

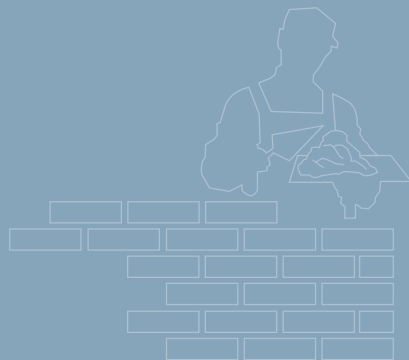
# Summary Plan Description and Plan Document

**For the Minnesota and North Dakota  
Bricklayers and Allied Craftworkers  
Health Fund**

## **MEDICARE SUPPLEMENT BENEFITS**

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Effective July 1, 2006



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

P.O. Box 257  
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(Administrator, as defined by law)

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**CONSULTANT TO THE HEALTH FUND**

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**ATTORNEY FOR THE HEALTH FUND**

Peter Rosene, Esq.  
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To Retired and Disabled Plan Participants:

The Board of Trustees is pleased to present you with this Summary Plan Description and Plan Document (SPD) which describes the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund Medicare Supplement Benefits in effect on July 1, 2006. This program is available only to retirees, totally disabled employees and surviving spouses who meet the eligibility provisions outlined in this booklet and who are also covered under Medicare (both Parts A and B). Throughout this SPD, the masculine term includes the feminine.

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

The SPD for the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund is separate and distinct from this SPD.

Sincerely,

BOARD OF TRUSTEES

This SPD explains only your Medicare Supplement Benefits. The information contained in this SPD is accurate and up-to-date as of the time of its printing.

## TABLE OF CONTENTS

<b>SCHEDULE OF BENEFITS</b> .....	1
<b>DEFINITIONS</b> .....	3
<b>ELIGIBILITY</b> .....	4
DISABLED OR RETIRED EMPLOYEES OR SURVIVING SPOUSES ELIGIBLE FOR COVERAGE PRIOR TO JANUARY 1, 1998 .....	4
DISABLED OR RETIRED EMPLOYEES OR SURVIVING SPOUSES ON OR AFTER JANUARY, 1998 – RETIREE CONTRIBUTION ALLOWANCE PLAN .....	4
SELF-PAYMENT RATE .....	8
MEDICAL REQUIREMENTS .....	8
<b>PREFERRED PROVIDER ORGANIZATIONS (PPOs)</b> .....	8
<b>MEDICARE SUPPLEMENT BENEFIT</b> .....	9
HOSPITAL EXPENSE BENEFIT .....	9
SKILLED NURSING FACILITY BENEFIT .....	9
HOME HEALTH SERVICES BENEFIT .....	10
HOSPICE BENEFIT .....	10
MEDICAL INSURANCE BENEFIT .....	10
BLOOD BENEFIT .....	11
PRESCRIPTION DRUG BENEFIT .....	11
PREVENTIVE DENTAL EXPENSE BENEFIT .....	12
COVERED DENTAL CHARGES .....	12
CANCER SCREENING TEST BENEFIT .....	12
<b>HEARING BENEFIT</b> .....	12
<b>VISION CARE PROGRAM</b> .....	13
<b>COORDINATION OF BENEFITS UNDER NO-FAULT AUTO LAW</b> .....	14
<b>GENERAL INFORMATION</b> .....	14
FACILITY OF PAYMENT .....	14
SUBROGATION .....	14
<b>BENEFIT CLAIMS AND APPEALS</b> .....	15
<b>PRIVACY</b> .....	20
<b>IMPORTANT INFORMATION ABOUT THE HEALTH PLAN</b> .....	21
<b>STATEMENT OF ERISA RIGHTS</b> .....	24
<b>PROCEDURE FOR OBTAINING ADDITIONAL PLAN DOCUMENTS</b> .....	25

## SCHEDULE OF BENEFITS

### Hospital Expense Benefit

Initial Hospital Expense (Medicare Part A Deductible) .....	100% per benefit period
Hospital Daily Rate:	
First 60 days .....	\$.00 (Medicare pays 100%)
61st through 90th days .....	Medicare's full coinsurance amount for each of these days per benefit period
60 lifetime reserve days .....	Medicare's full coinsurance amount

### Skilled Nursing Facility Benefit

(Benefits are only payable if the patient needs skilled nursing care and/or skilled rehabilitation services on a daily basis after a Hospital confinement of at least three consecutive days.)

