PLASTERERS AND CABINET MAKERS HEALTH FUND

Summary Plan Description and Plan Document

For Participants of

The Plasterers and Cabinet Makers Health Fund

Effective April 1, 2016

HOW TO USE THIS BOOK

This document has been revised to provide you with a more thorough explanation of the benefits available to you and your family under this Plan. All defined terms used in this Plan are capitalized. A summary is provided in the gray shaded box at the beginning of each section. These summaries provide you with an overview of the subjects discussed in each section and will be useful in answering many questions you have about the Plan. Of course, more details are provided after the summary of each section. You should always review the entire section or sections when determining what benefits you may be entitled to receive.

If you have any questions about the Plan, you should contact the Plan Administrator at 952-854-0795 or 1-800-535-6373.

To All Participants:

We are pleased to furnish you with this new Summary Plan Description and Plan Document. As Trustees of your Health Care Plan, we want you to have all the information about your Plan including the eligibility rules, a description of the types and amounts of benefits available, as well as any limitations and exclusions which may cause you to lose benefits. This Summary Plan Description (SPD) also provides you with instructions for filing a claim and tells you all of the requirements contained in the Employee Retirement Income Security Act of 1974 (ERISA).

The SPD can only be helpful to you if it is used. We urge you to read this SPD now and keep it available for future reference when you or your family needs information about your Health Care Benefits.

We administer your Plan with the help of a Plan Administrator, administrative office staff, professional benefits consultants, legal counsel, and a certified public accounting firm. As Trustees of your Plan, we will continue to manage the Plan in a financially responsible manner and to keep the level of benefits in line with medical care costs as permitted by Plan income and reserves.

We hope that you will find this explanation of your Plan helpful. However, if you have any questions at any time regarding your Plan, please contact the Plan Administrator's office, Wilson-McShane Corporation, at 952-854-0795 or 1-800-535-6373.

Sincerely,

The Board of Trustees

IMPORTANT NOTICE

This booklet is intended to give you a description of the life, disability and health care benefits adopted by the Trustees. This is the sole document that describes your eligibility and benefits.

Only the full Board of Trustees has the authority to interpret the health care benefits described in this booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

No employer or union nor any representative of any employer or union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. The Plan contains appeal procedures you may use if you feel you have wrongfully been denied benefits. Only after those procedures are exhausted can you challenge the Trustees' decision in Court.

If you want any information regarding this Plan, such information must be communicated to you in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Plan Administrator.

Trustee Authority

The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and their Beneficiaries. The right to change or eliminate any benefits provided for Retirees and their Dependents is a right specifically reserved to the Trustees. Therefore, this booklet may not accurately describe benefits to which you may be entitled. Notices of any changes will be sent to each participant's last known address within the time required by applicable regulations. Therefore, it is extremely important that you keep the Plan Administrator informed regarding any changes in your address. Changes, however, may take effect before you receive notification. Therefore, before receiving non-emergency care, you may wish to contact the Plan Administrator to confirm your current health benefits if you are unsure what they are.

GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, phone: 952-854-0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans."

BOARD OF TRUSTEES
OF THE
PLASTERERS AND CABINET MAKERS HEALTH FUND

UNION TRUSTEES	MANAGEMENT TRUSTEES
Mr. Timothy House, Chairman Plasterers Local #265 312 Central Avenue, Suite 386 Minneapolis, MN 55414	Mr. William Grimm, Secretary MN Drywall & Plaster Association 1270 Northland Drive, Suite 150 Mendota Heights, MN 55120
Mr. Richard Felber Plasters Local #265 312 Central Avenue, Suite 386 Minneapolis, MN 55414	Mr. Sean Conrad AE Conrad Company 308 W 59 ½ Street Minneapolis, MN 55419
Mr. Cliff Kerce Carpenters Industrial Council 404 N. Main Street, #205 Oshkosh, WI 54901	Mr. Kevin Davis Streater LLC 411 South First Avenue Albert Lea, MN 56007
	Mr. Brian Felber, Alternate Berg Drywall 118 Peavey Circle Chaska, MN 55318

PLAN ADMINISTRATOR

Wilson-McShane Corporation
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Bloomington, MN 55425
952-854-0795 or 1-800-535-6373

PLAN COUNSEL

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SUMMARY OF BENEFITS

SUMMARY

This Summary of Benefits provides you with a brief description of the benefits and the limits that apply to each type of benefit provided by the Plan. Benefits are payable to eligible participants and their Eligible Dependents for services described in this document that are Medically Necessary (see page 113) and not otherwise excluded (see page 69). More information about those benefits is provided in the later sections of this document. The page number where this information begins is listed next to each type of benefit.

This schedule describes the maximum amount payable for any benefit. Of course, the amount payable may be affected by the other provisions of this Plan, including the limitations provisions and the description of the specific benefits payable under the Plan contained in each section.

Coverage for the Employee Only

LIFE BENEFIT - $10,000 (Page 30)

ACCIDENTAL DEATH AND DISMEMBERMENT – Principal sum: $10,000 (Page 32)

WEEKLY DISABILITY BENEFIT - (Page 34)

- Maximum Period of Payment: 26 weeks.
- Benefits start after either the first day following the disability if the disability was caused by Injury or the eighth day if caused by Sickness.
- Benefit Amount: $315 per week.

Coverage for All Eligible Participants

Plan Maximums

Deductibles and annual major medical out-of-pocket maximums are kept separately for each Covered Individual and are determined and accumulated without distinction between Participating and Non-Participating Providers.

Deductible (applies to all Major Medical Benefits except where otherwise stated):

Individual -	$200
Aggregate Family -	$400

(The Deductible is waived on prenatal care and child health supervision services.)

Out-of-Pocket Maximum

The out-of-pocket maximum that you or your Beneficiaries must pay in a Calendar year is:

Per Person - $3,000 (Does not include the Deductible.)
Per Family - $6,000 (Does not include the Deductible.)

Lifetime Major Medical Maximum - Non-Essential Health Benefits

The Plan has a $200,000 lifetime maximum applicable to benefits that *do not* meet the definition of Essential Health Benefits.

The Plan has no annual or lifetime maximum that applies to Essential Health Benefits.

Major Medical Benefits

In general, after any applicable deductible is satisfied, the Plan will pay the following percentage of Reasonable and Customary charges for Medically Necessary Covered Medical Expenses except as otherwise limited or excluded:

80% (if the provider is a Participating Provider)
60% (if the provider is a Non-Participating Provider).

Preferred Provider Network – A Participating Provider is a medical provider that has an agreement with (1) Blue Cross Blue Shield of Minnesota to serve in the Blue Cross Blue Shield of Minnesota Aware Network or (2) another Blue Cross Blue Shield Association company in a state other than Minnesota to participate in the BlueCard Program. Any other provider is known as a Non-participating Provider. If you do not use a Participating Provider, you will be responsible for paying for any charges billed by the Non-Participating Provider which exceed the amount that would have been allowed if you had used a Participating Provider. In addition, for some benefits, you will be responsible for paying all charges if you do not use a Participating Provider.

Summary of Benefits – A summary of the Major Medical Benefits is provided below. Many of those benefits also have certain limitations and conditions, so it is also important that you read the section more fully describing each benefit in order to fully understand your Major Medical Benefits.

Summary of Major Medical Benefits

AMBULANCE BENEFITS - See page 41 for a description of these benefits.

CANCER SCREENING – See page 41 for a description of these benefits.

CHEMICAL DEPENDENCY TREATMENT BENEFITS - See page 42 for a description of these benefits.

DENTAL CARE BENEFITS - Dental Benefits provided under the Major Medical portion of the Plan are limited to treatment for injuries to natural teeth and certain disorders. See page 42 for a description of these benefits. In addition, the Plan provides a separate Dental Benefit through Delta Dental of Minnesota. Please see page 59 for a description of these benefits.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES BENEFIT - See page 43 for a description of these benefits.

> $350 maximum Calendar Year benefit for wigs, but the deductible does not apply to this benefit.

HOME HEALTH CARE BENEFITS - See page 45 for a description of these benefits.

> Benefit is limited to 180 visits per Calendar Year. A home health care visit means intermittent care up to two hours and/or extended care up to eight hours.

