

Summary Plan Description

For the Twin Cities Bricklayers Health and Welfare Fund

Effective January 1, 2003



**TWIN CITY BRICKLAYERS
HEALTH AND WELFARE FUND**

Summary Plan Description

Effective January 1, 2003

Final
June 2003

**TWIN CITY BRICKLAYERS
HEALTH AND WELFARE FUND**
7645 Metro Boulevard
Minneapolis, Minnesota 55439

BOARD OF TRUSTEES
(Administrator, as defined by law)

UNION TRUSTEES:

Mr. Roger Buirge
Mr. Michael Cook
Mr. Gary Goblirsch
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EMPLOYER TRUSTEES:

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Mr. Paul Weise

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**TWIN CITY BRICKLAYERS
HEALTH AND WELFARE FUND**

To All Plan Participants:

The Board of Trustees is pleased to present you with this updated Summary Plan Description. This booklet describes the Health and Welfare Plan in effect on January 1, 2003.

There have been several changes in your Health and Welfare Plan since the printing of the last booklet. Some of the more important changes are:

1. The Weekly Accident and Sickness benefit was increased from \$175 to \$300 a week.
2. Initial eligibility can be established over a 6 month period, instead of just a 3 month period.
3. The death benefit for active employees was increased from \$3,000 to \$10,000.
4. The vision benefit was increased from \$175 to \$225 for each two-calendar year period.

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

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

Sincerely,
BOARD OF TRUSTEES

<p>This Summary Plan Description explains your benefits under the Health and Welfare Plan. Every effort has been made to assure that the information contained in this booklet is accurate and up-to-date as of the time of its printing.</p>

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CLASSIFICATION OF PARTICIPANTS

- Class A** All Eligible Active Employees, Apprentices or Eligible Self-Employed Contractors and their Eligible Dependents

- Class B** All Eligible Retired or Disabled Employees **not** eligible for Medicare and/or their Eligible Dependents

SCHEDULE OF BENEFITS
Applicable to Class A Only

Death Benefit \$10,000

Weekly Accident and Sickness Benefit (Loss of Time)
(Non-Occupational)

Weekly Rate \$300

Maximum Number of Weeks Payable 26

Benefits are Payable From the:

4th day of a non-occupational Injury

8th day of a non-occupational Sickness

NOTE: The Death Benefit and the Weekly Sickness Accident and Sickness Benefit apply only to active Employees. These benefits are not available for dependents.

SCHEDULE OF BENEFITS
Applicable to Class A Only

Dental Expense Benefit

The Plan pays the following percentages of reasonable and customary dental charges up to the calendar year maximum:

	<u>Plan Co-payment</u>
Diagnostic & Preventive Services	100%
Basic Services (e.g., fillings)	85%
Endodontics (root canal therapy)	85%
Periodontics (gum disease)	85%
Oral Surgery (extractions)	85%
Major Restorative (crowns)	85%
Prosthetics (bridges & dentures)	85%
Prosthetic Adjustments	85%
Deductible	-0-
Calendar Year Maximum Per Covered Person	\$1,000

Orthodontia Benefit

Lifetime Maximum per Covered Dependent Child up to Age 19\$1,200

Physical Exam Benefit

Calendar Year Maximum per Covered Person
Maximum Amount Payable per Exam.....\$150
Number of Exams Per Year.....1

SCHEDULE OF BENEFITS
Applicable to Classes A and B

Home Health Care Expense Benefit

Maximum Amount per Visit.....	\$100
Maximum Number of Visits per Calendar Year	90

Chiropractic Expense Benefit

Maximum Daily Amount	\$40
Calendar Year Maximum	\$400

Hearing Benefit

Maximum Amount Every Five Calendar Years.....	\$750
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Comprehensive Major Medical Expense Benefit

Calendar Year Deductible Amount	
Per Covered Person	\$200
Per Family	\$300

Percentage paid after the Deductible Amount has been satisfied:

By the Plan.....	95%
By the Covered Person.....	5%

Percentage paid for Alcoholism, Drug Addiction, Chemical Dependency
and Mental or Nervous Disorders

By the Plan.....	80% of the first \$5,000, 50% of the excess in a calendar year
By the Covered Person.....	20% of the first \$5,000, 50% of the excess in a calendar year

Maximum out-of-pocket (after the Deductible Amount)

per Covered Person per Calendar Year	\$1,000
per Family per Calendar Year.....	\$2,500

Maximum Lifetime Amount Payable:

For all Expenses for Alcoholism, Drug Addiction, and Chemical Dependency	\$20,000
For all Expenses	\$250,000

Body Organ Transplant Benefit (included in the Comprehensive Major Medical Expense Benefit maximum lifetime amount payable)

Lifetime Maximum Recipient Benefit	\$125,000
Follow-up Expense Maximum Benefit	
Per calendar year	\$10,000
Per lifetime	\$30,000
Lifetime Maximum Donor Benefit	\$7,500

Cancer Screening Tests

Calendar Year Maximum per Covered Person:

Maximum Amount Payable for Mammogram	\$150
Maximum Amount Payable for Pap Smear	\$150
Maximum Amount Payable for PSA	\$150
Maximum Number of Exams Per Year	1

Vision Care Program

Maximum Amount Payable for Examinations and Vision

Materials in a Two-Calendar Year Period	\$225
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See the Vision Care Benefit for information on the two-calendar year period.

SCHEDULE OF BENEFITS
Applicable to Class B Only

Preventive Dental Expense Benefit

Deductible per Examination	\$5.00
Oral Exams and Routine Cleaning	twice per calendar year
Bitewing X-rays	once every 12 months
Full mouth X-rays	once every 5 years

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Plan currently uses the following preferred provider organizations (PPOs):

- Blue Cross/Blue Shield for medical care;
- Cole Vision for vision care;
- Delta USA for dental care; and
- Caremark for prescription drugs.

The Board of Trustees reserves the right to change or discontinue service with preferred provider organizations. The Plan may receive rebates from Caremark, which will be used to reduce the Plan's administrative expenses.

DEFINITIONS

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

CONTRIBUTING EMPLOYER: Any employer who, pursuant to the terms of a collective bargaining agreement or a participation agreement, agrees to contribute to the Twin City Bricklayers Health and Welfare Fund for hours worked by individuals employed by such Contributing Employer.

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

1. the Covered Employee's spouse.
2. the unmarried child or children of the Covered Employee, including step-children, adopted children, and children placed with the Covered Employee for adoption who are under nineteen years of age and dependent upon the Covered Employee for support and maintenance.
3. the unmarried child or children of the Covered Employee, as explained in paragraph 2 above, who are at least nineteen years of age but under twenty-three years of age provided such child is a student in an accredited school or college on a full-time basis and is dependent on the Covered Employee for support and maintenance. Documentation, such as a fee-statement, will be required to verify that a Dependent is a full-time student.
4. the unmarried child or children of the Covered Employee or spouse who are named as alternate recipients in a Qualified Medical Child Support Order entered by a court of proper jurisdiction and approved by the Trustees, provided they meet the other requirements of a Covered Dependent.

A child or children born to a Covered Employee's unmarried Covered Dependent child will be eligible for benefits under the Plan, subject to paragraphs 3 and 4 above.

If an unmarried Covered Dependent child is incapable of self-sustaining employment by reason of mental or physical handicap and became handicapped prior to the termination age stated above, then the Board of Trustees may waive the above stated age limits. The child may remain covered under the Plan if he/she is chiefly dependent upon the Covered Employee for support and maintenance and if the Fund receives due proof of incapacity within thirty-one days of the date the child's coverage under the Plan would otherwise terminate. The child's coverage may be continued under the Plan, at the option of the Covered Employee, as long as the Covered Employee's benefits remain in force and the child remains incapacitated. The Fund may periodically request proof of the

continued existence of such incapacity. Such proof will be supplied at the expense of the Covered Employee.

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

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

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

1. not Medically Necessary; or
2. in excess of the Reasonable and Customary Charge or negotiated network charge for such services or supplies.

FUND: The Twin City Bricklayers Health and Welfare Fund, including health and welfare funds which have merged into the Twin City Bricklayers Health and Welfare Fund.

