Your divorce.
- Your eligible child stops qualifying as a Dependent child under the Plan.
- 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:

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

5.7 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 will 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.

ARTICLE VI. APPEALS PROCEDURE

6.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims will 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.

6.2 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 will 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.

6.3 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 the 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 will be forfeited following a reasonable time after the date that any such payment first became due.

6.4 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 will, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued there under 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.

ARTICLE VII. GENERAL PROVISIONS

7.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Plan. The Board of Trustees may assess fees to some or all of the accounts, on a uniform and non-discriminatory basis.

7.2 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 will 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.

7.3 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 will 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.

7.4 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will 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.