First 20 days .....	\$.00 (Medicare pays 100% per benefit period*)
21st through the 100th day .....	Medicare's full coinsurance amount per benefit period*

\* A benefit period begins with the first day a Medicare entitled person receives inpatient hospital or nursing care (that is not part of a previous benefit period) and ends when the person has been out of a Hospital or Skilled Nursing Facility for 60 consecutive days.

### Home Health Services Benefit

(Benefits are not provided under Medicare or this Plan for custodial care.)

Unlimited Number of Visits .....	\$.00 (Medicare pays 100%)
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### Hospice Services Benefit

Expenses payable in excess of Medicare Payment .....	Medicare's full coinsurance amount per benefit period
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**Medical Insurance Benefit**

Initial Medical Expenses per Calendar Year (Medicare Part B Deductible) .....\$ 100  
Expenses payable in excess of Medicare Part B Deductible .....100% of Medicare approved charges not paid by Medicare

**Blood Benefit**

First three pints of blood .....Full Cost  
After the first three pints of blood .....\$ 0  
(Medicare pays 100%)

**Cancer Screening Tests (if not paid by Medicare)**

Calendar Year Maximum per Covered Retiree  
Maximum Amount Payable for Mammogram .....\$150  
Maximum Amount Payable for Pap Smear .....\$150  
Maximum Amount Payable for PSA .....\$150  
Maximum Number of Exams .....1

**Hearing Benefit**

Maximum Amount Every Five Calendar Years .....\$750

**Vision Care Program**

Maximum Amount Payable for Examinations and Vision  
Materials in a Two-Calendar Year Period .....\$225

**Prescription Drug Benefit**

Calendar Year Deductible Per Individual .....\$100  
Coinsurance Rate .....80%  
Calendar Year Maximum Per Individual .....\$4,000

Excludes any expenses paid by Medicare, Medicaid, or Tricare.

**Medicare Part D:**

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

**Preventive Dental Benefit**

Deductible per Examination .....\$5.00  
Coinsurance Rate .....100%  
Oral Exams and Routine Cleaning .....twice per calendar year  
Bitewing X-rays .....once every 12 months  
Full mouth X-rays .....once every 5 years

**Lifetime Maximum Benefit**

Per Individual .....\$100,000

**NOTE:** This lifetime maximum benefit is in addition to any Medicare benefits that you may receive.

## DEFINITIONS

**Benefit Period:** The time that begins with the first day you receive inpatient Hospital or nursing care, that is not considered part of the previous Benefit Period, if any, and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days.

**Covered Retiree:** Any retiree who is covered according to the rules explained in this booklet under Eligibility For Retired Or Disabled Employees or Surviving Spouses.

**Custodial Care:** Long-term type care that consists primarily of observation and helping you with daily living activities.

**Fund:** The Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund.

**Medicare Approved Charges:** Charges determined according to a fee schedule published and updated annually. Medicare generally pays 80% of the approved charge and the Plan pays 20%.

**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:** This Summary Plan Description and Plan Document adopted by the Trustees which describe the benefits to be provided for Covered Retirees, eligibility requirements, termination rules and the rules and regulations pertaining to Plan administration.