HOME HEALTH CARE AGENCY: Any agency or organization which:

1. is primarily engaged in providing nursing and other therapeutic services;
2. is federally certified and duly licensed by the state in which the care is given, if such licensing is required;
3. 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;
4. provides for full-time supervision of such services by a Physician or by a registered nurse;
5. has its own administrator; and
6. maintains a complete medical record on each patient.

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

1. who is under the care of a Physician; and
2. who would need Hospital confinement without home health care.

A **Home Health Care Plan** must:

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

2. be provided for a condition which would require a Hospital confinement if the Home Health Care Plan was not implemented and be so certified by the attending Physician; and
3. be reviewed at least every thirty days by the attending Physician.

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

1. an institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and surgery and having twenty-four hour nursing service;
2. a community mental health center or mental health clinic; or
3. a residential primary treatment facility, for treatment of mental or nervous disorders, alcoholism, chemical dependency or drug addiction.

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

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

MEDICALLY NECESSARY: A service or supply which the Fund's medical staff and/or an independent review panel believes:

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

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

The Board of Trustees will initially require certification of **Total Disability** by a Medical Doctor (M.D.) and may require proof of continued disability. In addition, the Board of Trustees has the right, at their expense, to have the Covered Employee submit to a medical examination.

PHYSICIAN: Any individual who is licensed to practice medicine by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of his practice. However, for purposes of coverage under the Plan, **Physician** is interpreted to include a psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, and doctor of dental surgery provided such individual is licensed and acting within the usual scope of his practice.

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

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

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

SKILLED NURSING CARE CONFINEMENT: Confinement in a Skilled Nursing Care Facility:

1. upon the specific recommendation and under the general supervision of a legally qualified Physician;
2. beginning within fourteen days after discharge from a Medically Necessary Hospital confinement lasting at least three days for which room and board benefits are paid; and
3. for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the previous Hospital confinement.

SKILLED NURSING CARE FACILITY: An institution or that part of any institution which operates to provide convalescent or nursing care and:

1. is primarily engaged in providing to inpatients:
 - a. skilled nursing care and related services for patients who require medical or nursing care; or
 - b. rehabilitation services for the rehabilitation of injured, disabled or sick persons;
2. has policies, which are developed with the advice of (and with provisions for a review of such policies by) a group of professional personnel, including one or more

Physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

3. has a medical staff responsible for the execution of such policies;
4. has a requirement that the health care of every patient be under the supervision of a Physician;
5. provides for having a Physician available to furnish necessary medical care in case of emergency;
6. maintains clinical records on all patients;
7. provides twenty-four-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed and has at least one registered professional nurse employed full-time;
8. provides appropriate methods and procedures for the dispensing and administering of prescription medications;
9. in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:
 - a. is licensed pursuant to such law; or
 - b. is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
10. meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to their physical facilities.

TRUSTEES: The Board of Trustees of the Twin City Bricklayers Health and Welfare Fund.

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

RULES OF ELIGIBILITY

Employees, including apprentices, are eligible for the benefits described in this booklet provided they:

- Â are employed or available for employment under the jurisdiction of the Union, and
- Â have sufficient contributions for hours worked submitted by Contributing Employers.

Self-employed contractors are also eligible, provided they have signed a current Participation Agreement with the Board of Trustees, continuously meet the rules and regulations established by the Board of Trustees, and pay the required quarterly premium.

How Eligibility Is Determined

Eligibility is attained by completing the prescribed number of hours as identified in the following **QUALIFYING SCHEDULE**:

<u>Qualifying Period</u>	<u>Prescribed Hours</u>	<u>Coverage Period</u>
Jan, Feb, Mar	375 Hours	Jul, Aug, Sep
Apr, May, Jun	375 Hours	Oct, Nov, Dec
Jul, Aug, Sep	375 Hours	Jan, Feb, Mar
Oct, Nov, Dec	375 Hours	Apr, May, Jun

Initial Eligibility

EMPLOYEES - You will become covered on the first day of a **Coverage Period** following the **Qualifying Period** in which you complete 375 hours. If you complete at least 350 hours but not 375 hours, you will be allowed to self-pay for the difference between the number of hours worked and the number of prescribed hours. That self-payment will not be counted towards the maximum of four consecutive self-payments allowable under the Plan. If you are absent from active work because of an Injury or Sickness on that day, you will still become covered for all benefits except for the **Weekly Accident and Sickness Benefit (Loss of Time)**. The **Weekly Accident and Sickness Benefit** will begin when you return to active work.

Initial eligibility can be established over a period of 3 months or 6 months. If you work at least 375 hours in a quarter, coverage will begin according to the schedule above. If you work at least 375 hours in your first six months, the following qualifyingschedule will apply:

<u>Qualifying Period</u>	<u>Prescribed Hours</u>	<u>Coverage Period</u>
Jan, Feb, Mar, Apr, May, Jun	375 Hours	Oct, Nov, Dec
Apr, May, Jun, Jul, Aug, Sep	375 Hours	Jan, Feb, Mar
Jul, Aug, Sep, Oct, Nov, Dec	375 Hours	Apr, May, Jun
Oct, Nov, Dec, Jan, Feb, Mar	375 Hours	July, Aug, Sep

Any bank hours credited will remain in your hour bank if you do not attain eligibility during your first quarter of work. If you do not attain eligibility in the second quarter of work, all hours, including those from the first quarter will be forfeited. For example, if you work 350 hours in January, February and March 2003 and 375 hours in April, May and June 2003, then you will first become eligible for benefits on October 1, 2003 and 350 hours will remain in your hour bank. If you work 150 hours in January, February and March 2003 and 100 hours in April, May and June 2003, then you will not be eligible for benefits and the 250 hours in the hour bank will be forfeited.

SELF-EMPLOYED CONTRACTORS – You will become covered on the first day of a Coverage Period following the date of signing a Participation Agreement with the Union and paying the premiums for the two quarters immediately preceding the first day of coverage and the quarter of coverage, unless eligibility had been pre-established. Your company must also have contributions due to the Fund for at least 3,000 hours of collectively bargained work each year. Collectively bargained work is work in the bricklaying trade performed by union bricklayers who have no ownership in your company. These contributions must be received prior to the non-bargaining participant requesting to apply for the self-pay program through the Fund. Individuals with any ownership interest in an entity such as a sole proprietorship, partnership, joint venture, or corporation, who seek coverage under the Plan must contribute at the self-employed contractor’s rate. If a self-employed contractor works for another Contributing Employer, then those contributions received for the self-employed contractor may be credited towards the quarterly premiums, upon request. Self-employed contractors must continuously be in compliance with the rules and regulations established by the Board of Trustees.

APPRENTICES – If you are an apprentice who is registered with the Division of Apprenticeship and Training, then you will become covered on the first day of a **Coverage Period** following the **Qualifying Period** in which you complete 250 hours and make self-payments for the difference between the work hours and 375 hours. If you attend daytime apprentice school, then you will be credited with up to 72 hours per quarter if you remain in the program and complete all course requirements. The self-payment rate is 60% of the rate required of Employees. If you are

absent from active work because of an Injury or Sickness on that day, then you will still become covered for all benefits except for the **Weekly Accident and Sickness Benefit (Loss of Time)**. The **Weekly Accident and Sickness Benefit** will begin when you return to active work.

DEPENDENTS - Your Covered Dependents (as described under **Definitions**) will become covered on the same date that you become covered. Eligible Dependent children born after coverage begins will be covered on the date of their birth. If there are new dependents in the family by virtue of your marriage, then the new dependents will become covered on the date of marriage. Children placed for adoption will become covered on the date of placement.

Continued Eligibility

1. You will remain eligible for coverage as long as the combination of contributed work hours and reserve hours meet the necessary **Prescribed Hours** explained in the **Qualifying Schedule**.
2. You are allowed to accumulate a maximum of 1,600 bank hours in excess of 375 hours per coverage period. When you accumulate the maximum bank hours, the Fund will provide coverage for four **Coverage Periods**. These bank hours are not vested. The hours are forfeited if you leave or become unavailable for covered employment.
3. If you fail to attain the required number of hours for continued eligibility, but you have worked 325 hours or more during the **Qualifying Period**, then you will be allowed to self-pay for the difference between the number of hours worked and the number of prescribed hours. That self-payment will not be counted towards the maximum of four consecutive self-payments allowable under the Plan. The Trustees reserve the right to change the maximum number of consecutive self-payments.
4. If you fail to acquire the prescribed number of hours to continue eligibility, but you have worked less than 325 hours during the **Qualifying Period**, you will be allowed to self-pay for the difference between the hours worked and hours required, if you are available for work in covered employment. You may make self-payments until the earlier of:
 - A. The date you become eligible for health coverage through employment with the same or another Contributing Employer; or
 - B. The end of the coverage period following the receipt of four consecutive quarterly self-payments.