HOME INFUSION THERAPY BENEFITS - See page 45 for a description of these benefits.

INFERTILITY BENEFITS - See page 46 for a description of these benefits.

INPATIENT HOSPITAL BENEFITS - See page 47 for a description of these benefits.

MATERNITY BENEFITS - See page 48 for a description of these benefits.

MENTAL HEALTH CARE BENEFITS - See page 48 for a description of these benefits.

OUTPATIENT HOSPITAL BENEFITS - See page 49 for a description of these benefits.

PHYSICAL EXAMINATION – See page 50 for a description of these benefits.

PHYSICIAN SERVICES BENEFITS - See page 50 for a description of these benefits.

RECONSTRUCTIVE SURGERY BENEFITS - See page 51 for a description of these benefits.

REHABILITATION SERVICES BENEFITS - See page 51 for a description of these benefits.

SKILLED NURSING FACILITIES BENEFITS - See page 52 for a description of these benefits.

VENTILATOR - DEPENDENT COMMUNICATION SERVICES BENEFITS - See page 52 for a description of these benefits.

> Limited to 120 hours per Hospital admission.

Special Medical Programs Sponsored by the Plan

In addition to Major Medical Benefits, the Plan provides some additional non-Major Medical or Special Medical Programs which are:

CHILD HEALTH SERVICES – See page 53 for a description of the benefits.

PRENATAL CARE – See page 53 for a description of the benefits.

PRESCRIPTION DRUG BENEFITS – See page 54 for a description of the benefits.

VISION CARE – See page 55 for a description of the benefits.

ORGAN AND BONE MARROW TRANSPLANT COVERAGE – See page 55 for a description of the benefits.

DOCTOR ON DEMAND – Covered at 100%, no copayment or coinsurance. See page 58 for program description.

Other Medical Benefits

In general, the Plan pays for the following medical benefits, subject to the coinsurance and other limitations applicable to each benefit.

DENTAL BENEFITS - See page 59 for a description of dental benefits provided through Delta Dental of Minnesota.

FAMILY ASSISTANCE PROGRAM THROUGH BLUE CROSS BLUE SHIELD - See page 68 for a description of the family assistance and counseling benefits available through Blue Cross Blue Shield of Minnesota.

Retired Participants

Retired participants are eligible to continue coverage under the Plan as described on pages 19 through 22. Retiree coverage does not include Life Benefits, Accidental Death and Dismemberment Benefits and Weekly Disability Benefits.

ELIGIBILITY

SUMMARY

This section of the document describes how you and your dependents become eligible for benefits under the Plan and the various ways you can maintain that eligibility.

Once you become eligible, you will continue to be covered if you satisfy the requirements of the Plan as described more fully in this section.

Employees

For Plasterers, eligibility is determined on a quarterly basis, as follows:

Hours worked in the following months:	**Provides coverage in these months:**
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

For Cabinet Makers, eligibility is determined on a monthly basis, as discussed further below in this section.

Initial Eligibility for Employees

If you are a Plasterer, you are eligible in the first quarter (according to the above table) following either the three or six month period (whichever is shorter) in which you work at least 350 hours (and the Plan receives Contributions). Once you meet this initial eligibility requirement, you will be covered for at least one quarter.

If you are a Cabinet Maker,

You are eligible on the first day of the month *following* the first month in which -

- You work in a position for which your employer is required to contribute to the Plan on your behalf, and
- Your employer timely makes this required contribution to the Plan on your behalf, as required by the applicable bargaining agreement.

If you are an Industrial Carpenter transferring to the Plan from Non-Minnesota Industrial Carpenter Health Plans on or after July 1, 2011,

You are initially eligible for coverage under this Plan on the first day of the month following the first month in which –

- You work in a position for which your employer is required by a Collective Bargaining Agreement to contribute to the Plan on your behalf; and

- You first exhaust any dollar bank, hours bank or other banked coverage you have available under the health fund you were covered under as of June 30, 2011; and

- Following exhausting any dollar, hours or other banked coverage from your prior health plan, you have sufficient Employer Contributions to pay the premium for one month of coverage under this Plan.

Your monthly premium for coverage is dictated by the hourly or monthly contribution amount provided for in your Collective Bargaining Agreement. The premiums for coverage under the Plan are subject to review and change by the Board of Trustees on a periodic basis.

This Industrial Carpenter eligibility provision is also subject to these additional ongoing eligibility rules:

- Six-Months to Establish Eligibility: You will have six-months, once Contributions start being made to the Plan, to establish initial eligibility for coverage under the Plan. If you are unable to establish initial eligibility, the Contributions on your behalf will be forfeited.

- Dependent Child Coverage: As of January 1, 2015, if you work for an employer who is considered a large employer under the Affordable Care Act (50 or more full-time employees), and only have single coverage, you will have the option of electing for (1) single coverage or (2) coverage for you and your Dependent Children (children under age 26). If you elect to add Dependent Child Coverage, the additional cost of that coverage will be your responsibility.

- Dollar Bank: You will be allowed to build a Dollar Bank for coverage of up to $2,000 dollars. The Dollar Bank can be used in months in which your employer contributions are insufficient to pay the monthly premium for coverage.

- Self-Paying for Coverage: If, once you've established eligibility for coverage under the Plan, the amount of contributions received, as well as any available banked dollars, are insufficient to pay the premium for one month's coverage, you can continue your coverage by:

    - Making self-payments for the difference between your available contributions and bank dollars and the required monthly premium for coverage for up to eighteen consecutive (18) months; or

    - Electing for COBRA Continuation Coverage.

- Disability Coverage: Participants are eligible for disability coverage (including for disability for a work related injury) and will be covered for up to 26 weeks as long as they remain Disabled and otherwise meet the following requirements:

    - A Participant's dollar bank will be credited daily or weekly based upon whether the Participant has family or single coverage and dependent upon the amount and method their individual contributions are made to the Plan per their participation agreement. Crediting will work as follows:

    - For example, if your monthly premium is $858 for family coverage, you will be credited with $214.50 per week or $30.64 per day to continue your coverage due to your disability; or

    - For example, if your monthly premium is $367.50 for single coverage, you will be credited with $91.88 per week or $13.13 per day to continue your coverage due to your disability.

    - **Note**: The above noted dollar amounts are subject to change from year to year and merely serve as examples of how the dollar bank will be credited.

    - Participants will need to be credited with sufficient dollars in their dollar bank to maintain their coverage if Disabled.

    - Participants will need to follow the same procedures as required for Plasterers and Cabinet Makers as detailed on Page 14.

- Retiree Coverage: Participants who become eligible under this Industrial Carpenter eligibility provision are not eligible for Retiree Coverage under the Plan.

If you are a Non-Bargaining Unit Employee, you are eligible on the first day of the first month following the month in which you begin working, as long as your employer enters into a participation agreement that allows for your participation in the Plan and as long as your employer pays the contribution to the Plan on a timely basis as required under the participation agreement.

Continuing Eligibility

If you are a Plasterer, once Covered Under The Plan, you will remain covered for an additional quarter if you are credited with at least 350 hours of Employer Contributions per working quarter (under the table above).

If you are a Cabinet Maker, once Covered Under The Plan, you will be eligible for continued coverage in any month *following* a month in which your employer timely makes a contribution to the Plan on your behalf. For example, your employer's timely contribution in September 2015 will provide you with coverage in October 2015.

If you are an Industrial Carpenter, once Covered Under the Plan, you will remain covered as long as the amount of Contributions received, as well as any available banked dollars, are sufficient to pay the premium for one month's coverage. Your monthly premium for coverage is dictated by the hourly contribution amount provided for in your Collective Bargaining Agreement. The premiums for coverage under the Plan are subject to review and change by the Board of Trustees on a periodic basis.

If you are a Non-Bargaining Unit Employee, once Covered Under The Plan, you will remain covered for each additional month in which your employer makes the contribution to the Plan on a timely basis, as required under your employer's participation agreement with the Plan.

