

## Summary of Material Modification

December, 2003

To all Plan participants:

The following changes amend the Summary Plan Description effective January 1, 2003:

Comprehensive Major Medical: Covered Charges:

- Routine colonoscopy or flexible sigmoidoscopy for adults aged 50 and over or eligible members and dependents under age 50 based on family health history, even though no cancer symptoms are present.
- Services performed at Quick Medx / Minute Clinic.

Please keep this Summary of Material Modification with your Summary Plan Description so you will have an up-to-date description of the Plan's benefits. If you have any questions about this benefit, contact the Fund Office at the address or phone number shown above.

Board of Trustees  
Twin City Bricklayers Health and Welfare Fund

204599/00827.001

## SUMMARY OF MATERIAL MODIFICATION

May 2004

To all Plan participants:

In an attempt to balance Fund expenses with revenue, the Trustees of the Twin City Bricklayers Health and Welfare Fund have adopted the following benefit changes effective May 1, 2004:

### **Major Medical Out-of-Pocket Maximum**

The out-of-pocket maximum per calendar year will be increased to \$2,000 from \$1,000 per covered person. The family maximum per calendar year will be increased to \$5,000 from \$2,500.

Please contact the Fund Office if you have any questions.

**Please keep this Summary of Material Modifications with your Benefit Plan booklet so that you will have an up-to-date description of the Plan's benefits. If you have any questions about this benefit, contact the Fund Office at the address or phone number shown above.**

Board of Trustees  
Twin City Bricklayers  
Health and Welfare Fund

## SUMMARY OF MATERIAL MODIFICATION

December 2004

To All Plan Participants:

The Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health and Welfare Fund have adopted the following benefit changes.

### **Effective September 15, 2004:**

#### Definition of Durable Medical Equipment:

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

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

### **Effective January 1, 2005:**

#### Cole Vision Arrangement

The Plan's vision discount program through Cole Vision will terminate. The Plan's Vision Care Program benefits for examinations and materials will not change.

#### Physical Examination / Cancer Screening Benefits:

For Classes A (actives) and B (pre-Medicare retirees), the Physical Examination and Cancer Screening benefits will be combined, subject to an annual maximum of \$300 for all routine examinations, immunizations, mammograms, pap smears and PSA tests. This benefit applies to participants and dependents age 6 and older.

#### Nutritional Counseling / Diabetic Education Program:

The Plan will provide benefits for educational programs designed to improve patients' knowledge and learn techniques for self-management of diabetes and other medical conditions, subject to a lifetime maximum of \$500.

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

SUMMARY OF MATERIAL MODIFICATION  
DECEMBER, 2004

- a. The participant submits a receipt showing the:
  - i. name of the patient
  - ii. cost of the program
  - iii. name, address, and telephone number of the program sponsor
  - iv. dates and times classes were held
  - v. classes actually attended by the patient
  
- b. The patient attends 80% or more of the scheduled classes

Dollar Bank Upon Death, Retirement or Change from Bargaining to Contractor Status

If a contributing member dies while an active employee and is **not** eligible for the retiree pre-funding plan, the member's bank hours will be converted to dollars based on the current active contribution rate, and the surviving spouse and/or dependents can use the funds to pay for COBRA coverage.

If a contributing member dies while an active employee and the member **is** eligible for the retiree pre-funding plan, the member's bank hours will be converted to dollars based on the current active contribution rate, and the surviving spouse and/or dependents can use the funds to pay for coverage. When the dollar bank is depleted, coverage can continue under the retiree pre-funding rules.

Participants who retire after January 1, 2005 and are **not** eligible for the retiree pre-funding will forfeit their bank hours. These retirees may continue coverage through COBRA, and must elect COBRA upon retirement to continue coverage.