You may be able to make a 5th and 6th **consecutive** quarterly self-payment in addition to the four consecutive self-payment maximum. These additional payments would be available if you have 800 hours of actual employer contributions made on your behalf during the four qualifying Quarters which correspond to the first four self-payment Quarters. The 5th and 6th consecutive quarterly self-payments must immediately follow the previous four consecutive self-payments.

In addition, if you do not have enough hours for continued eligibility, have not worked any hours in the **Qualifying Period**, and are receiving Workers' Compensation Benefits from a Contributing Employer during the **Qualifying Period**, you will be allowed to self-pay the required amount for continued coverage and such self-payment will not count against the maximum number of consecutive self-payments allowed under the Plan. There is no limit on the number of self-payments under these circumstances as long as you have not retired or become eligible for Medicare.

Self-payment will be allowed only for Covered Employees working or available for work under covered employment or receiving benefits from the Workers' Compensation insurer of a Contributing Employer.

5. A self-employed contractor will remain eligible if his quarterly premiums are paid, and he is in compliance with the rules and regulations established by the Board of Trustees.
6. Apprentices will remain eligible if they have 250 hours and make self-payments for the difference between the hours worked (including any hours credited for participation in apprenticeship school) and 375 hours per **Qualifying Period**. Self-payment by apprentices for the duration of their apprenticeship is 60% of the rate required of Employees. That self-payment will be counted toward the maximum consecutive self-payments allowed under the Plan.

Self-Payments

The Trustees reserve the right to change the number and amount of allowable consecutive self-payments.

The Board of Trustees will accept self-payment contributions **from only you or your spouse**. If the Board of Trustees learns that a self-payment contribution is being made on your behalf by a third-party, your self-payment contribution will be refused and eligibility for you and/or your dependents may be terminated. This does not apply in the case of COBRA Continuation Coverage.

Change of Classification

When you retire or become disabled, the benefits for which you are eligible will change effective at the beginning of a **Coverage Period**. This change in benefits will apply only to claims incurred on and after that date. You must meet the eligibility requirements outlined under **Maintaining Eligibility for Disabled or Retired Employees or Surviving Spouses**. However, the actual date of retirement shall be the determining factor for Medicare eligibility and Coordination of Benefits ("COB") with Medicare.

Non-Bargained Employee Participation

The Board of Trustees, at its sole discretion, reserves the right to implement participation rules for non-bargained Employees, and to change those rules, including eliminating such participation entirely. Any such rules that are adopted by the Board of Trustees for non-bargained Employees are incorporated into this booklet by this reference. Please call the Fund for more information on non-bargained participation rules.

Termination of Eligibility

Your coverage will terminate on the last day of the **Coverage Period** if the combination of contributed work hours and reserve hours in the applicable **Qualifying Period** is not sufficient to meet the **Prescribed Hours** for the upcoming **Coverage Period**, except as described under **Continued Eligibility**.

You will be provided with certification of coverage upon termination from this Plan.

Service in the Armed Forces

The Uniformed Services Employment and Reemployment Act provides certain benefit protections to employees on military leave in the uniformed services. If you enter active military service for up to 30 days, then you can continue medical, dental and vision coverage during that leave period if you either continue to pay the required contributions or use reserve hours for coverage during that period of that leave. If you are in active military service for 31 or more days and your bank hours have been exhausted, then you may be able to continue medical, dental and vision coverage at your own expense for up to 18 months. Contact the Fund for further information.

You will be covered on the first day of the month following honorable discharge or release from duty if you return to work for a Contributing Employer within the time limits below.

<u>If you were in military service</u>	<u>You must</u>
1 to 30 days	Report to a Contributing Employer by the beginning of the first regularly scheduled workday more than 8 hours after you return home.
31 to 180 days	Submit an application for reemployment to a Contributing Employer within 14 days after the completion of your service.
More than 180 days	Submit an application for reemployment to a Contributing Employer within 90 days after the completion of your service.

The Fund may request that you provide documentation to establish the timelines of the application for reemployment. Documentation may include a copy of your discharge papers which show the date of enlistment, the date of discharge, and whether the discharge was honorable.

Coverage for a child who is a Covered Dependent will end when the child no longer meets this Plan's definition of a Covered Dependent.

When coverage ends, you may be eligible to continue coverage through self-payments or COBRA. These options are explained below. Election of one of these continuation options is considered rejection of the other.

Reinstatement of Eligibility

If you were previously covered and terminated, you must again meet the **Initial Eligibility** rules outlined previously under **Rules of Eligibility**.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) creates a federal right for Covered Employees who qualify to take up to twelve weeks of unpaid leave if they are seriously ill, after the birth or adoption of a child or to care for their seriously ill spouse, parent or child. You must notify the Fund if you qualify to take a family or medical leave. If your Contributing Employer is required to comply with FMLA, it must give the Fund the necessary information to verify that the leave qualifies under the FMLA. Your Contributing Employer must certify eligibility and pay the required premium for the extension of coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA GENERAL COBRA NOTICE

Introduction

You are receiving this notice because you have been or recently become covered under **Twin City Bricklayers Health and Welfare Fund** (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plan and under federal law, you should either review the information contained in this Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is the Board of Trustees of the Twin City Bricklayers Health and Welfare Fund, and the Plan's Third-Party Administrator is Zenith Administrators, Inc., 7645 Metro Boulevard, Edina, Minnesota 55439 (952) 835-7035. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 45 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator with 60 days after the qualifying event occurs. You must send this notice to: Zenith Administrators, Inc., 7645 Metro Boulevard, Edina, Minnesota 55439 (952) 835-7035.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Zenith Administrators, Inc., 7645 Metro Boulevard, Edina, Minnesota 55439 (952) 835-7035.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependant children if the former employee dies, enrolls in Medicare (Part A, Part B, or both),

or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:** Zenith Administrators, Inc., 7645 Metro Boulevard, Edina, Minnesota 55439 (952) 835-7035.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Zenith Administrators, Inc., 7645 Metro Boulevard, Edina, Minnesota 55439 (952) 835-7035, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Medical Examination Requirements

No medical examination is required of either you or your dependent in order to become covered under the Plan. You have the right to select your own Physician or Hospital.

RETIREE ELIGIBILITY

Retired or disabled employees and spouses who are eligible for Medicare will receive benefits from the Medicare Supplement Plan, which are described in a separate Summary Plan Description booklet. See that booklet for a description of eligibility and benefits.

Disabled or Retired Employees or Surviving Spouses Prior to January 1, 1998

You must meet the following requirements to become eligible for Plan benefits as a Retired Employee:

1. Be at least age fifty-five and currently eligible under the Plan;
2. Receive monthly payments from the Twin City Bricklayers Pension Fund; or
3. If you are not eligible for a pension from the Twin City Bricklayers Pension Fund, you must have worked a minimum of 3,500 hours in covered employment for a Contributing Employer required to make contributions to this Welfare Fund during the sixty-month period preceding the date you become eligible for Plan benefits as a Retired Employee.

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

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

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

Your surviving spouse may continue coverage by making self-payments until he/she remarries or becomes covered under a group plan if he/she was covered by this Plan immediately prior to your death.

Disabled or Retired Employees or Surviving Spouses on or After January 1, 1998 – Retiree Contribution Allowance Plan

General Eligibility Requirements:

1. You must have earned at least 10 service credits and attained age 55 (except in the case of pre-retirement death or disability).
2. You must have worked at least 160 hours in covered employment for a

Contributing Employer after May 1, 1997 and retire on or after January 1, 1998.