Hours Bank (Plasterers)

Any hours worked in excess of 350 in a calendar quarter are recorded as bank hours. The maximum number of bank hours you can accumulate is 750. If you work less than 350 hours in a calendar quarter, you will be allowed to use your bank hours to continue coverage under the Plan for the next coverage quarter. To continue coverage under this provision, the Plan will subtract the number of hours you worked in the quarter from 375, and the result will be taken from your bank and applied to continue coverage under the Plan for the next coverage quarter.

Monthly Eligibility Bank (**Cabinet Makers)**

Each Cabinet Maker Employee employed in that capacity after April 2003 is eligible to gain up to two (2) months of bank coverage in the Plan. Bank coverage is used to extend eligibility in the Plan in the event the Employee terminates employment in a covered position or if the employer fails to timely make Contributions to the Plan.

One month of bank coverage will be granted for each six-consecutive-month period in which the Employee is Covered Under The Plan after April 2003 due solely to timely Employer Contributions (that is, coverage is not attributable to the use of bank coverage or COBRA payments). After one month of bank coverage has been earned, a new six-month eligibility period will begin and the Employee may earn a second month of bank coverage. An Employee may maintain a maximum of two months of bank coverage at any time.

Dollars Bank (Industrial Carpenters)

If, once you've established eligibility for coverage under the Plan, the amount of Employer Contributions received exceeds the amount needed to pay the premium for the current month's coverage, you will be allowed to build a Dollar Bank for coverage with the excess Contributions of up to $2,000 dollars. The Dollar Bank can be used in months in which your Employer Contributions are insufficient to pay the monthly premium for coverage.

Termination of Eligibility and Cancellation of Bank Coverage

If you stop working in a job classification for which contributions must be made to the Plan, you will immediately become ineligible for Plan benefits, your Hours Bank (Plasterers) and Dollars Bank (Industrial Carpenters) or Monthly Eligibility Bank (Cabinet Makers) hereafter referred to collectively as Bank (or your Bank), will be cancelled (reduced to zero), and you will have no right to continue to be covered under the Plan (other than any right you may have under COBRA), if all of the following are true:

- You work for an employer or as an employer that is not obligated to contribute to the Plan;
- Your work is of a type for which Employers contribute to the Plan; and
- Employer contributions for your work would be due to the Plan if you were working under a Collective Bargaining Agreement.

If your eligibility is terminated and your Bank is cancelled, any period of time you were covered by your Bank after you last worked in employment for which your Employer contributed to the Plan will count as part of any Continuation Coverage under COBRA period to which you may be entitled.

If you are maintaining coverage via your Bank and if the Plan requests, you must provide to the Plan access to reasonable information for the purpose of verifying your employment. The information which the Plan may require for this purpose may include, but is not limited to: paycheck stubs, Internal Revenue Forms 1040 (with attachments), and release forms permitting the Plan to obtain information from your employer.

The Plan is entitled to request that you periodically:

- Certify to the Plan in writing on a form acceptable to the Plan that you are unemployed or, in the alternative,
- Provide information satisfactory to the Plan to enable the Plan to conclude that any employment in not of a type that would cause you to lose your eligibility and Bank.

If you fail to respond to the Plan's request for information or certification or provide an incomplete or inadequate response, the Plan may do one (1) or more of the following:

- Terminate your eligibility;
- Cancel your Bank, or;
- Withhold payment of benefits until you respond or provide a complete and adequate response.

The Plan will notify you in writing if it terminates your eligibility and terminates your Bank.

Eligibility During Disability

If, after becoming eligible for coverage, you are eligible to receive or are receiving Weekly Disability Benefits pursuant to page 34 of this booklet, or if you are eligible to receive benefits under any worker's compensation, occupational disease law, or no-fault automobile insurance policy, you will be able to maintain eligibility for coverage for up to 26 weeks as follows:

If you are a Plasterer: You will be credited with thirty (30) hours per week for any week in which you are certified to be Disabled.

If you are a Cabinet Maker: You will remain covered for any month in which you are unable to perform any work and are certified to be Disabled.

If you are an Industrial Carpenter: Your dollar bank will be credited daily or weekly based upon whether the Participant has family or single coverage and dependent upon the amount and method their individual Contributions are made to the Plan per their participation agreement. Crediting will work as follows:

- For example, if your monthly premium is $858 for family coverage, you will be credited with $214.50 per week or $30.64 per day to continue your coverage due to your disability; or

- For example, if your monthly premium is $367.50 for single coverage, you will be credited with $91.88 per week or $13.13 per day to continue your coverage due to your disability.

- **Note**: The above noted dollar amounts are subject to change from year to year and merely serve as examples of how the dollar bank will be credited.

Self-Pay (Applies only to Plasterers)

If you (a Plasterer) do not work 350 hours in a quarter and you do not have enough hours in your hour bank to continue coverage, you can still continue coverage in the Plan for the next coverage quarter by self-paying. The amount you will need to self-pay is determined by subtracting the number of hours worked during a quarter and any hours in your hour bank from 375. The remainder is the number of hours you will need to self-pay to continue coverage for the next quarter. The amount of the self-payment is the number of hours you need to self-pay multiplied by the current hourly contribution rate in the Collective Bargaining Agreement.

For example, a Plasterer has worked 200 hours in a quarter and has 100 hours in his hours bank. In order to continue coverage for the next coverage quarter, the Plasterer would need to make a self-payment equal to 75 hours times the current Plasterer hourly contribution rate. (375 - 200 - 100 = 75 hours needed.)

The maximum time you can self-pay is SIX QUARTERS (18 months).

Self-Pay (Applies only to Industrial Carpenters)

If, once you've established eligibility for coverage under the Plan, the amount of Contributions received, as well as any available banked dollars, are insufficient to pay the premium for one month's coverage, you can:

- Continue your coverage by making self-payments for the difference between your available Contributions and bank dollars and the required monthly premium for coverage for up to eighteen (18) months; or

- You may continue your coverage via the COBRA Continuation Coverage provisions of the Plan.

Self-Pay – When Is Payment Due? (Applies only to Plasterers and Industrial Carpenters)

If you choose to make self-payments, you must make your first self-payment to the Plan Administrator's office within 30 days of receiving written notice from the Plan Administrator. Failure to make payment within 30 days will cause your self-payment coverage to end.

If you do not elect to make self-payments, you can still elect for COBRA coverage. As further described in the COBRA section starting on Page 23, you have 60 days from the date of a qualifying event, to elect for COBRA coverage. The qualifying event date will

also be the date reflected on the self-payment notice. Your 30-day period to make your first self-payment also constitutes the first 30 days of your COBRA election period. If you fail to make self-payment within 30-days, you still have an additional 30 days to elect for COBRA.

For example, if you receive written notice on April 1st that you have 30 days to elect and make self-payments, your first self-payment is due by April 30th. If you fail to make your self-payment by April 30th and therefore lose the self-payment coverage option, you still have until May 30th (an additional 30 days) to elect for COBRA coverage. As mentioned previously, see the COBRA coverage section beginning on Page 23 for more details regarding electing and paying for COBRA coverage.

Note: If you elect to self-pay, you will not be able to later elect COBRA Continuation Coverage.

Reinstatement of Eligibility

If you are a Plasterer, you are eligible in the first quarter (according to the above table) following either the three or six month period (whichever is shorter) in which you work at least 350 hours (and the Plan receives Contributions). Once you meet this initial eligibility requirement, you will be covered for at least one quarter.

If you are a Cabinet Maker, if you become ineligible for Plan benefits, your coverage will be reinstated according to the rules for Initial Eligibility, above.

If you are an Industrial Carpenter, if you become ineligible for Plan benefits, your coverage will be reinstated when your Contributions are sufficient to pay the monthly premium for coverage.

If you are a Non-Bargaining Unit Employee, if you become ineligible for Plan benefits, your coverage will be reinstated in any month in which your employer makes a full and timely contribution to the Plan on your behalf for hours worked as a Non-Bargaining Unit Employee.

Eligibility through Reciprocity

Employer Contributions made on your behalf to another health plan other than this Plan can be transferred to this Plan if the Trustees have signed a reciprocity agreement with the other plan and you would have been eligible for coverage under this Plan if the Contributions had been made to this Plan.

Contact the Plan Administrator at 952-854-0795 or 1-800-535-6373 to see if any work you are performing outside the jurisdiction of the Union is covered by a reciprocity agreement.