For participants who retire after January 1, 2005 and **are** eligible for the retiree pre-funding plan, bank hours will be converted to dollars based on the current active contribution rate. The resulting dollar bank balance will be used to pay the full cost of retiree coverage. In the first quarter in which a retiree's dollar bank balance is insufficient to cover the cost of coverage, the retiree will be billed for either a partial self-payment of premium, or the premium rate based on his contribution allowance through the pre-funding plan, whichever results in the lesser payment for the participant. If a retiree is billed for a partial self-payment of premium, the remaining dollar bank balance may be applied toward the partial self-payment of premium. However, once a retiree begins drawing a contribution allowance through the pre-funding plan, any remaining balance in the dollar bank will be forfeited.

If a contributing member leaves covered employment to work as a contractor within the industry, the member's bank hours will be converted to dollars based on the current active contribution rate. The member and his or her dependents can use the funds to pay for COBRA coverage until the dollar bank is depleted. Subsequent coverage under the self-employed contractor provisions of the plan is contingent upon the member meeting the eligibility requirements for non-bargained coverage.

Comprehensive Major Medical Expense Benefit

Percentage paid after the deductible amount has been satisfied

- By the Plan 80%
- By the Covered Person 20%

Dental Expense Benefit (Class A Only)

Basic Services, Endodontics, Periodontics, Oral Surgery, Major Restorative, Prosthetics and Prosthetic adjustments will be covered at 80%

There will be no change in the reimbursement level for Diagnostic and Preventive services.

Plan Name

The name of the Plan is being changed from the Twin City Bricklayers Health and Welfare Fund to the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health and Welfare Fund in order to better represent the membership being served.

Trustee Changes

Gary Goblirsch has resigned as a Labor Trustee.

Full Labor Trustee:

Mike Hawthorne  
Bricklayers Local #1  
312 Central Ave NE #328  
Minneapolis, MN 55414

Alternate Management Trustee:

Mike Lapensky  
Twin City Tile & Marble  
900 Montreal Circle  
St Paul, MN 55102

**Please keep this Summary of Material Modifications with your Benefit Plan booklet so that you will have an up-to-date description of the Plan's benefits. If you have any questions about this benefit, contact the Fund Office at the address or phone number shown above.**

Board of Trustees  
Minnesota and North Dakota  
Bricklayers and Allied Craftworkers  
Health and Welfare Fund

**MINNESOTA AND NORTH DAKOTA BRICKLAYERS  
AND ALLIED CRAFTWORKERS HEALTH FUND**

c/o Zenith Administrators  
P.O. Box 295  
Minneapolis, MN 55440-0295  
(651)256-1801

**SUMMARY OF MATERIAL MODIFICATION**

April 2005

To all Plan participants:

The Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund have adopted the following benefit change.

**Effective March 8, 2005:**

If you exhaust your maximum lifetime amount payable under the Fund's Comprehensive Major Medical Expense Benefit or the Body Organ Transplant Benefit, then the Fund will reimburse you for the cost of obtaining other coverage, such as Qualified Plan No. 2 from the Minnesota Comprehensive Health Association or other appropriate state plan. Reimbursement will be made for the premium payable for the plan, plus any annual deductible and applicable co-payments. The maximum reimbursement in a calendar year is \$15,000.

Participants are eligible for reimbursement only if they continue to work in covered employment and the Fund receives contributions on their behalf, or if they continue to self-pay their premiums to the Fund.

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Board of Trustees  
Minnesota and North Dakota  
Bricklayers and Allied Craftworkers Health Fund

MINNESOTA AND NORTH DAKOTA BRICKLAYERS  
AND ALLIED CRAFT WORKERS HEALTH FUND  
c/o Zenith Administrators  
Po Box 257  
Minneapolis, MN 55440-0257  
(651) 256-1801

**The Trustees of the Minnesota and North Dakota Bricklayers and Allied Craft Workers Health Fund announce the following changes:**