3. You must be eligible for coverage under the Health and Welfare Fund at the time of retirement, death, or disability.
4. If you are eligible for a pension from the Twin City Bricklayers Pension Fund, you must be receiving monthly payments from that fund.
5. Contributions must have been paid by your Contributing Employer to the Health and Welfare Fund for your hours worked in each of the five calendar years preceding the calendar year during which you become eligible for the retiree health benefit.
6. Self-employed contractors are not eligible for the retiree contribution allowance.
7. Retired coverage must be continuous from active employment (it cannot be delayed for any reason). The spouse of a retiree who retired on January 1, 1998 and after may delay coverage under the Plan if he/she has other group coverage through an employer. The spouse can be covered as a dependent of the retiree when he/she becomes Medicare eligible (usually age 65). A spouse who delays coverage may also return on a one time only basis if coverage through his/her employer is terminated. In that case, the retiree must notify the Fund within 31 days of the date the spouse's coverage was terminated, and send in any required self-payment contribution. Coverage under this Plan for the spouse would become effective on the first day of the month following the date the notification and self-payment contribution was received.

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

In order for a spouse to re-claim eligibility for coverage under this Plan, the retiree must be covered under this Plan on the date the spouse becomes eligible. If the retiree is deceased at the time the surviving spouse becomes Medicare eligible, then the surviving spouse can become re-eligible under this Plan if the deceased retiree was eligible on the date of death, or had not yet become Medicare eligible at the time of death.

The Plan does not have the obligation and will not notify the retiree and/or spouse who has delayed coverage under this plan, that their specific re-eligibility date is approaching. It is entirely the responsibility of the retiree and/or spouse to notify the Fund when becoming re-eligible under this Plan.

8. For general eligibility and service credit determinations for purposes of computing retiree contribution allowances, the Plan will recognize contributions and/or service for participants of local unions that have been merged into Bricklayers and

Allied Craftworkers Union Local #1 of Minnesota. The Board of Trustees will determine what records provide the best evidence of a participant's history with a merged local union's prior health plan, and the Board of Trustees will utilize that history for computations for retiree contribution allowances.

Service Credit:

1. For past service, cumulative contribution hours under Twin City Bricklayers Pension Fund through December 31, 1997 are divided by 1,600 (rounded to nearest full credit). For employees who are not Pension Fund participants, years of covered employment under this Health and Welfare Fund prior to January 1, 1998 will be determined by the Trustees.
2. For future service, cumulative contribution hours under Health and Welfare Fund on and after January 1, 1998 are divided by 1,600 (rounded to nearest full credit).
3. Service credits are provided for Contributing Employer hours only. Self-pay hours and self-employed contractor premiums do not count.
4. Prior service is lost if a member has two consecutive One-Year Breaks in Service. Prior to January 1, 1998, a One-Year Break in Service is defined as a calendar year in which the member does not have at least 160 hours of covered employment under the Pension Fund or any other pension plan, annuity plan, or defined contribution plan sponsored by the International Union of Bricklayers and Allied Craftworkers or any affiliate thereof. After January 1, 1998, a One-Year Break in Service is defined as a calendar year in which the member does not have at least 160 hours of covered employment under the Health and Welfare Fund.

Accrued Contribution Allowance:

Provided Prior to Medicare Eligibility:

\$14.50 per service credit to a maximum of 30 credits (48,000 hours). Maximum contribution allowance is \$435 per month. For those who retire on or after January 1, 2004 the maximum credits will be 35 (56,000) hours.

Provided After Medicare Eligibility:

\$11.00 service credit to a maximum of 30 credits (48,000 hours) for a retiree on Medicare with a spouse who is not yet eligible for Medicare covered under the Plan. Maximum contribution allowance is \$330 per month. For those who retire on or after January 1, 2004 the maximum credits will be 35 (56,000) hours.

\$7.25 per service credit to a maximum of 30 credits (48,000 hours). Maximum contribution allowance is \$217.50 per month. For those who retire on or after January 1, 2004 or after the maximum credits will be 35 (56,000) hours.

Normal Retirement:

Eligibility: Age 60 with 10 service credits

Contribution Allowance: Full accrued amount

Early Retirement:

Eligibility: Age 55 with 10 service credits

Contribution Allowance: Accrued amount reduced .25% for each month retirement precedes age 60

Disability:

Eligibility: 10 service credits and Permanently and Totally Disabled as defined in the Plan.

Contribution Allowance Prior to Medicare Eligibility:

Full accrued amount

Contribution Allowance After Medicare Eligibility:

Same as for Normal Retirement

Surviving Spouse:

Eligibility: 10 service credits

Contribution Allowance: 100% of the early retirement amount that would have been provided at your earliest retirement age, provided immediately to surviving spouse.

Treatment of Bank Hours:

Bank hours are used to remain eligible for active coverage until all hours are used. You can self-pay to make up any difference in final quarter.

DEATH BENEFIT
Applicable to Class A Only

The **Death Benefit** is payable to your beneficiary if you die from any cause while you are eligible for benefits under the Plan. The amount of the **Death Benefit** is shown in the **Schedule of Benefits**, and it is paid in a lump sum after a death certificate is submitted to the Fund Office.

Dependents are not eligible for Death Benefit coverage.

Beneficiary

Your beneficiary is any person or persons named on a designated form kept on record at the Fund. You may change your beneficiary at any time by submitting a new beneficiary form to the Fund. You do not need the consent of your current beneficiary to change your beneficiary. A change of beneficiary will become effective when the new beneficiary form is received by the Fund, and it will automatically replace any previously submitted beneficiary form.

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

1. surviving spouse, if any;
2. child and/or children, if any;
3. parents, if living; or
4. estate.

**WEEKLY ACCIDENT AND SICKNESS BENEFIT
(LOSS OF TIME)
Applicable to Class A Only**

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

Dependents are not eligible for Weekly Accident and Sickness Benefits.

The amount of the **Weekly Rate** and the **Maximum Number of Weeks Payable** are shown in the **Schedule of Benefits** stated in this booklet. The **Weekly Accident and Sickness Benefit (Loss of Time)** will begin on the fourth day of a disability due to an Injury and on the eighth day of a disability due to a Sickness. Sickness includes physical illness, including pregnancy, and mental or nervous disorders.

Successive Periods of Disability

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

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

Exclusions and Limitations

No benefits are payable under this **Weekly Accident and Sickness Benefit (Loss of Time)** for any:

1. disability resulting from Sickness or accidental Injury for which you are not under the care of a legally qualified Medical Doctor (M.D.);
2. disability covered by Workers' Compensation or any occupational Sickness law;
3. disability due to an occupational Injury that occurred while working for pay or profit; or
4. disability after retirement, even if you are using bank hours to retain active coverage.

NOTE: The Tax Reform Act of 1986 provides that any benefit that you receive as **Weekly Accident and Sickness Benefits (Loss of Time)** (such as under the provisions of this benefit program) are no longer tax exempt and must be included as part of your annual gross income. The **Weekly Rate** shown in the **Schedule of Benefits** has

already been reduced by the amount of your share of FICA tax.

DENTAL EXPENSE BENEFIT

Applicable to Class A Only

The **Dental Expense Benefit** is payable if you incur Expenses for covered dental charges. This benefit will not exceed the **Calendar Year Maximum** for covered charges shown in the **Schedule of Benefits** stated in this booklet. Expenses in excess of the **Calendar Year Maximum** shown in the **Schedule of Benefits** will **not** be covered under the **Comprehensive Major Medical Expense Benefit**.

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

Covered Dental Charges

Covered Dental Charges include Expenses for the following:

1. Oral examinations, including scaling and cleaning of teeth, but not more than two examinations or scalings and cleanings per calendar year.
2. Topical application of sodium or stannous fluoride, once in each period of twelve consecutive months, but only if the Covered Dependent is less than sixteen years old.
3. Dental X-rays, including bitewing X-rays once every twenty-four months for adults and once every twelve months for children. Full-circle X-rays will be covered once every three years.
4. Extractions.
5. Oral surgery, including excision of impacted teeth.
6. Fillings (including composite fillings).
7. General anesthetics administered in connection with oral surgery or other covered dental services.
8. Injection of antibiotic drugs by the attending dentist.
9. 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 license.
10. Space maintainers and retainers.
11. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
12. Endodontic treatment, including root canal therapy.
13. 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 on or after the date the Covered Person becomes eligible for the **Dental Expense Benefit**, of one or more natural teeth, accidentally injured or diseased, and such denture or bridgework includes the replacement of teeth so extracted.