Eligibility During Periods of Military Service

You must inform the Plan Administrator in writing as soon as you know that you are entering military service.

For Dependents Entering into Military Service

Coverage for a Dependent will cease on the date that a Dependent enters military service.

For Employees Entering into Military Service

Employees entering military service may elect to have their coverage (and coverage for their Dependents) frozen during military service (see "Freezing Coverage", below) or may elect to continue coverage during that period (see "Military Continuation Coverage" below).

Freezing Coverage

Unless you and/or your Dependents choose to continue coverage as described below, coverage for you (the Employee) and your Dependent(s) will cease on the date you enter military service. Your eligibility status will be "frozen" when you enter military service and will be fully restored when you return to work with a Contributing Employer (or are available for work for a Contributing Employer, but no such work is available). Please refer to the section entitled "Coverage Following Military Service" below, for information about the time requirements and time limits for returning to work.

Military Continuation Coverage

You may elect to freeze your eligibility status as indicated previously. However, if you choose not to freeze your status and wish to continue your coverage while on military leave you have two options: (1) If you are a Plasterer, you may first use any available bank hours. If you are a Cabinet Maker you may first use any available bank coverage. If you are an Industrial Carpenter, you may first use any available dollar bank. Once bank hours, bank coverage or dollar bank is exhausted, you may then continue coverage by electing and paying for coverage as provided and available under COBRA Continuation Coverage; or, (2) If you do not have any available bank hours, bank coverage or dollar bank, or choose not to use such hours, coverage or dollar bank, you may elect to self-pay for Military Continuation Coverage. You may continue your coverage for up to 24 months.

If you choose option (1) above and exhaust any available bank hours, bank coverage or dollar bank, following discharge from military duty, you will first have to satisfy the initial eligibility requirements before you and your Dependents will be covered or you may continue your coverage by making self-payments until the initial eligibility requirements are satisfied.

If you choose option (2) above, and you did not have any bank hours, bank coverage, or dollar bank, you may make self-payments to continue your coverage. If you did have bank hours, bank coverage or dollar bank and did not use them during your military leave, you can access them to continue your coverage.

Coverage Following Military Service

If you do not elect military Continuation Coverage, your eligibility status is frozen when you enter military service provided you have notified the Plan Administrator of that service. If you and your Dependents were eligible for coverage when you entered active duty, you again will be covered when you return to work for a participating Employer within the time limits provided below. You will also be covered if no work is available when you leave active duty, but you are available for work for a participating Employer. These time limits may be extended if you have suffered a service-connected Injury or Sickness. You should contact the Plan Administrator if that has occurred.

Time limits to return to work

If you were in military service	You must
1 to 30 days	Report to your Employer (or another participating Employer) by the beginning of the first regularly scheduled work day more than eight hours after you return home.
31 to 180 days	Submit an application for reemployment to your employer (or another participating Employer) within 14 days after the completion of your service.
More than 180 days	Submit an application for reemployment to your employer (or another participating Employer) within 90 days after the completion of your service.

If you do not return to work with the same participating Employer, you should notify your Local Union that you are available for work with a participating Employer.

Family and Medical Leave

Under the Family and Medical Leave Act of 1993 (the “FMLA”) you may be entitled to coverage under the Plan for up to 12 weeks if you are away from work for certain reasons. You will only be eligible for this protection if you have worked for a covered Employer for at least one year, and you have worked at least 1,250 hours for the same Employer over the previous 12 months. Your coverage under the Plan will continue provided your Employer continues to make Contributions on your behalf while you are on FMLA leave.

State Family and Medical Leave Laws

Many states, including Minnesota, also have laws governing family and medical leave, which may give you additional rights. You should contact your Employer or the Plan Administrator to see if your state's laws give you additional rights under your state's family and medical leave laws.

Retiree Benefits

You should know that Retiree benefits are not an "accrued" or "vested" benefit. That is, there is no guarantee that the benefits will continue into the future. Retiree benefits may be changed, reduced or eliminated at any time based on decisions made by the Trustees.

Retiree Benefits are available only to Plasterers and Cabinet Makers. Non-Bargaining Employees and Industrial Carpenters are not eligible for Retiree Benefits.

When you retire, there are two ways of continuing your coverage for yourself and your Dependents;

> **Continuation Coverage** is available up to 18 months for you and in some cases, 36 months for your dependents, provided you timely make the correct Self-Contributions. Refer to "Continuation Coverage under COBRA" (page 23) in this booklet for more information. If you elect this coverage at retirement, you cannot be covered under the Retiree Benefits when this coverage ends. However, if you are on COBRA coverage at the time you meet eligibility for Retiree Benefits, you may elect for Retiree Benefits at that time and discontinue your COBRA coverage.
>
> **Retiree Benefits** provided under the Plan are available for you and your Dependents as long as you satisfy the eligibility requirements and timely make the correct Self-Contributions. These Retiree benefits are described below.

Continued Eligibility While Retired

If you are either (a) at least age 57 at the time that you retire or (b) at least age 57 and are disabled, you may continue coverage for yourself and your Dependents on a self-payment basis.

This coverage is subject to the following rules:

- You may no longer be actively working in the trade;
- You must be Covered Under The Plan when you turn 57, either through active employment or COBRA Continuation Coverage;

- If you are a Plasterer, you must have been actively eligible for at least 12 of the last 20 coverage quarters, which may include self-pay short hours preceding retirement;

- If you are a Cabinet Maker, you must have been actively eligible 36 of the previous 60 months through active coverage provided via Employer Contributions;

- You must elect to be covered as a Retiree within 60 days of the date that you cease to be Covered Under The Plan as an Employee.

If you return to work for a Contributing Employer and subsequently become eligible under the Plan as an active Participant, any Contributions received on your behalf will be used to pay your premium, as an active Employee. In addition, the self-contribution requirement will cease until you re-retire and re-enter the "Retiree Plan."

If after obtaining coverage under this Retiree Coverage section, you return to work for a Contributing Employer and then once again retire, you will not have to re-qualify for Retiree coverage.

Retiree benefits include most of the medical benefits provided to all other Plan participants. However, Retiree benefits do not include Life Benefits, Accidental Death and Dismemberment Benefits or Weekly Disability Benefits.

Coverage for Eligible Dependents

If you elect coverage as a Retiree, coverage will be extended to all of your Eligible Dependents for as long as you remain a Participant in the Plan, you submit timely Self-Contributions, and those individuals remain Dependents. If you decline to elect Retiree coverage, your Eligible Dependents may elect COBRA Continuation Coverage, as explained on page 23.

If you become eligible for and elect for other medical coverage through the government, such as Medicare or Veteran's Administration coverage, either before or after you elect for coverage as a Retiree, your spouse will remain eligible for coverage under this Retiree Benefits section as long as you or your spouse make timely payment for coverage as further described in the section entitled "Payment of Self-Contributions for Retiree Benefits."

If you die while Covered Under The Plan as a Retiree, your Eligible Dependents may maintain coverage under the Plan's "Coverage for Surviving Dependents of Retirees" provisions, described below.

Payment of Self-Contributions for Retiree Benefits

To ensure maximum benefits under the "Retiree Plan", you should follow these rules for the payment of Self-Contributions:

1. The amount of the monthly self-contribution is determined by the Trustees and may be changed at any time.

2. The individual making the election for Retiree benefits will have forty-five (45) days after the date of the election to make the initial payment for any coverage provided between the date that coverage would have otherwise terminated and the date the election was made.

3. The due date for all subsequent monthly Self-Contributions is the first day of the month in which coverage is to be provided. (Example: payment for January coverage is due on or before January 1). You should make payments by this due date in order to assure continuous eligibility in the Plan. If your payment is late, but made during the grace period described below, Plan records may not show you and your Dependents eligible for benefits until the payment is received.

4. A monthly self-contribution will be considered to have been made on a timely basis if the full payment is received by the Plan within thirty (30) days of the due date.

5. If a monthly self-contribution is not made within the thirty (30) day grace period specified above and coverage terminates for all affected individuals, the overdue payment may not be made up nor may coverage be reinstated by the making of further payments.