**Effective July 1, 2005**

- All forms of prescription birth control will be covered. Coverage is limited to methods of birth control that are available only with a physician's prescription, and includes, but is not limited to, birth control pills, patches and injections; diaphragms; and intrauterine devices (IUDs).
- Treatment of Temporomandibular Joint Syndrome (TMJ) will be subject to a lifetime maximum benefit of \$2,500. The lifetime maximum benefit will apply to all TMJ-related services, including, but not limited to, diagnostic testing, surgical correction and surgical follow-up care, and appliance therapy. TMJ benefits will be covered as any other medical expense, subject to the major medical plan provisions.
- Hospice Care will be covered as described below:

Lifetime maximum number of days 185

Hospice services for a Participant who has been diagnosed as Terminally Ill up to the Lifetime Maximum Number of Days, Lifetime Maximum for Counseling and Lifetime Maximum for Bereavement Counseling shown in the Schedule of Benefits. Charges must be incurred during a confinement in a hospice or under the direction of a Hospice Agency following a Hospice Plan. Covered expenses include:

- a. counseling of a Participant and the eligible dependents; and
- b. bereavement counseling of the eligible dependents

Counseling and bereavement counseling must be provided by a:

- a. psychiatrist
- b. licensed psychologist
- c. licensed social worker

Inpatient hospice benefits are payable when:

- a. there are no suitable caregivers available to provide home hospice care;
- b. it is determined by the Hospice Agency that home hospice is impractical because the people who regularly assist with home care find the patient unmanageable; and/or
- c. respite care is needed.

Payment will not be made for:

- a. Hospice Services and supplies which are not part of a Hospice Plan;
- b. services of a caregiver or a person who lives in the Participant's home or is a member of his or her family;
- c. domestic or housekeeping services that are unrelated to the patient's care;
- d. services that provide a protective environment when no skilled service is required, including companionship or sitter services other than Respite Care.

- e. services which are not directly related to a Participant's medical condition, including (but not limited to):
  - i. estate planning, drafting of wills or other legal services;
  - ii. pastoral counseling or funeral arrangements or services;
  - iii. nutritional guidance or food services such as meals on wheels; or
  - iv. transportation services.

**Definitions:**

Hospice Agency: A public or private organization which:

1. administers and provides hospice care; and
2. is one of the following:
  - a. licensed or certified as such by the state in which it is located;
  - b. certified (or is qualified and could be certified) to participate as such under Medicare;
  - c. accredited as such by the Joint Commission on the Accreditation of Hospitals;or
  - d. meets the standards established by the National Hospice Organization.

Hospice Plan: A coordinated, interdisciplinary program to meet the physical, psychological and social needs:

1. of terminally ill persons and their families;
2. by providing palliative (pain control) and supporting medical, nursing and other health services; and
3. be provided through home or inpatient care during the sickness or bereavement.

Hospice Services: Any services provided

1. under a Hospice Plan; or
2. by a hospital or related institution, home health agency, hospice or other facility licensed by the state to operate a hospice.

**MINNESOTA AND NORTH DAKOTA BRICKLAYERS  
AND ALLIED CRAFTWORKERS HEALTH FUND**

c/o Zenith Administrators  
P.O. Box 257  
Minneapolis, MN 55440-0257  
(651) 256-1801

The Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund announce the following plan changes, effective September 13, 2005. Outlined below you will find a revised list of exclusions for the Comprehensive Major Medical Expense Benefit.

If you have any questions, please contact the Fund office at (651) 256-1801

**GENERAL PLAN EXCLUSIONS AND LIMITATIONS**

The Plan does not cover:

1. Injury or illness which arises out of or occurs in the course of any occupation or employment for wage or profit.
2. Injury or illness which arises out of declared or undeclared war, or any act thereof, or military or naval service of any country.
3. Treatment or surgical procedures of an elective nature, 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:

- a) Corrective surgery which is performed for the correction of defects incurred through traumatic injuries, infection, or other diseases of the involved part sustained by the covered individual;
  - b) The correction of congenital defects;
  - c) Corrective surgical procedures on organs of the body which perform or function improperly
  - d) Vasectomies and tubal ligation procedures
  - e) Surgery and other treatment as required by the Women's Health and Cancer Rights Act of 1998.
4. Dental treatment, except dental treatment made necessary by an injury to sound natural teeth, and except as specifically provided under the **Dental Expense Benefit**.
  5. Vision Therapy.
  6. Hearing aids, except as specifically provided under the **Hearing Benefit**.
  7. Expenses incurred for medical examinations for "check-up" purposes, including immunizations, except as specifically provided under the **Physical Exam/ Cancer Screening Benefit** or under the **Comprehensive Major Medical Expense Benefit** for children under the age of six.
  8. 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.

9. Expenses incurred during confinement in a Hospital owned or operated by a state, province or political subdivision, unless you are legally required to pay for those expenses.
10. Expenses incurred for the treatment of alcoholism, drug addiction and chemical dependency in excess of the amount shown in the Schedule of Benefits.
11. Expenses for services or supplies which are:
  - 1) not provided in accordance with generally accepted professional medical standards;
  - 2) not proved to be safe and effective; or
  - 3) investigational or experimental in nature.
12. Services provided by a family member or a person who ordinarily lives in the Employee's or Retiree's or in the home of the Dependent who is receiving care.
13. 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.
14. Non-emergency Hospital admissions on Fridays, Saturdays or Sundays.
15. Medical or surgical treatment for weight-related disorders including, but not limited to, surgical interventions, dietary programs and prescription drugs.
16. Any expense or charge for orthopedic shoes and orthotics for Dependents.
17. Smoking cessation therapy, including nicotine transdermal systems.
18. Hypnosis or bio-feedback.
19. Nutritional counseling or nutritional supplements, including vitamins, even if prescribed by a Physician, except as specifically provided under the **Nutritional Counseling and Diabetic Education Benefit**.
20. LASIK, radial keratotomy or other surgery to correct refractive errors and related charges.
21. Reversal of cosmetic surgery and related charges.
22. Sterilization reversals and related charges or charges from complication of a reversal.
23. Drugs or procedures attempting to promote artificially assisted conception, including but not limited to those related to in-vitro fertilization, gamete intrafallopian transfer, artificial insemination or fertility, and related charges.
24. Any loss, expense or charge for sex transformation or complications, or any treatment related to non-organic sexual dysfunction.
25. Supplies or equipment that do not meet the Plan's definition of Durable Medical Equipment, including, but not limited to those for personal hygiene, comfort or convenience such as air conditioning, humidifiers, physical fitness and exercise equipment or programs, waterbeds, tanning beds, home traction units and home lifts.
26. Wigs, with the exception of one wig per year following chemotherapy or radiation treatment.
27. Charges incurred for Custodial Care or any care that is designed primarily to assist an individual in meeting the activities of daily living.

28. Charges incurred for confinement and services at a halfway house or group home.
29. Charges that the Eligible person is not required to pay, including those that would not have been made if this Plan did not exist.
30. Hospital charges incurred in connection with dental treatment.
31. 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.
32. Court-ordered treatment or confinement of any kind, except as specified as a covered expense under the **Mental and Nervous Treatment Disorder Benefit**.
33. Services, supplies, treatments and procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily injury or sickness unless the charges are specifically identified as being Covered Expenses under the Plan.
34. 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.
35. 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.
36. Mental and Nervous treatment / counseling for oppositional or behavioral disorders; Marriage counseling.
37. Special home construction and automobile modification.
38. Educational service and/or materials, except as specifically provided under the **Nutritional Counseling and Diabetic Education Benefit**.
39. Any treatment or service not prescribed by a Physician, or not recommended or approved by the attending Physician.
40. 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.
41. 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.
42. 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.