14. The replacement or alteration of full or partial dentures or fixed bridgework which is necessary because of:
 - a. oral surgery resulting from an accident; or
 - b. oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue;but only if this occurs after the Covered Person has become eligible under this **Dental Expense Benefit**, and the replacement or alteration is completed within twelve months after such surgery.
15. The replacement of a full denture which is necessary because of:
 - a. structural change within the mouth, but only if more than five years has elapsed since the initial placement;
 - b. the initial placement of an opposing full denture, but only after the Covered Person has been covered under this **Dental Expense Benefit** for at least two years; or
 - c. the prior installation of an immediate temporary denture, but only within twelve months of the installation of the temporary.
16. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, but only if:
 - a. the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while eligible under this **Dental Expense Benefit** and after the existing denture or bridgework was installed; or
 - b. 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.
17. The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.
18. Inlays, gold fillings, crowns, including precision attachments for dentures.
19. Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.
20. Orthodontia treatment for dependent children up to age 19.

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

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

is performed.

Exclusions and Limitations

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

1. Expenses incurred after termination of eligibility, except for prosthetic devices which were fitted and ordered prior to termination and which were delivered to an eligible Covered Person within thirty days after the date of termination of eligibility;
2. prosthetic services (including bridges and crowns) started or under way prior to the date a Covered Person became eligible under this **Dental Expense Benefit**;
3. denture rebasing or relining less than six months from the date of initial placement and not more often than once in any two-year period;
4. replacement of lost or stolen prosthetics;
5. replacement of prosthetics less than five years after placement, except as specifically provided;
6. orthodontic care, treatment, services and supplies, including extraction of teeth relating to orthodontic care received after the Covered Dependent's nineteenth birthday;
7. treatment on or to the teeth or gums for cosmetic purposes (including realignment of teeth); or
8. the application of dental sealants after the Covered Dependent's sixteenth birthday.

PREVENTIVE DENTAL EXPENSE BENEFIT
Applicable to Class B Only

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

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

Covered Dental Charges

Covered dental charges include expenses for the following:

1. Oral examinations, including routine cleaning of teeth, but not more than two examinations and cleanings per calendar year.
2. Bitewing X-rays once every 12 months. Full-mouth X-rays will be covered once every five years.

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

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

PHYSICAL EXAMINATION BENEFIT
Applicable to Class A Only

This **Physical Examination Benefit** is provided by the Plan to encourage you to have routine physical examinations as a means of maintaining good health and identifying potential medical problems while they are still at an early stage.

The **Physical Examination Benefit** is payable up to the amount shown in the **Schedule of Benefits** for one routine physical examination per calendar year for each Covered Person. Physical examination Expenses in excess of the amount shown in the **Schedule of Benefits** are your responsibility, and they will **not** be considered a Covered Expense under any other benefits of this Plan, including the **Comprehensive Major Medical Expense Benefit**. Physical examinations in conjunction with cancer screening tests will first be paid under the Cancer Screening Benefit and then under the Physical Examination Benefit.

Exclusions and Limitations

Covered Expenses under the Physical Examination Benefit do **not** include the following:

1. services received which are not performed by a Physician or under a Physician's direct supervision;
2. services received while confined in a Hospital, convalescent or Skilled Nursing Care Facility, nursing home, night-care center or similar institution;
3. medicines, drugs, appliances, equipment, materials or supplies;
4. physical examinations to determine the existence or nonexistence of pregnancy, during the term of pregnancy, or within ninety days after termination of pregnancy;
5. psychiatric, psychological and personality or emotional testing or examination;
6. premarital examinations; and
7. expenses in excess of the specified maximum set forth by the Plan during the calendar year.

HOME HEALTH CARE BENEFIT
Applicable to Classes A and B

Home Health Care charges are covered up to the **Maximum Amount per Visit** and up to the **Maximum Number of Visits per Calendar Year** shown in the **Schedule of Benefits** which are furnished by a Home Health Care Agency in accordance with a Home Health Care Plan.

Benefits will be payable for the following services and supplies:

1. Part-time or intermittent nursing care, provided by a:
 - a. registered nurse; or
 - b. licensed practical nurse supervised by a registered nurse.
2. Part-time or intermittent home health aide services which consist primarily of medical care or therapy for the Covered Person.
3. Physical, occupational or speech therapy.
4. Medical supplies, drugs and medicines, and related pharmacy and laboratory services, which are prescribed by a Physician and would be covered if the Covered Person was confined in a Hospital.

One home health care visit consists of:

1. one visit by a Home Health Care Agency representative; or
2. a visit of four hours or less by a home health aide.

A visit by a nurse or physiotherapist in excess of eight hours or by a home health aide in excess of four hours will be considered an additional visit. The second visit on the same day is subject to the same time restraints.

Exclusions and Limitations

Benefits will **not** be paid for:

1. services which consist primarily of the duties of a housekeeper, companion or sitter;
2. services and supplies not included in the Home Health Care Plan;
3. services of a person who is a member of the Covered Person's immediate family or otherwise lives in the Covered Person's home;
4. Expenses for which benefits are payable under any other provisions of the Plan; and
5. services provided outside the Covered Person's home.

CHIROPRACTIC EXPENSE BENEFIT
Applicable to Classes A and B

Chiropractic charges are covered up to the **Maximum Daily Amount** and the **Calendar Year Maximum** shown in the **Schedule of Benefits**. Chiropractic charges in excess of the amount shown in the **Schedule of Benefits** are your responsibility, and they will **not** be considered a Covered Expense under any other benefits of this Plan, including the **Comprehensive Major Medical Expense Benefit**.

HEARING BENEFIT
Applicable to Classes A and B

Charges for hearing examinations, purchase of hearing aids and fitting of hearing aids are covered up to the **Maximum per Five Calendar Years** shown in the **Schedule of Benefits**. Charges in excess of the amount shown in the **Schedule of Benefits** are your responsibility, and they will **not** be considered a Covered Expense under any other benefits of this Plan, including the **Comprehensive Major Medical Expense Benefit**.

Exclusions and Limitations

Benefits will **not** be paid for:

1. replacement batteries, or
2. repair and maintenance of hearing aids.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT
Applicable to Classes A and B

The **Comprehensive Major Medical Expense Benefit** is payable if you incur covered Expenses as the result of an Injury or Sickness that is covered by this Plan. This Plan will pay the **Comprehensive Major Medical Expense Benefit** as outlined in the **Schedule of Benefits**.

Benefits

Benefits are payable at the percentage shown in the **Schedule of Benefits** for Expenses incurred in excess of the deductible amount.

Benefits payable under the **Comprehensive Major Medical Expense Benefit** will not exceed the lifetime maximums shown in the **Schedule of Benefits**.

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. Reimbursement will be made for the premium payable for the Qualified Plan No. 2 plus the annual \$500.00 deductible and any applicable co-payments. The maximum reimbursement in a calendar year is \$3,000.00.

If you incur covered Expenses during any calendar year in excess of the out-of-pocket maximum shown in the **Schedule of Benefits**, then benefits for that person are payable at 100% for the remainder of the calendar year.

Deductible Amount

The deductible amount is the amount of covered Expenses which you must pay each calendar year before the **Comprehensive Major Medical Expense Benefit** will be paid. The deductible amount consists of the **Calendar Year Deductible Amount** shown in the **Schedule of Benefits**.

Deductible Provisions

The **Calendar Year Deductible Amount** has these special provisions:

1. **Family Deductible:** When two or more Covered Persons of the same family satisfy the **Family Deductible** shown in the **Schedule of Benefits**, no other Deductible Amount will be required by other Covered Persons in that family for the remainder of the calendar year.
2. **Three-Month Carryover:** Any Expenses incurred in the last three months of a Calendar Year which are used to satisfy the **Calendar Year Deductible Amount**, in part or in full, are also applied to the **Calendar Year Deductible Amount** for the following year.