6. Notices of due Self-Contributions will not be sent to Retirees or their Dependents by the Plan Administrator.

Termination of Coverage for Retirees and Their Dependents

Coverage for Retirees will terminate under this Plan on the first to occur of the following dates:

1. The date the Trustees terminate this Plan;

2. The date the Trustees terminate Plan benefits for Retirees or a class of Retirees in which you are included;

3. The last day of the benefit month for which you made a proper and on-time self-contribution;

4. The date on which you reach age 65 or become eligible to receive benefits under Medicare;

5. The date of your death; or

6. The date you return to work for a non-Contributing Employer or engage in self-employment in the same trade or craft.

Benefits for your Dependent(s) will end on the earliest to occur of the following dates:

1. The date the Trustees terminate this Plan;

2. The date the Trustees terminate Plan benefits for Retirees or a class of Retirees in which you are included;

3. The date the Trustees terminate Dependent Benefits under this Plan;

4. The date on which the Retiree's eligibility for Plan coverage terminates (except that if the Retiree's eligibility ends because they reach age 65, and the spouse has not yet reached age 65, the spouse may remain on the Plan until reaching age 65);

5. The date the Dependent ceases to meet this Plan's definition of a Dependent unless the Dependent is entitled to enroll and does enroll for continued coverage (refer to "Continuation Coverage Under COBRA" section in this booklet);

6. The date at the end of the last day of the 36-month period for which correct and on-time Self-Contributions have been made for Continuation Coverage under COBRA, or on the date of occurrence of any event stated in the "Continuation Coverage Under COBRA" section in this booklet which causes that coverage to terminate.

7. If you die while making Self-Contributions for Retiree benefits, Dependent coverage will end:

    a. At the end of the last day of the last benefit month for which you had made a self-contribution before your death unless your Dependent elects to continue coverage (see page 19) and Self-Contributions are made by or on behalf of the Dependent;

    b. When the COBRA Continuation Coverage maximum period ends for your spouse or any Dependent children;

    c. On the date when a correct and on-time self-contribution fails to be made by or on behalf of the Dependent;

d. On the date the Dependent fails to meet the definition of a Dependent;

e. For the surviving spouse, on the date the surviving spouse remarries or dies, whichever occurs first.

CONTINUING ELIGIBILITY THROUGH SELF-CONTRIBUTIONS (CONTINUATION COVERAGE UNDER COBRA)

If you lose your job or do not work enough hours to maintain eligibility, you can make self-Contributions to continue your coverage. Your Dependents can also make Self-Contributions if they are going to lose coverage for certain reasons as explained below.

A federal law, (known as COBRA) gives you and your Dependents the right to make Self-Contributions for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "COBRA Continuation Coverage." The following is an outline of the rules governing COBRA Continuation Coverage. If you have any questions about this coverage, call the Plan Administrator's office.

Please note that additional or alternative coverage (other than COBRA Continuation Coverage) may be available to Employees working reduced hours or who are laid off, to Retired Employees, to spouses, and to other Dependents. Those types of coverage are described elsewhere in this Eligibility section (pages 9 through 22).

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

COBRA Qualifying Events

You are entitled to elect COBRA Continuation Coverage and to make Self-Contributions for coverage for <u>up to 18 months</u> if coverage terminates due to one of the following events (called "qualifying events"):

1. A reduction in your hours; or

2. Your loss of employment (which includes retirement), except for termination of employment due to gross misconduct.

3. For military leaves occurring on or after December 10, 2004, coverage may last up to 24 months if the reduction of hours is the result of military leave (see "Eligibility During Periods of Military Service" on Page 17 for more details).

In addition, your Dependents are entitled to elect COBRA Continuation Coverage and to make Self-Contributions for the coverage for up to 36 months after coverage terminates if their coverage terminates due to one of the following events (called "qualifying events"):

1. Your divorce or legal separation from your spouse;
2. A child's failure to meet the Plan's definition of a Dependent;
3. Your death;
4. You become enrolled in Medicare (Part A, Part B, or both); or

Weekly Disability Benefits, Accidental Death and Dismemberment Benefits, and Life Benefits are **NOT** provided under COBRA Continuation Coverage.

COBRA Notification Responsibilities

1. You, your spouse or your Dependent child must notify the Plan Administrator if you get **divorced** or **legally separated** or if a **child loses Dependent status** or any **change in address**. The Plan Administrator must be notified within 60 days of the date of any of these qualifying events or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. In providing notice, you must provide documentation to the Plan Administrator to support the qualifying event. In case of a divorce, a copy of the divorce decree or similar document evidencing the date of the divorce will be required. In case of a Dependent losing Dependent status, documentation indicating the date Dependent status ended will be required.

2. It is your employer's responsibility to notify the Plan Administrator's office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a Dependent should also notify the Plan Administrator any time any type of qualifying event occurs.

3. You must notify the Plan Administrator within 60 days of the date of a disability determination from the Social Security Administration and within the first 18 months of COBRA coverage in order for you, your spouse or your Dependent child, who is or becomes disabled to become eligible for an additional 11 months of coverage (a total of 29 months) which is available to disabled individuals (as explained below). In providing notice, you must provide documentation to support the qualifying event to the Plan Administrator. In the case of a disability extension, you must provide a copy of the Social Security Administration determination of disability status.

COBRA Maximum Coverage Period

Eighteen months is the maximum period of time that you (the Employee), your spouse and Dependents can have COBRA Continuation Coverage if the COBRA Continuation Coverage is the result of your termination or reduction in hours of employment. For you, this maximum period can only be extended in a disability situation, as described below. For your spouse and Dependents, the maximum period can be extended for up to a maximum of 29 months in a disability situation or to a maximum of 36 months if one or more new qualifying events occurs while covered under COBRA Continuation Coverage. "Disabled" means becoming entitled to disability benefits under the Social Security Act.

Thirty-six months is the maximum period of time that your spouse and Dependents can have COBRA Continuation Coverage if a qualifying event occurs other than a termination or reduction in hours of employment. Thirty-six (36) months is also the maximum period of time that your spouse and Dependents can have COBRA Continuation Coverage even if one or more new qualifying events occur to the person while covered under COBRA Continuation Coverage.

> For example, suppose that your death occurs while you are making Self-Contributions for COBRA Continuation Coverage because of reduced hours. You and your family had been covered under COBRA Continuation Coverage for 6 months before your death. Since your death is a qualifying event for your Dependents, your spouse elects to continue coverage by making Self-Contributions for himself or herself and your Dependent children. Your spouse is entitled to continue coverage for himself/herself and the children for an additional 30 months (the maximum coverage period of 36 months minus the number of Self-Contributions you had already made (36 - 6 = 30).
>
> Then, after your spouse has continued coverage for 15 of the remaining 30 months for himself or herself and the children, one of the children turns age 26 and no longer meets the Plan's definition of a Dependent. This is a qualifying event for the child entitling him or her to make Self-Contributions for COBRA Continuation Coverage for himself or herself. However, the 36-month maximum coverage period is reduced by the 21 months of COBRA Continuation Coverage already received (6 months from your Self-Contributions before your death plus 15 months from your spouse's Self-Contributions). The child is, therefore, entitled to make Self-Contributions for COBRA Continuation Coverage for up to 15 months (36 - 21 = 15).
>
> Another example of this extension rule would involve a situation when the qualifying event is the end of your employment, and you became entitled to Medicare benefits less than 18 months before your employment termination (qualifying event). COBRA Continuation Coverage for qualified beneficiaries other than you, lasts until 36 months after the date of your Medicare entitlement. For example, if you become entitled to Medicare 8 months before you terminate your employment, COBRA Continuation Coverage for your spouse and children

can last up to 36 months after the date of your Medicare entitlement, which is equal to 28 months after the date of your employment termination (36 months minus 8 months).

If you, your spouse or a Dependent are disabled when you elect this coverage, or become disabled within the first 60 days after you elect to continue coverage under COBRA, it may be extended for a period of up to 29 months.
To take advantage of the rules allowing for extended COBRA Coverage, evidence supporting the occurrence of the second qualifying event must be provided to the Plan Administrator to receive the extended COBRA Coverage. As mentioned previously, in case of a divorce, a copy of the divorce decree or similar documentation must be provided; in the case of a Dependent losing Dependent status, documentation indicating the date Dependent status ended; or in the case of a disability determination, a copy of the Social Security disability determination.