**Reasonable and Customery 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 Physician.

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

## ELIGIBILITY

### **DISABLED OR RETIRED EMPLOYEES OR SURVIVING SPOUSES ELIGIBLE FOR COVERAGE 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 Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund; or
3. If you are not eligible for a pension from the Minnesota and North Dakota Bricklayers Allied Craftworkers 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 Health 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 Health 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 Health 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 ELIGIBLE FOR COVERAGE 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 Fund immediately prior to the time of retirement, death, or disability. Coverage for your spouse may be delayed according to #7 below.
4. If you are eligible for a pension from the Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund, then you must also be receiving monthly payments from that Pension Fund.
5. Contributions must have been paid by your Contributing Employer to the Health 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. See #4 under Service Credit on the next page for Break-In-Service Rules.
6. Self-employed contractors are not eligible for the retiree contribution allowance.
7. Retired coverage must be continuous from active employment, and it cannot be delayed for any reason. Your spouse, if you retired on January 1, 1998 and after, may delay coverage under the Plan if he/she has other group coverage through an employer. Your spouse can be covered as your dependent when he/she becomes Medicare eligible (usually age 65). If your spouse delays coverage, he/she may also return on a one time only basis if coverage through his/her employer is terminated. In that case, you must notify the Fund within 31 days of the date your spouse's coverage was terminated, and send in any required self-payment contribution. Coverage under this Plan for your spouse would become effective on the first day of the month following the date the notification and self-payment contribution were received.

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

In order for your spouse to re-claim eligibility for coverage under this Plan, you must be covered under this Plan on the date your spouse becomes eligible. If you are deceased at the time your surviving spouse becomes Medicare eligible, then your surviving spouse can become re-eligible under this Plan if you would have been eligible on the date of death, or had not yet become Medicare eligible at the time of your death.

The Plan does not have the obligation and will not notify you and/or your spouse who has delayed coverage under this plan, that their specific re-eligibility date is approaching. It is entirely your and/or your spouse's responsibility 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 the International Union of Bricklayers and Allied Craftworkers, Local #1 Minnesota/North Dakota. The Board of Trustees will determine what records provide the best evidence of a participant's history with a merged local union's prior health plan, and the Board of Trustees will utilize that history for computations for retiree contribution allowances.

### **Service Credit:**

1. For past service, cumulative contribution hours under Minnesota and North Dakota Bricklayers and Allied Craftworkers Pension Fund through December 31, 1997 are divided by 1,600 (rounded to nearest full credit). For employees who are not Pension Fund participants, years of covered employment under this Health Fund prior to January 1, 1998 will be determined by the Trustees.
2. For future service, cumulative contribution hours under the Health Fund on and after January 1, 1998 are divided by 1,600 (rounded to nearest full credit).
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 you have two consecutive One-Year Breaks in Service. Prior to January 1, 1998, a One-Year Break in Service is defined as a calendar year in which you do 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. After January 1, 1998, a One-Year Break in Service is defined as a calendar year in which you do not have at least 160 hours of covered employment under the Health 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 \$435.00 per month. For those who retire on or after January 1, 2004 the maximum credits will be 35 (56,000) hours or \$507.50.

#### 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 \$330.00 per month. For those who retire on or after January 1, 2004 the maximum credits will be 35 (56,000) hours or \$385.00.

\$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 or \$253.75.

**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 Health Plan.
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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.

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

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

If contributing member dies while an active employee and the member **is** eligible for the retiree pre-funding plan, the member's bank hours will be converted to dollars based on the current active

contribution rate, and the surviving spouse and/or dependents can use the funds to pay for coverage. When the dollar bank is depleted, coverage can continue under the retiree pre-funding rules.

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

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

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

## **SELF-PAYMENT RATE**

The self-payment rate is determined by the Board of Trustees, which has the authority to periodically adjust the rate.

## **MEDICAL REQUIREMENTS**

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

## **PREFERRED PROVIDER ORGANIZATIONS (PPOs)**

The Plan currently uses various preferred provider organizations (PPOs):

Blue Cross/Blue Shield for medical care,  
Delta Dental 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.

## MEDICARE SUPPLEMENT BENEFIT

The Plan offers Medicare Supplement Benefits to you and your spouse if eligible for Medicare. A spouse who is not eligible for Medicare may be covered by the active employees plan, and that spouse will pay a premium as set and periodically adjusted by the Board of Trustees. The benefits described in this booklet are designed to supplement Medicare by paying the deductibles and co-insurance amount required by Medicare. The Medicare supplement benefit only pays Medicare-approved charges. If Medicare does not cover a service, then this Plan will not cover the service either.