3. **Common Disaster:** If two or more Covered Persons of the same family are injured in the same accident or contract the same contagious disease within thirty days, only **Calendar Year Deductible Amount** for one person will be applied against the combined total covered Expenses resulting from the accident or contagious disease. This combined **Calendar Year Deductible Amount** will also apply to future **Calendar Year Deductible Amounts**.

Covered Charges

Covered Charges are the Reasonable and Customary Charges or network contracted charges incurred for the following Medically Necessary services and supplies recommended by the attending Physician for the treatment of an Injury or Sickness:

1. **Inpatient and Outpatient Hospital Expenses** - including:
 - a. Hospital Room and Board, up to the average semi-private room rate charged by the Hospital. (If the Hospital has no semi-private accommodations, 90% of the Hospital's minimum daily private room and board rate will be the Covered Charge.)
 - b. 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.
2. **Surgical Expenses** - Cutting, suturing, correction of a fracture, reduction of dislocation, electrocauterization, 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 pays up to 20% of the surgical reimbursement for anesthesia Expenses when not billed as part of the Hospital charges.
 - a. **Multiple Operations** - A separate payment is made for each operation performed. However, when two or more surgical procedures are performed through the same abdominal incision, then the total benefit will be the amount payable for the operation with the highest allowance. If two or more surgical procedures are performed at the same time through separate incisions, then the total benefit for all such operations will not exceed one and one-half (1-1/2) times the amount payable for the operation with the highest allowance.
 - b. **Successive operations** - are considered performed during one continuous period of disability unless:
 - i. they are due to entirely unrelated causes;
 - ii. you have fully recovered from the Injury or Sickness which made the previous surgery necessary; or

- iii. you have returned to active employment for at least one full working day between surgeries.

- 3. **Inpatient Treatment for Alcoholism, Chemical Dependency, Drug Addiction, and Mental or Nervous Disorders** for confinement in a licensed Hospital or residential primary treatment program for the treatment of alcoholism, chemical dependency, drug addiction or a mental or nervous disorder after diagnosis or upon recommendation of a Physician. Physician visits include visits by licensed psychologists and licensed consulting psychologists.

Benefits for alcoholism, chemical dependency or drug addiction will not exceed the **Lifetime Maximum** amount stated in the **Schedule of Benefits** for all such services or treatments.

- 4. **Outpatient Treatment for Alcoholism, Chemical Dependency, Drug Addiction and Mental or Nervous Disorders** - Outpatient treatment for alcoholism, chemical dependency and drug addiction in a non-residential treatment program approved by an authorized state agency.

Outpatient treatment for mental or nervous disorders includes consultation, diagnosis and treatment which are provided by any of the following:

- a. a licensed psychiatrist, a licensed consulting psychologist or a licensed psychologist practicing under state law;
- b. a licensed or accredited Hospital; or
- c. a community mental health center or a mental health clinic approved or licensed by the appropriate authorized State agency.

Benefits for alcoholism, chemical dependency or drug addiction will not exceed the **Lifetime Maximum** amount stated in the **Schedule of Benefits** for all such services or treatments.

- 5. **Medical and surgical expenses for mastectomies** as required by the Women's Health and Cancer Rights Act of 1998, including
 - a. reconstruction of the breast on which the mastectomy has been performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

- 6. **Maternity Expenses** resulting from a pregnancy are covered immediately for Expenses incurred on or after the effective date of your coverage under the Plan. Under federal law, the Plan may not restrict the hospital stay for childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery. 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 newborn earlier than 48 hours (or 96 hours as applicable). The Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

7. **Nursery care** for each newborn dependent child will be covered for Hospital room and board and miscellaneous charges during the period the mother is confined in the Hospital as the result of giving birth. Such benefits will be payable only if the mother was eligible for maternity benefits at the time the child was born. In no event will Hospital room and board and miscellaneous benefits continue after the mother is released from the Hospital unless special care and treatment is required by the child as a result of the following:
 - a. Sickness contracted or Injury suffered;
 - b. a congenital defect; or
 - c. a premature birth.
8. **Well Baby Care** - Well baby Physician office visits and necessary inoculations (such as polio and DPT) for Covered Dependents from birth until their sixth birthday.
9. **Diagnostic Laboratory and X-Ray** charges for laboratory tests or X-rays made or recommended by a Physician while not Hospital confined.
 - a. The following services are not covered:
 - i. examinations made for routine check-up purposes;
 - ii. dental care or treatment;
 - iii. eye refractions; or
 - iv. therapeutic X-rays.
10. **Radiation therapy and chemotherapy**, as ordered by a Physician.
11. **Skilled Nursing Care Facility** charges for a Skilled Nursing Care Confinement as the result of an Injury or Sickness. Benefits will be payable for the Reasonable and Customary Charges incurred for the period of confinement in a Skilled Nursing Care Facility.
12. **Body Organ Transplants** - Expenses for transplant surgery will be paid when the recipient is a Covered Person under this Plan for the following:
 - a. For a recipient up to the Lifetime Maximum Recipient Benefit shown in the **Schedule of Benefits**:
 - i. the use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
 - ii. multiple transplant(s) during one operative session;

- iii. replacement(s) or subsequent transplant(s); and
 - iv. follow-up Expenses for covered services (including immuno-suppressant therapy) up to the Follow-up Expense Maximum.
- b. For a donor up to the Lifetime Maximum Donor Benefit shown in the **Schedule of Benefits**:
- i. testing to identify suitable donor(s);
 - ii. the Expense for the acquisition of organ(s) from a donor;
 - iii. the Expense of life support of a donor pending the removal of a usable organ(s);
 - iv. transportation for a living donor;
 - v. transportation of organ(s) or a donor on life support.

Benefits under the Lifetime Maximum Donor Benefit are payable only when the recipient is a Covered Person under this Plan.

c. Definitions

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

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

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

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

d. Benefits will not be paid for:

- i. organ transplants unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable and/or more hazardous than a transplant;
- ii. any animal organ or mechanical equipment, device or organs, except as provided under the benefits for a recipient;
- iii. any financial consideration to the donor other than for a Covered Expense which is incurred in the performance of or in relation to transplant surgery;
- iv. organ transplants that you may not be legally required to pay for;
- v. anything excluded under the General Exclusions and Limitations, and
- vi. body organ transplant Expenses which are in excess of the Lifetime

Maximum Benefit as stated in this booklet.

13. **Other Expenses** - including:
- a. Treatment by a legally qualified Physician.
 - b. Treatment by a physiotherapist.
 - c. Dental treatment by a Physician, dentist or dental surgeon for a fractured jaw or for an Injury to natural teeth including replacement of such teeth within six months after the date of the accident.
 - d. X-ray or radium treatment.
 - e. X-ray and laboratory examinations, excluding dental X-rays unless rendered for dental treatment of a fractured jaw or for an Injury to natural teeth within six months after the date of the accident.
 - f. Professional ambulance service for Medically Necessary transportation to the nearest Hospital equipped to provide the appropriate treatment. This does **not** include common carriers such as railroad, ship, bus or airplane.
 - g. Human growth hormone injections.
 - h. The following Medical Supplies:
 - i. drugs and medicines legally obtained from a licensed pharmacist only upon prescription of a currently licensed Physician, but specifically excluding those drugs or any other form of medication which may be obtained without such a prescription, even though they may be so prescribed. However, prescribed infant formula and prescribed supplements to the formula may be covered if the Board of Trustees decides, based on reasonable medical evidence, that they are Medically Necessary and that no reasonable alternative for the formula or supplements exists.
 - ii. blood and blood plasma;
 - iii. artificial limbs and eyes;
 - iv. surgical dressings;
 - v. casts, splints, trusses, braces, crutches;
 - vi. rental of wheel chairs or Hospital beds;
 - vii. oxygen and the rental of equipment for its administration; and
 - viii. rental of durable medical equipment prescribed by a Physician but not to exceed the actual purchase price. The equipment may also be purchased if the Board of Trustees determines that a purchase is in the best financial interest of the Fund.
 - i. **Dental treatment** when necessary due to an Injury to sound natural teeth.

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

CANCER SCREENING TEST BENEFIT
Applicable to Classes A and B

This **Cancer Screening Test Benefit** is provided by the Plan to encourage you to have routine cancer screening tests as a means of identifying potential medical problems at an early stage.