43. 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.
44. 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.
45. Any loss, expense or charge arising in connection with the commitment of a felony.
46. 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.
47. Acupuncture
48. Massage therapy, except as provided by a Licensed Physical Therapist..
49. Shipping charges and sales tax, with the exception of Minncare tax, which is paid on allowable charges.
50. Medical-related services provided by a school district (e.g., physical therapy, speech therapy, aides, etc).
51. Magnetic devices or magnet therapy.
52. Allergy food drops, sublingual drops or oral immunotherapy.
53. Dental treatment, including but not limited to dental implants and orthodontics, except as specified in the **Dental Expense Benefit**.
54. Chelation therapy, except in documented cases of heavy metal poisoning.
55. Genetic testing, except pre-natal genetic testing of a fetus through amniocentesis or chorionic vilus sampling.

**MINNESOTA AND NORTH DAKOTA BRICKLAYERS  
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c/o Zenith Administrators, Inc.  
PO Box 257  
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**Please read this important announcement about the prescription drug benefits provided to Medicare eligible retirees through the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund:**

In 2004, Congress passed the Medicare Modernization Act, which created the most significant changes to Medicare since its creation in 1965. The Medicare Modernization Act added a prescription drug benefit, called Medicare Part D, which became effective on January 1, 2006.

When you become eligible for Medicare Parts A and B you are also eligible to enroll in a Medicare Part D Prescription Drug Plan (Medicare PDP). There are many Medicare PDPs available, each with different benefits and premiums. Enrollment in a Medicare PDP is voluntary.

**Medicare Eligible Retirees With Prescription Drug Coverage:**

If you are a participant in the plan with prescription drug coverage, you will continue to be eligible for prescription drug benefits through the Fund. We encourage these participants to ***decline coverage*** in a Medicare PDP, as the prescription drug benefits through the Fund are intended to replace Medicare Part D for the Fund's retirees. If your coverage through the Bricklayers plan ends at a later date, you will receive a certificate of creditable coverage, verifying that you had prior drug coverage. This certificate will prevent Medicare from assessing a penalty for late enrollment.

***If you enroll in Medicare Part D and continue coverage through the Medicare Supplement Plan, your prescription drug coverage through this plan will terminate, and your premiums will not be reduced. If your prescription drug coverage terminates due to enrollment in a Medicare PDP, you will not be permitted to re-enroll in the prescription drug benefits in this plan at any time in the future.***

Note that while you may not enroll in a Medicare PDP and continue prescription coverage through this plan, you would not benefit by having double coverage. Participants in Medicare Part D will be subject to a "True Out-of-Pocket" rule. With this rule, only the Medicare beneficiary can pay out-of-pocket prescription drug costs and have that payment count toward the Part D out-of-pocket maximum. If a beneficiary receives any payments from a group health plan such as the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund, the payments will not count toward the individual's Part D out-of-pocket maximum. Medicare will audit plans to determine if any prescription drugs are reimbursed for Part D participants.

## **Medicare-Eligible Retirees Without Prescription Drug Coverage:**

Since you do not have prescription drug coverage through the Fund, you may wish to enroll in the Medicare Part D prescription drug plan during the initial enrollment period (November 2005 through May 15, 2006). If you do not enroll in the plan during the initial enrollment period and wish to enroll at a later date, you will be assessed a penalty equal to 1% of the premium for each month in which you did not enroll.

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**MINNESOTA AND NORTH DAKOTA BRICKLAYERS  
AND ALLIED CRAFTWORKERS HEALTH FUND**

c/o Zenith Administrators, Inc.

PO Box 257

Minneapolis, MN 55440-0257

(651) 256-1801

Summary of Material Modification

The Trustees of the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund announce the following plan change effective April 1, 2006:

Coverage of Wigs

The Plan provides coverage for wigs when hair loss is due to illness or injury. Wigs for hair loss due to male or female pattern baldness are not covered.

Benefits are subject to a maximum of \$350 every two years, and \$1400 per lifetime.

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