The Fund's Medicare supplement benefit is described in the following paragraphs.

**NOTE: You and your spouse who receive Social Security benefits must apply for and pay the required premium for Medicare Part B to become entitled to Medicare Part B benefits. Benefits are paid under this Medicare Supplement Benefit as if you are entitled to both Part A and Part B of Medicare whether or not you have actually enrolled in Medicare Part B.**

## HOSPITAL EXPENSE BENEFIT

Benefits are payable if you are confined in a hospital as the result of an accidental Injury or Sickness.

Covered expenses include charges for the following:

1. Initial hospital expenses - 100% of Medicare's Part A deductible for each benefit period. Medicare pays 100% of the first 60 days of hospital expense after the Part A deductible.
2. Supplemental hospital expenses - Medicare's full coinsurance amount for the 61st through 90th day of hospitalization per benefit period. Medicare pays the remainder of the hospital expenses for the 61st through the 90th day of hospitalization.
3. Excess supplemental hospital expenses - Medicare's full coinsurance for each of the 60 lifetime reserve days. Medicare pays the remainder of the hospital expenses for these 60 lifetime reserve days.

## SKILLED NURSING FACILITY BENEFIT

Benefits are payable if you are confined in a skilled nursing facility as the result of an accidental injury or sickness. Such confinement must be recommended by a Physician and you must be seen by the Physician at least once a week. The skilled nursing facility confinement must follow a hospital confinement of at least 3 consecutive days and begin within 14 days of such hospital confinement. You

must be in need of skilled nursing care and/or skilled rehabilitation services on a daily basis for Medicare to determine that confinement in a skilled nursing facility is medically necessary. The Plan will pay Medicare's full coinsurance amount for each period of confinement, beginning with the 21st day of such confinement and continuing through the 100th day for confinements that Medicare determines to be medically necessary. The maximum benefit period for any one skilled nursing facility confinement will, in no event, exceed 100 days.

Custodial Care is not covered.

## **HOME HEALTH SERVICES BENEFIT**

Medicare Part A provides an unlimited number of home health visits made under a plan of treatment established by a Physician. Neither Medicare nor this Plan will pay for Custodial Care or private-duty nursing.

## **HOSPICE BENEFIT**

Medicare Part A covers hospice care if you who are terminally ill and diagnosed as having a life expectancy of six months or less. Most services provided by a hospice are covered, including the services of staff doctors. The services of your private doctor (if the doctor is not on the hospice's staff) are paid separately under Part B. If you live longer than six months, then additional periods are covered if the prognosis remains the same.

## **MEDICAL INSURANCE BENEFIT**

When you require medical or other health services as the result of accidental injury or sickness, the Plan will pay:

1. initial medical expenses per calendar year - the full cost of Medicare's Part B Deductible; and
2. the remainder of Medicare's Part B approved charges that are not paid by Medicare.

The Medical Insurance Benefit (Medicare Part B) includes the following items or services unless they would otherwise constitute inpatient hospital services, skilled nursing facility services, or home health care services:

1. physicians' services;
2. services and supplies (including drugs and biologicals which according to regulations cannot be self-administered) furnished by a Physician's professional service, which are commonly provided without charge or are included in the Physicians' bills, and hospital services provided to outpatients;

3. diagnostic X-ray, laboratory, and other tests;
4. X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
5. surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations;
6. rental of durable medical equipment used in your home (including an institution used as your home);
7. professional local ambulance service where the use of other methods of transportation is contraindicated by your condition;
8. prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices; and
9. leg, arm, back, and neck braces, and artificial limbs and eyes, including replacements if required because of a change in your physical condition.

Covered physician services includes professional services performed by physicians, including surgery, consultations, and hospital calls necessary as the result of an injury or sickness. No benefits will be provided for expenses incurred for routine foot care.

## **BLOOD BENEFIT**

This benefit pays the full cost for the first three pints of blood. Medicare pays the full cost after the first three pints of blood.