The **Cancer Screening Test Benefit** is payable up to the amount shown in the **Schedule of Benefits** for one routine mammogram, pap smear or PSA test per calendar year for each Covered Person. Cancer screening test Expenses in excess of the amount shown in the **Schedule of Benefits** will be considered under the Physical Examination Benefit.

VISION CARE PROGRAM
Applicable to Classes A and B

This benefit is designed to pay a portion of the Expense of eye examinations and glasses.

Benefits are payable for Expenses for eye examinations performed by a legally qualified ophthalmologist or optometrist and the prescribed frames and lenses. The **Maximum Amount Payable for Examinations and Vision Materials** for each Covered Person during a two-calendar year period is shown in the **Schedule of Benefits**. The two-year calendar year period is a fixed schedule that applies equally to all Covered Persons. The periods are 2001-2002, 2003-2004, 2005-2006 etc.

The following services and supplies are covered under this **Vision Care Program**:

1. **EXAMINATION** - complete examination including dilation of pupils and/or relaxing of focusing muscles by drops, refraction of vision, and examination for pathology.
2. **VISION MATERIALS** - New or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist and including the fitting and cost of supplies.

An Expense is considered to be incurred on the date on which the service or materials are provided or obtained.

Exclusions and Limitations

No payment will be made under this **Vision Care Program** for Expenses incurred for the following:

1. Special supplies or services not listed as covered Expenses.
2. Any eye examination required by an employer as a condition of employment.
3. Medical or surgical treatment.

**EXCLUSIONS AND LIMITATIONS TO THE
COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT**

Comprehensive Major Medical Expense Benefits will **not** be payable for Expenses incurred for, or resulting from:

1. Injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit;
2. declared or undeclared war, or any act thereof, or military or naval service of any country;
3. cosmetic surgery, except for treatment for an Injury sustained in an accident or 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 where necessary for the treatment of an illness or as specifically provided under the **Physical Exam 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; and
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:
 - a. not provided in accordance with generally accepted professional medical standards;
 - b. not proved safe and effective; or
 - c. investigative or experimental treatments.
12. services provided by a family member.

BENEFIT CLAIMS AND APPEALS

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

How to File a Claim

A “claim for benefits” is a request for Fund benefits made in accordance with the Fund’s reasonable claims procedures. In order to file a claim for benefits offered under this Fund, you must submit a completed claim form to the Fund. Inquiries or phone calls about the Fund’s provisions that are unrelated to any specific benefit claim will not be treated as claim for benefits. In addition, your request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits.

A claim form may be obtained from the Fund Office by calling (952) 835-7035. If you use the services of a network provider, the provider will generally file your claims for you. 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.

- Â Participant name;
- Â Patient name;
- Â Patient Date of Birth;
- Â Social Security Number of participant or retiree;
- Â Date of Service;
- Â CPT-4 (the code for physician services and other health care services found in the most current edition of the Current Procedural Terminology, as maintained and distributed by the American Medical Association);
- Â ICD-10 (the diagnosis code found in the most current edition of the International Classification of Diseases, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Â Billed charge;
- Â Number of Units (for anesthesia and certain other claims);
- Â Federal taxpayer identification number (TIN) of the provider;
- Â Billing name and address; and
- Â If treatment is due to accident, accident details.

When Claims Must Be Filed

You must file your claim for benefits within 90 days after the date you incurred the charges. If you fail to file your claim within the time required, then 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

12 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.

Where Claims Must Be Filed

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

Twin City Bricklayers Health and Welfare Fund
P. O. Box 257
Minneapolis, Minnesota 55440-0257

Facility of Payment

If payments, which should have been made under this Plan, have been made under any other plan or plans, then the Fund may, at its sole discretion, pay any organizations making such other payments the amount which the Fund determines will satisfy the intent of this provision. Amounts so paid are considered benefits paid under this Plan and, to the extent of such payments, the Fund will be fully discharged from liability.

Benefits payable under the Plan for a loss, other than continuing loss, will be paid upon receipt of due proof. Upon receipt of proof, all claims for continuing loss will be paid each two weeks during any period for which the Fund is liable and any balance remaining unpaid immediately upon receipt of due proof.

If any benefits of the Plan will be payable to a Covered Person who is a minor or otherwise not competent to give a valid release, the Fund may pay such indemnity up to an amount not to exceed \$5,000.00 to any relative by blood or marriage of the Covered Person who is considered by the Fund to be entitled. Any payment made by the Fund in good faith and pursuant to this section will fully discharge the Plan to the extent of such payment.

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

Authorized Representatives

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

Medical Claim Decisions

Ordinarily, you will be notified of the decision on your medical 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 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). The Fund then has 15 days to make a decision on a medical claim and notify you of the determination.

Weekly Accident and Sickness (Loss of Time) Claims

For Weekly Accident and Sickness (Loss of Time) 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 control of the Fund, 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 Fund 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.

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:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Fund upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. 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;
5. 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;
6. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for medical and weekly accident and sickness (loss of time) claims that are denied due to:
 - a. Medical necessity;
 - b. Experimental treatment; or
 - c. 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 Fund Office if your claim for benefits is denied by the Fund. You must make your request to the Fund Office within 180 days after you receive notice of denial. 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:

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

Second Level of Review – Appeal to the Board of Trustees

If you still disagree with the determination of your claim, then you may make an appeal to the Fund’s Board of Trustees. Ordinarily, decisions on appeals involving Post-Service Medical Claims, Disability or Life Insurance Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once 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 5 days after the decision has been 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:

- Â The specific reason(s) for the determination.
- Â Reference to the specific Fund provision(s) on which the determination is based.
- Â 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.
- Â 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, then you may receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, then you may receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

Legal Actions

You may not start a lawsuit until after:

1. you have requested both levels of review and a final decision has been reached, or
2. you have not received a final decision or notice that an extension will be necessary to reach a final decision in the appropriate time frame described above.

Any lawsuit based on the denial of your appeal by the Fund’s Board of Trustees is governed by

the applicable statute of limitations.

PRIVACY

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which will be distributed to you by April 14, 2003 and upon eligibility. The privacy notice will be available from the Fund Administrator.

Effective April 14, 2003, this Fund will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Fund will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Fund.

Under HIPAA, effective April 14, 2003, you will have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Office for Civil Rights at the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Fund will maintain a privacy notice effective April 14, 2003, that provides complete description of your rights under HIPAA's privacy rules. Please contact the Fund:

Â For a copy of the notice;

Â If you have questions about the privacy of your health information; or

Â If you wish to file a complaint under HIPAA.

COORDINATION OF BENEFITS

The purpose of this Plan is to help you meet the cost of needed medical care or treatment. No Covered Person should receive benefits greater than actual Expenses incurred. In no event will payment under this Plan exceed the amount which would have been allowed if no other plan were involved. All medical benefits provided under this Plan are subject to these rules.

Definitions

Plan means any plan providing benefits or services for or by reason of medical, dental, or vision care or treatment under:

1. group insurance;
2. group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis, or other group prepayment coverage;
3. labor-management trustee plans, or employee benefit organization plans;
4. governmental programs, or coverage required or provided by any statute;
5. any group coverage of a child sponsored by, or provided through any educational institution;
6. group arrangements for members of associations of individuals; and
7. group or individual automobile No-Fault coverage.

The term **Plan** is construed separately as to each policy, contract, or other arrangement for benefits or services, and separately as to any part of a Plan which may consider benefits or services of other Plans in determining its benefits and any part which does not.

An **Allowable Expense** means any necessary, reasonable, and customary item of expense, at least a part of which is covered under one of the Plans covering the person for whom claim is made.

If a Plan provides benefits in the form of services and supplies instead of cash, the reasonable cash value of the service provided and supplies furnished (if otherwise an **Allowable Expense**) will be deemed both an **Allowable Expense** and a benefit paid.

Effect on Benefits

If you are covered by another plan or plans, then the benefits under this Plan and the other plans will be coordinated. This means one plan pays its full benefits first, then the other plan pays its benefits.

1. The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this rule.
2. The secondary plan (is the plan that pays benefits after the primary plan) will limit

the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:

- a. 100% of total **Allowable Expenses**; or
- b. the amount of benefits it would have paid had it been the primary plan.