COBRA Self-Contribution Procedures and Rules

1. When the Plan Administrator's office is notified of a qualifying event, an Election Notice will be sent to you and/or your Dependent(s) who would lose coverage due to the event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for payments, the benefit options that can be elected, the amount of the monthly self-contribution for each option, and other important information.

2. An Election Form will be sent along with the Election Notice. This is the form you or a Dependent must complete and send back to the Plan Administrator in order to elect COBRA Continuation Coverage.

3. The person electing COBRA Continuation Coverage has 60 days after he or she has been sent the Election Notice or 60 days after the coverage would terminate, whichever is later, to send back the completed Election Form. However, it is strongly recommended that the form be sent back as soon as possible. An election of COBRA Continuation Coverage is considered to be made on the date the Election Form is postmarked.

4. If the Plan Administrator is not notified of the COBRA Continuation Coverage Election within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

5. A person electing COBRA Continuation Coverage has 45 days after the signed Election Form is returned to make his or her initial payment. (However, it is strongly recommended that the payment be made as soon as possible so that a number of months won't have to be paid for all at once.) The initial payment must be sufficient to pay all current and past due Contributions.

6. COBRA Continuation Coverage Self-Contributions must be made monthly. After the initial self-contribution, each subsequent monthly self-contribution is due by the first day of the benefit month for which the self-contribution is being made (the "due date"). A self-contribution will be considered on time if it is received by the Plan Administrator within 30 days of the due date.

7. If a self-contribution is not made in the correct amount within the time allowed, COBRA Continuation Coverage for all affected family members will terminate. The self-contribution may not be made up nor may coverage be reinstated by making future Self-Contributions.

8. Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA Continuation Coverage.

9. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents unless they make a separate election.

10. An election on behalf of your minor child can be made by you or another parent or legal guardian.

11. The amount of the monthly Self-Contributions is determined by the Trustees based on Federal regulations. The contribution amount is subject to change, but usually not more often than once a year unless substantial changes are made in the benefits provided to participants and Beneficiaries.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage for a person will be terminated before the end of the maximum coverage period when the first of the following events occurs:

1. A correct and on-time self-contribution is not made to the Plan;

2. The Plan no longer provides group health coverage to any Employees;

3. After the COBRA election, the person first becomes covered under another group health insurance plan with no pre-existing condition limitation or a limitation provision that does not apply to the person or which the person in question satisfies; or

4. After the COBRA Election, the person becomes covered by Medicare.

Coverage for Surviving Dependents

The Plan provides extended coverage to your surviving Dependents, subject to the following rules:

1. Coverage will be available only to persons who are your Dependents on the date of your death *(however, a child of yours born after your death will also be treated as a Dependent under this provision)*;

2. The premium for the survivor coverage will be equal to the COBRA premium but shall be subject to change at the discretion of the Trustees, and shall be payable at the same time and under the same terms as COBRA self-payments;

3. Survivor coverage for a surviving spouse will extend until the earlier of:

    a. The date the surviving spouse dies;

    b. The date the surviving spouse becomes first eligible for Medicare coverage;

    c. The date the surviving spouse remarries or becomes covered under another group health plan;

    d. The date a timely premium payment is not made; or

    e. The date the Plan is terminated or survivor coverage is discontinued.

4. Survivor coverage for Eligible Dependents will extend until the earlier of:

    a. The date the Dependent no longer qualifies as a Dependent under the terms of the Plan;

    b. The date the Dependent becomes covered under another group health plan;

    c. The date a timely premium payment is not made; or

    d. The date the Plan is terminated or surviving Dependent coverage is terminated.

Dependent HSA Opt-Out

Your dependent spouse may elect to opt-out of coverage under this Plan only if they are eligible for a Health Savings Account (HSA) health plan provided by their employer.

By having your spouse opt-out of coverage under the Plan, you and your spouse understand that:

1. Your spouse will not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, prescription drug benefits, dental benefits, vision care or any other form of retiree benefits under the Plan.

2. You will have no right or claim to any contributions made to the Plan for the purposes of funding your spouse's eligibility for coverage.

3. Your spouse forfeits any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by your spouse's employer.

4. Your spouse and/or dependent(s) may return to coverage under the Plan under the following circumstances:

    a. The spouse drops their coverage under their employer's plan during the employer's annual open enrollment period;

    b. The spouse loses coverage under their employer's plan due to a termination of employment; or

    c. The spouse otherwise suffers a special enrollment event as required by the Health Insurance Portability and Account Ability Act (HIPAA).

To opt-out of coverage under this provision, your spouse must complete the HSA Opt-Out election form which can be requested from the Plan Administrator.

LIFE BENEFIT

SUMMARY

The Plan provides a benefit to your designated Beneficiary in the event of your death if you are covered under this portion of the Plan.

You have the right to name a Beneficiary to receive these benefits in the event of your death. To do so, or to change that designation, contact the Plan Administrator's office.

If you (the Employee) suffer accidental death or the accidental loss of your sight or one or more limbs, the Plan also pays a separate benefit which is described in the Section entitled, "Accidental Death and Dismemberment Benefit," beginning on page 32.

This is a fully-insured benefit governed by an insurance policy through USAble Life. The provisions of this section are a summary of the key provisions from the USAble Life policy. If there is any conflict between this section and the insurance policy, the insurance policy will govern.

The Plan will pay a Life Benefit of $10,000 if you die from most causes while Covered Under The Plan. A proper application is required before any benefits will be paid. If you intend to designate a minor as your Beneficiary, a proper designation includes information about the minor's guardian or the trust from which payments will be made.

If your death is accidental, your Beneficiaries will also receive an additional Accidental Death and Dismemberment Benefit, described on page 32.

The Life Benefits under the Plan are an insured benefit. This means the Plan pays an insurance premium to USAble Life to provide these benefits. The insurance premium is paid from the Plan's assets, but the life benefits are not. USAble Life issues a Group Life and Disability Insurance Policy which explains the benefits under the policy as well as the limitations on this benefit. If the terms of the Group Life and Disability Insurance Policy differ from the benefits described in this booklet, the terms of the Group Life and Disability Insurance Policy govern.

Beneficiary

At the time of enrollment, you must complete a form naming your Beneficiary. If you name two or more persons as Beneficiaries, the benefit would be shared equally by any surviving Beneficiaries unless otherwise specified. It is important to keep your Beneficiary information up to date. If, for example, there is a change in your marital status or the birth of a child, you may wish to complete a change of Beneficiary form. If you fail to designate a Beneficiary, this Life Benefit will be payable to individuals in the following order:

1. Your Surviving Spouse;

2. Your Surviving Children (including any legally adopted children);

3. Your Surviving Parents;

4. Your Surviving Brothers and Sisters; or

5. Your Estate

If you designate a minor child as your Beneficiary, you must provide the Plan Administrator information regarding the child's guardian or the trust to which benefits will be paid.

Limitations

The Life Benefit will not be payable for any loss caused by or resulting from:

1. Your death due to an accident occurring for any of the reasons stated in the "Plan Conditions, Limitations and Exclusions" provisions, beginning on page 69.

2. Your death due to Suicide, unless the suicide results from a medical condition.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

SUMMARY

If you (the Employee) suffer accidental death or accidental loss of your sight or one or more limbs, the Plan will pay a benefit as set forth in this Section. This benefit is payable regardless of whether the accident occurs during the course of your employment or not. You have the right to name a Beneficiary to receive any benefits in the event of your death. To do so or to change that designation, contact the Plan Administrator's office.

No benefits will be paid for injuries or death that occurs due to any of the limitations described in the Plan's "Life Benefit" provisions or for any intentionally self-inflicted Injury (unless the self-inflicted Injury results from a medical condition).

This is a fully-insured benefit governed by an insurance policy through USAble Life. The provisions of this section are a summary of the key provisions from the USAble Life policy. If there is any conflict between this section and the insurance policy, the insurance policy will govern.