## **PRESCRIPTION DRUG BENEFIT**

The Prescription Drug Benefit is payable up to the amount shown in the Schedule of Benefits. Any expenses that are paid by Medicare, Medicaid or Tricare will not be covered by this Plan.

Medicare Part D:

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

## **Filing a Claim**

You can use any pharmacy you wish, but if you use a Caremark Prescriptions pharmacy, be sure to show your I.D. card in order to get a discount. You pay for the prescription. If you purchase your prescriptions at a Caremark network pharmacy, then Caremark will send the claim electronically to the Fund. If you do not purchase your prescription at a Caremark network pharmacy, then you must send

the receipts to the Fund Office, making sure to include your unique identifier and stating that you are a retiree under the Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund. Reimbursement checks will be sent directly to you.

## **PREVENTIVE DENTAL EXPENSE BENEFIT**

The Preventive Dental Expense Benefit is payable if you incur 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.

## **CANCER SCREENING TEST BENEFIT**

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 while 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. The benefit will only be paid if the charges are not paid by Medicare.

## **HEARING BENEFIT**

Charges for hearing examinations, purchase of hearing aids and fitting of hearing aids are covered up to the **Maximum per Five Calendar Years** shown in the **Schedule of Benefits**. 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.

### **VISION CARE PROGRAM**

This benefit is designed to pay a portion of your expense of eye examinations and glasses, when required.

Benefits are payable for expenses which you are required to pay for eye examinations performed by a legally qualified ophthalmologist or optometrist and the frames and lenses which are prescribed. The maximum amount payable for examinations and vision materials for each Covered Retiree 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 Retirees. The periods are 2005-2006, 2007-2008, 2009-2010, etc.

The following is an outline of the services and supplies which 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. Any vision service or vision materials for which no charge is made, or that are furnished by or payable under any plan or law of any federal or state government or any political subdivision.
2. Aniseikonia lenses or special supplies or services not listed as covered expenses.
3. Any eye examination required by an employer as a condition of employment.
4. Medical or surgical treatment.

## **COORDINATION OF BENEFITS UNDER NO-FAULT AUTO LAW**

The State of Minnesota statutes enable the Fund to coordinate benefit payments under the No-Fault Auto Law.

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 fail to purchase No-Fault Auto Insurance, the Plan will coordinate benefits as if you had purchased No-Fault Auto Insurance. The Plan will pay benefits only after you provide evidence that the statutory No-Fault minimum amounts have been paid.

## **GENERAL INFORMATION**

### **FACILITY OF PAYMENT**

If payments which should have been made under this Plan as stated in this provision have been made under any other plan or plans, this Plan may, at its sole discretion, pay any organizations making such other payments the amount which it 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 under this Plan.

### **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 part 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 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.

## **BENEFIT CLAIMS AND APPEALS**

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

### **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. 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.

A claim form may be obtained from the Fund by calling 651-256-1801 or 1-800-879-4412. If you use the services of a network provider, the provider will generally file your claims for you.

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

- Participant name;
- Patient name;
- Patient Date of Birth;
- Language unique identifier of participant or retiree;
- Date of Service;
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);

- ICD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge;
- Number of Units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

### **When Claims Must Be Filed**

You must file your claim for benefits as soon as possible following the date you incurred the charges. If you fail to file your claim within the time required, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, in that case, you must submit your claim as soon as reasonably possible and in no event later than 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 to have been filed as soon as it is received at the Fund Office. You should file your claims with the Fund at the following address:

Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund  
PO Box 257  
Minneapolis, Minnesota 55440-0257

### **Facility of Payment of Claims**

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

If any claim is payable to your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, the Trustees may pay the claim, up to an amount not exceeding \$5,000.00, to any relative by blood or connection by marriage of the Employee or beneficiary who is deemed by the Trustees to be equitably entitled. Any payment made by the Trustees in good faith according to this provision will fully discharge the Trustees to the extent of the payment.

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

### **Physical Examinations and Autopsy**

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

## **Discretionary Authority of Fund Administrator**

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

## **Authorized Representatives**

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

## **Assignment of Benefits**

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

## **Medical Claim Decisions**

When you file a medical claim, you have already received the services in your claim.