When you are eligible under another plan, there are rules which determine the order in which benefits are paid:

1. When the other plan does not have Coordination of Benefits rules (COB rules), that plan is primary and must determine benefits first.
2. When another plan does have COB rules, the first of the following rules to apply governs:
 - a. If one of the plans covers the claimant as an employee, then that plan will be primary and determines benefits before a plan that covers the claimant as other than an employee.
 - b. If a Covered Dependent child whose parents are not divorced, the plan of the parent whose birthday anniversary is earlier in the calendar year will pay for **Allowable Expenses** incurred first; except:
 - i. if both parents' birthdays are on the same day, the plan that covered the Covered Dependent child (or the parent) longest will be primary and determine benefits first.
 - ii. if the other plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefit payment.
 - c. If an eligible dependent child whose parents are divorced, then the following rules apply:
 - i. The plan which covers the parent who must provide health coverage by court decree will be primary and determine benefits first. If a parent fails to provide court ordered health benefits, this Plan will **not** pay any benefits.
 - ii. When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - (A) When the parent who has custody of the child has not remarried, the custodial parent's plan will be primary and determine benefits first.
 - (B) When the parent who has custody of the child has remarried, then the custodial parent's plan will be primary and determine benefits first, the step-parent's plan will determine benefits

second and the non-custodial parent's plan will determine benefits third.

- d. If none of the above rules apply, the plan which has covered the claimant for the longest period of time will pay its benefits first; except when:
 - i. one plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and
 - ii. the other plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

In this case, the plan which covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of the plan coordinates benefits and a part does not, each part will be treated like a separate 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 any of your Covered Dependents are involved in an accident involving a vehicle and medical payments are received from a policy (or self-insured program) for the vehicles involved, Plan benefits will be coordinated with such payments. If you or your Covered Dependent fails to purchase No-Fault Auto Insurance, the Plan will coordinate benefits as if you were covered by No-Fault Auto Insurance. The Plan will not pay benefits until the statutory No-Fault minimum amounts have been paid.

SUBROGATION

The Fund shall have a first priority right to recovery against any party or any source for your injury or sickness 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 shall be paid in full before, and it shall take precedence over any claim by you for general or special damages. Any state law requiring you to be made whole before the Fund is entitled to reimbursement does not apply.

You agree to 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 for equitable relief under the Employee Retirement Income Security Act (ERISA) 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. Any such proceeds shall be held by you in trust for the benefit of the Fund, and the Fund shall be entitled to recover reasonable attorney fees it may incur in collecting any proceeds held by you. All future benefit payments are specifically conditioned on your compliance with this provision.

You agree to execute documents as the Fund requires to facilitate its subrogation / reimbursement rights. You agree the Fund may withhold and suspend adjudication of benefits payable until you execute all of the documents provided by the Fund. The Fund may condition payments of medical claims and/or disability claims on the written agreement by you and your

attorney to:

1. reimburse the Fund to the extent of benefits paid by the Fund, and/or
2. hold all proceeds received by you, or any entity acting on your behalf, in constructive trust for the Fund's benefit.

If you recover lost wages benefits from another source, then the Fund has the right to seek repayment from you of any Accident and Sickness Weekly Benefits which, 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 your 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 INFORMATION ABOUT THE WELFARE PLAN

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

1. The Plan is known as the Twin City Bricklayers Health and Welfare Fund. The Plan Document is in the possession of the Board of Trustees and may be inspected by you at any time during business hours at the Fund Office.
2. A Board of Trustees is responsible for the operation of this Welfare Fund. The Board of Trustees has the responsibility of determining the eligibility rules for participation by Covered Employees in the benefit Plan and for determining the benefits to be offered to Covered Employees and their Covered Dependents. The Board of Trustees is also responsible for seeing that information regarding the Plan is reported to the government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of ERISA.
3. The Board of Trustees is both the Plan Sponsor and Plan Administrator of the Health and Welfare Fund. If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Twin City Bricklayers Health and Welfare Fund
c/o Zenith Administrators
P.O. Box 257
Minneapolis, Minnesota 55440-0257
952-835-7035

As of January 1, 2003, the Trustees are:

UNION TRUSTEES

Mr. Roger Buirge
2476 Tiemey Avenue
North St. Paul, Minnesota 55109

Mr. Gary Goblirsch
Bricklayers Local #1
Room 328
312 Central Avenue
Minneapolis, Minnesota 55414

Mr. James Lundquist
Bricklayers Local #1
Room 328
312 Central Avenue
Minneapolis, Minnesota 55414

Mr. Michael Cook
Bricklayers Local #1
Room 328
312 Central Avenue
Minneapolis, MN 55414

Alternate Union Trustees

Mr. Michael Hawthorne
Bricklayers Local #1
Room 328
312 Central Avenue
Minneapolis, MN 55414

Mr. Mark E. Caron
Bricklayers Local #1
Room 328
312 Central Avenue
Minneapolis, MN 55414

EMPLOYER TRUSTEES

Mr. David Semerad
Associated General Contractors of
Minnesota
2515 Wabash Avenue, Ste. LL-1
St. Paul, MN 55114-1055

Mr. James Hagman
Hagman Construction Company,
Inc.
5353 Gamble Drive
Parkdale 4, Suite 100
Minneapolis, Minnesota 55416

Mr. Dale Johnson
14180 Greenview Court
Eden Prairie, Minnesota 55346

Mr. Paul Weise
Weise Masonry, Inc.
14798 Maple Trail SE
Prior Lake, Minnesota 55372

4. This Health and Welfare Fund is self-funded.
5. This booklet describes the requirements and eligibility for participation, the types of benefits available and the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits.
6. All assets are held in trust by the Board of Trustees.
7. In accordance with Collective Bargaining Agreements in effect with the Union, the Health and Welfare Fund receives money from Contributing Employers on an hourly basis for each hour worked by all persons covered by the agreement. The terms of the collective bargaining agreement also indicate the effective dates of the Collective Bargaining Agreement and specify the contribution rate required from the Contributing Employer to be paid to the Welfare Fund. Copies of the Collective Bargaining Agreement are available at the Union and the Fund.
8. The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 41-6023461. The Number assigned to this Plan by the Board of Trustees pursuant to the instructions of IRS is 501. The Department of Labor Number issued to the Board of Trustees is WP-156206.
9. The Fund's fiscal year for the purpose of maintaining records and filing various governmental records and filing various governmental reports is the annual period January 1 through December 31.
10. The person designated as Agent for Service of legal process is:
Peter Rosene, Esq.
Rosene, Haugrud & Staab, Chartered
400 Robert Street North
Suite 1800
St. Paul, Minnesota 55101
11. The Board of Trustees intends to continue the Welfare Plan indefinitely. The Board of Trustees retains the right to amend the Plan at any time. Any amendment to the Plan will be binding on all Covered Persons covered under the Plan prior to or on or after the effective date of the amendment. The Board of Trustees also retains the right to terminate the Welfare Plan and Welfare Trust Fund if all Contributing Employers are no longer obligated through written agreement to make required contributions. In this event, the monies of the Trust Fund will be applied to all existing benefit obligations in effect on the date of termination of the Welfare Plan and Trust. Termination of the Plan will be binding on all Covered Persons who were covered under the Plan prior to termination.

Any balance of the Welfare Trust Fund that cannot be so applied, will be applied to other uses as, in the opinion of the Board of Trustees, will best serve the intentions of the Welfare Plan. Upon the disbursement of the entire Trust, the Trust will then terminate.

STATEMENT OF ERISA RIGHTS

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

ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, 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.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for preexisting condition under your group plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called

"fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the Contributing Employer, 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.

If a claim for a welfare benefit is denied in whole or in part, a written explanation of the reason for the denial must be received. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps that can be taken to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty 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 \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If a claim for benefits is denied or ignored, in whole or in part, a suit may be filed in a state or federal court.

If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person 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 the claim is frivolous.

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, you should contact the nearest office of the Office of Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

PROCEDURE FOR OBTAINING ADDITIONAL PLAN DOCUMENTS

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

**TWIN CITY BRICKLAYERS HEALTH AND
WELFARE FUND**
c/o Zenith Administrators
P.O. Box 257
Minneapolis, Minnesota 55440-0257

Return Service Requested



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