If you suffer bodily injury caused by accidental means and the injury causes your death or the loss of a limb or the loss of sight of an eye within 90 days of the date of the accident, the Plan will pay an Accidental Death and Dismemberment Benefit in the principal sum of $10,000.

The Plan will pay the full Accidental Death and Dismemberment Benefit for loss of:

1. Life;
2. Both hands or both feet;
3. One hand and one foot;
4. Sight of both eyes;
5. One hand and sight of one eye;
6. One foot and sight of one eye.

The Plan will pay one-half the Accidental Death and Dismemberment Benefit for loss of:

1. One hand;
2. One foot; or
3. Sight of one eye.

If you suffer more than one accident, payment will be made only for the one loss for which the larger amount is payable.

The accidental death and dismemberment benefits under the Plan are an insured benefit. This means the Plan pays an insurance premium to USAble Life to provide these benefits. The insurance premium is paid from the Plan's assets, but the benefits are not. USAble Life issues a Group Life and Disability Insurance Policy which explains the benefits under the policy, as well as the limitations on this benefit. If the terms of the Group Life and Disability Insurance Policy differ from the benefits described in this booklet, the terms of the Group Life and Disability Insurance Policy will govern.

Limitations

These benefits do not cover losses from:

1. Disease, bodily or mental infirmity, or infection (except bacterial infection of a visible injury);

2. Suicide or intentionally self-inflicted injury, whether sane or insane,

3. Your commission of a felony;

4. War or any act of war, declared or undeclared;

5. Your voluntary use of any narcotic unless prescribed by a Physician;

6. Travel or flight in, or descent from, any aircraft unless as a fare paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight;

7. Your driving or operating a Motor Vehicle while being intoxicated as defined by the laws of the jurisdiction in which the accident occurred.

Benefits for loss of life will be payable to your Beneficiary or Beneficiaries. All other Benefits will be paid directly to you.

Upon receipt of a proper application, the Plan will pay an Accident Death and Dismemberment (AD&D) Benefit in the principal sum of $10,000 if you suffer any of the listed bodily Injuries that are caused by an accident while you are Covered Under The Plan.

WEEKLY DISABILITY BENEFIT

SUMMARY

The Plan provides specific benefits ("loss-of-time benefits") if an employee becomes Totally Disabled at a time when he or she is otherwise covered by this Plan. The requirements to receive those benefits are set forth in this portion of the document.

If you (the Employee) have been disabled, contact the Plan Administrator's office to determine if you are eligible for this valuable benefit. This benefit is available only to active Employees.

Eligibility for Benefits

To be eligible for Weekly Disability Benefits, you must meet all of the following requirements:

1. You must be Totally Disabled as a result of an Injury or Illness and must satisfy the Plan's definition of Total Disability; and

2. You must have been Covered Under The Plan as an Eligible Employee (and not as a Retired Employee) on the date that you first satisfy the Plan's definition of Total Disability; and

3. You must be under the care of a Physician for the disability, and;

4. You may not be receiving salary, wages, unemployment compensation or any retirement benefits.

An Eligible Employee "Covered Under The Plan," for purposes of this Weekly Disability Benefit, will also include an Employee eligible for coverage by making Self-Contributions (excluding those made via COBRA) who suffers an injury which causes the Employee to be Totally Disabled and the injury causing the Total Disability is suffered in a month in which the Employee's Employer makes a contribution to the Plan for work performed by the Employee.

Indemnity Limits and Benefit Provisions

1. Benefits will be payable in an amount not to exceed the weekly Maximum Benefit of $315.

2. Benefits will be payable for up to, but will not exceed, the maximum indemnity period of 26 weeks during any one Period of Disability.

3. Benefits are not payable during the waiting period for sickness (7 days).

4. Benefits will be payable on the basis of a seven-day week.

5. If benefits due to you are for a fractional part of a week, you will receive one-seventh of the weekly benefit for each day of disability.

6. Your payments will be reduced by the amount of FICA taxes required by law to be withheld.

7. A disability will not be considered to have begun until, at the earliest, the first day that you are actually examined or treated by a Physician for the Injury or Sickness causing such disability.

8. If a female Employee is Totally Disabled as a result of maternity or a pregnancy or a pregnancy-related condition, the disability will be considered a disability due to Sickness.

Amount and Commencement of Benefits

The amount of your Weekly Disability Benefit is dependent upon whether the disability is due to a Sickness or Injury. It is subject to the following schedule:

Disability Due to Accident

Maximum Benefit Period	Waiting Period Before Benefits Will Be Paid	Maximum Weekly Benefit
26 weeks	No waiting period	$315

Disability Due to Sickness

Maximum Disability Period	Waiting Period Before Benefits Will Be Paid	Maximum Weekly Benefit
26 weeks	7 days	$315

Successive Periods of Disability

When you have two or more periods of disability for the same or a related cause, they will be considered as one period of disability. The second period of disability will be considered a continuation of the first one for benefit purposes. No waiting period is required. Your Weekly Disability Benefit would begin on the first day you are unable to work, and would be paid for any remaining weeks in the Disability Period. In addition, if you do not return to work for two weeks or more between periods of disability, it will be presumed that the disabilities are for the same or a related cause unless you provide the Plan with reasonable evidence that the disabilities are the result of separate causes.

For example, suppose that you were receiving Weekly Disability Benefits, you subsequently recovered and then returned to work. Suppose that after having returned to work for a period of less than two weeks, you became Totally Disabled again as a result of that same disability. This would be considered one period of disability.

Now let's assume that you returned to full-time work for a participating employer for two weeks or less (but at least 1 day) and become disabled from an Illness or Injury different from the one causing your earlier disability. Your second disability is considered separate from the first one for benefit purposes, and a new Disability Period (and Waiting Period) applies.

Weekly Disability Benefit Exclusions and Limitations

No benefits will be payable under these Weekly Disability Benefit Provisions under the following conditions:

1. For any disability due to an Injury or Illness for which the Employee is not under the direct and continuing care of a Physician;

2. For any disability that results from any Injury sustained while performing any act or duty pertaining to any occupation or employment for remuneration or profit;

3. For any disability which results from any Injury or Illness for which the Eligible Employee is or may be entitled to receive benefits in whole or in part under the provisions of any Workers' Compensation law, Occupational Diseases law, Employer's Liability law, No-Fault insurance, or similar law; and

4. For any period of disability during which the Eligible Employee qualifies for unemployment compensation under any federal or state law.

Taxation of Weekly Disability Benefits

In general, Weekly Disability Benefits are subject to Social Security taxes (FICA). You pay half of the tax, and the Plan, standing in place of and acting as your employer, pays the other half. According to federal law, the Plan will withhold your share of the FICA tax from each weekly benefit check paid to you during the first six full months of your disability, and will send it to the government. You must include your Weekly Disability Benefits in your gross income and pay federal income tax on the benefits as income.

You should contact a competent tax advisor or attorney if you have any questions regarding taxes on your Weekly Disability Benefits.

MAJOR MEDICAL BENEFIT

SUMMARY

This and the next section (Covered Medical Expenses) of the document describe most of the benefits payable when you or your Dependent is injured or sick. When you or a family member incurs charges for benefits payable under this section, an annual deductible will apply. You will also be required to pay a portion of the charges for benefits, up to an annual out-of-pocket maximum amount.

Benefits are payable only to Covered Individuals for services described in this document that are Medically Necessary and are not otherwise excluded.

If you have questions about the benefits payable under these sections, please contact the Plan Administrator.

Preferred Provider Network

The Plan offers a Preferred Provider Network, which is a network of doctors, hospitals, and other health care providers that have contracted with the Plan to provide discounted medical services. Covered Individuals will be issued a Preferred Provider identification ("ID") card. If you have any questions regarding whether a provider that you would like to see is a Participating Provider, please contact the Plan Administrator or consult the Blue Cross Blue Shield of Minnesota Web Site (www.bluecrossmn.com).

You must present your ID card whenever you receive treatment from a Participating Provider. The Participating Provider will file claims with the Plan directly for Covered Individuals.