The following procedures apply to Medical Claims:

- Obtain a claim form (or a claim may be filed for you by a PPO or other network provider).
- Complete your (the employee's) portion of the claim form.
- Have your Physician complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or doctor's statements that describe the services rendered.

To speed the processing of your claim, check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. If the claim forms have to be

returned to you for information, delays in payment will result.

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

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.

### **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 loss of time weekly 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 if your claim for benefits is denied by the Fund. You must make your request to the Fund 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:

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

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

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

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

## **Second Level of Review – Appeal to the Board of Trustees**

If you still disagree with the determination of your claim, you may make an appeal to the Board of Trustees. Ordinarily, decisions on appeals involving Medical 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:

- The specific reason(s) for the determination.
- Reference to the specific Fund provision(s) on which the determination is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

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

### **Legal Actions**

You may not start a lawsuit to obtain benefits until after you have requested both a review by the Fund Office and an appeal to the Board of Trustees and a final decision has been reached, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. Any lawsuit based on the denial of your appeal by the Fund's Board of Trustees 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 upon eligibility. The privacy notice will be available from the Fund.

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, 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 maintains a privacy notice that provides complete description of your rights under HIPAA’s privacy rules. Please contact the Fund:

- For a copy of the notice;
- If you have questions about the privacy of your health information; or
- If you wish to file a complaint under HIPAA.

### **IMPORTANT INFORMATION ABOUT THE HEALTH PLAN**

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

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

Minnesota and North Dakota Bricklayers and Allied Craftworkers Health Fund  
c/o Zenith Administrators  
PO Box 257  
Minneapolis, Minnesota 55440-0257  
651-256-1801 or 1-800-879-4412

As of July 1, 2006, the Trustees are:

**UNION TRUSTEES**

Mr. Roger Buirge  
2476 Tierney Avenue N.  
St. Paul, Minnesota 55109

Mr. Michael Cook  
312 Central Avenue N.E.  
Room 328  
Minneapolis, MN 55414

Mr. Michael Hawthorne  
312 Central Avenue N.E.  
Room 328  
Minneapolis, MN 55414

Mr. James Lundquist  
312 Central Avenue N.E.  
Room 328  
Minneapolis, MN 55414

**EMPLOYER TRUSTEES**

Mr. Mike Lapensky  
Twin City Tile & Marble  
900 Montreal Circle  
St. Paul, MN 55102-4246

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

Mr. David Semerad  
A.G.C. of Minnesota  
525 Park Street  
Capital Office Building, Suite 110  
St. Paul, MN 55103

Mr. Paul Weise  
11798 Maple Trail S.E.  
Prior Lake, MN 55372

**ALTERNATE UNION TRUSTEE**

Mr. Mark Caron  
901 Barron Road  
Faribault, MN 55021

**ALTERNATE EMPLOYER TRUSTEE**

Mr. Paul Widmer  
Knutson Construction Services  
5500 Wayzata Blvd., #300  
Minneapolis, MN 55416-1229

4. The benefits of this Health Fund are 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 from time to time with the International Union of Bricklayers and Allied Craftworkers Local No. 1 Minnesota/North Dakota and all its participating chapters or sublocals, the Health Fund receives money from contributing employers on an hourly basis for each hour worked by all employees covered by the agreement. The terms of the collective bargaining agreement also indicate the beginning

and expiration dates of the collective bargaining agreement and specify the contribution rate required from the contributing employer to be paid to the Health Fund. Copies of the collective bargaining agreement are available at the Union Office and the Fund Office.

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 Health 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, #1800  
St. Paul, Minnesota 55101

11. The Board of Trustees intends to continue the Health 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 Retirees 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 Health Plan and Health 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 Health Plan and Trust. Termination of the Plan will be binding on all Covered Retirees who were covered under the Plan prior to termination.

Any balance of the Health 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 Health 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 Plan documents, 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 booklet 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 conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from 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 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 his 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 his 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 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Retiree up to \$110.00 a day until he receives 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, he 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 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.