If you use a Participating Provider, you will benefit from discounts the Plan has negotiated with Participating Providers. You may choose, however, to use a Non-Participating Provider, although the price of the services provided (and, by extension, the dollar amount of any applicable coinsurance) will likely be higher than if you use a Participating Provider, you will be responsible for paying for any charges that exceed the Reasonable and Customary Charge, and, for some types of services, no benefits at all will be paid under the Plan.

Unless otherwise provided in the Plan, the Plan will pay the Reasonable and Customary charges made by a provider for Medically Necessary Covered Medical Expenses. Each covered expense is deemed to be incurred on the date the underlying service or supply is provided to the Covered Individual.

Calendar-Year Deductibles

Individual Deductible

Each Covered Individual must pay a certain dollar amount, set forth in the Summary of Benefits, of Covered Medical Expenses in a Calendar Year before the Plan will pay any benefits.

Family Deductible

A Covered Individual may receive Plan benefits without first paying his or her deductible amount if the Covered Individual's family has already fully paid the family deductible amount in a Calendar Year.

Deductible Rules

1. All deductibles are based on an accumulation period of a Calendar Year (January 1 through December 31 of each year).

2. Only Covered Medical Expenses can be used to satisfy a deductible.

3. If an Eligible Family Member is suffering from a condition for which Covered Medical Expenses are incurred in two or more years, the deductible must be satisfied each year.

4. Each Eligible Family Member must satisfy the individual deductible each year except that once the family deductible is satisfied during a year, no further individual deductibles must be satisfied by any other family members during that year.

Coinsurance

Once the deductible is satisfied, the Plan will pay the percentage of major medical benefits indicated in the Summary of Benefits for covered treatment received. The remaining percentage is known as "coinsurance", which you must pay out-of-pocket until you reach the annual major medical out-of-pocket maximum specified in the Summary of Benefits. You must also, of course, pay any expense that is not covered by the Plan at all.

Annual Major Medical Out-of-Pocket Maximum

Amounts paid for deductibles and coinsurance for major medical benefits count towards the annual major medical out-of-pocket maximum. Amounts paid to a Non-participating Provider which are not covered by the Plan because they exceed the Reasonable and Customary charge, however, do <u>not</u> count towards the annual major medical out-of-pocket maximum. Nor do charges that are not covered by the Plan because they exceed the lifetime major medical benefit

Lifetime Maximum

Once the Plan has paid a certain dollar amount, specified in the Summary of Benefits, for Non-Essential Health Benefits on behalf of a Covered Individual, the Plan will never make any more payments for major medical benefits on behalf of the Covered Individual.

The Plan has no annual or lifetime maximum that applies to Essential Health Benefits.

Maximum Out-of-Pocket Expense - Example

The Plan limits the amount you have to pay for Covered Medical Expenses in any Calendar Year. The out-of-pocket expense for each Covered Individual is the amount paid toward the individual or family deductible plus your share of the Covered Medical Expenses.

Currently, the annual (per Calendar Year) out-of-pocket expense maximum limits (in addition to the deductible) are:

$3,000 per person; and
$6,000 per family.

Once the deductible is satisfied and out-of-pocket expenses reach the annual major medical out-of-pocket maximum, the Plan pays 100% of Covered Medical Expenses for major medical benefits for the rest of the year.

For example, assume that a provider billed you $8,000 for Covered Medical Expenses, but the allowed amount under the Plan's Preferred Provider network arrangement is $7,000. The amount that you must pay out-of-pocket will depend upon whether the provider was a Participating Provider:

I. Services Provided by a Participating Provider

You have Covered Medical Expenses of	*$8,000*
Under the Preferred Provider network agreement, the provider discounts the charges by $1,000	*-1,000*
You pay the individual deductible	*-200*
	$6,800
You pay 20% of the remaining expenses (the coinsurance) because you have not yet reached the annual out-of-pocket maximum of $3,000	*-1,360*
The Plan Pays	*$5,440*

The total amount you would pay for this procedure is $1,560 ($200 deductible plus $1,360 coinsurance). You would still have to pay $1,640 in coinsurance on

future charges during the Plan year in order to reach the annual major medical out-of-pocket maximum of $3,000 during the Plan year ($3,000 - $1,360 = $1,640).

*II. Services Provided by a **Non**-Participating Provider*

You have Covered Medical Expenses of	*$8,000*
You pay all charges exceeding the amount that would be allowed based on the Reasonable and Customary Charge.	*-1,000*
You pay the individual deductible	*- 200*
	$6,800
You pay 40% of the remaining expenses (the coinsurance) because you have not yet reached the annual out-of-pocket maximum of $3,000	*-2,720*
The Plan Pays	*$4,080*

In this example, the amount you paid for this procedure is $3,920 ($200 deductible plus $1,000 for provider charges exceeding the amount allowed under the Preferred Provider network plus $2,720 coinsurance). You would still have to pay $280 in coinsurance on future charges during the Plan year in order to reach the annual major medical out-of-pocket maximum of $3,000 ($3,000 - $2,720 = $280). Furthermore, the $1,000 you paid because the provider's charge exceeds the Reasonable and Customary charges is not applied to the annual major medical out-of-pocket maximum.

If you have any questions regarding the determination of the amount of your out-of-pocket expense that will count towards your maximum out-of-pocket amount, please contact the Plan Administrator.

COVERED MEDICAL EXPENSES

The Plan will pay for Covered Medical Expenses of a Covered Individual, subject to the Plan's conditions, limitations, and exclusions (including Plan deductibles and coinsurance).

Covered Medical Expenses are the Reasonable and Customary charges that are incurred by a Covered Individual for the Medically Necessary treatment of conditions covered under this Plan, which includes the following services, supplies and types of treatment:

Ambulance

Charges for air or ground transportation for basic or advanced life support from the place of departure to the nearest facility equipped to treat the Illness provided the Covered Individual is too ill or injured to travel by other modes of transportation.

If air ambulance was not Medically Necessary but ground ambulance would have been, the Plan will pay up to the Reasonable and Customary charge for Medically Necessary ground ambulance.

The following charges are not covered:

- Transportation services that are not necessary for basic or advanced life support; and
- Transportation services that are mainly for your convenience.

Cancer Screening Tests

Covered charges include the following cancer screening tests:

- Prostate Antigen Test (PSA)
- Mammograms
- Sigmoidoscopy
- Pap Smear
- Colonoscopy

This benefit also includes the associated office visit to administer any of the above listed cancer screening tests.

Chemical Dependency Treatment

Covered charges include charges for chemical dependency or abuse for outpatient and inpatient treatment.

The following charges are not covered:

- Services to hold or confine a person under chemical influence when no medical services are required, regardless of where the services are received;
- Services for a condition which the Plan Administrator determines cannot be improved with treatment; and
- Custodial Care and supportive care.

Dental Care

The charges for treatment of the following:

- For accident related dental services by a Physician or Dentist to treat an Injury to sound natural teeth;
- Temporomandibular joint (TMJ) and craniomandibular disorders (including surgical and nonsurgical treatment).

The following conditions apply to this benefit:

- Treatment must occur while you are a Covered Individual;
- Services must be started within six months of the Injury;
- You will pay all charges that exceed the allowed amount when you use a Non-Participating Provider.

The following are not covered:

- Accident related dental services to treat an Injury from biting or chewing;

- Accident related dental services received beyond the initial treatment for the Injury;
- Dental prosthesis needed because of an accident related Injury;
- Dental implants and prosthesis, including any related hospital charges;
- Osteotomies and other procedures associated with the fitting of dentures or dental implants;
- Any orthodontia, including associated orthographic procedures or accident related dental injuries;
- Tooth extractions, unless otherwise specified; and
- Any other dental procedures or treatment.

IMPORTANT NOTE: The Plan provides an additional Dental Benefit through Delta Dental, which covers other dental charges. This benefit is described on page 59.

Durable Medical Equipment and Medical Supplies

Charges for:

- Durable Medical Equipment (DME), which includes wheel chairs, hospital beds, iron lungs, oxygen equipment, and siderails;
- Medical supplies, including splints, nebulizers, surgical stockings, casts, dressings, and blood clotting factors;
- Wigs when there is hair loss caused by alopecia areata
  - → Maximum benefit of $350 per year;
  - → Deductible does not apply to this wig benefit;
- Prosthetics, including breast prosthesis, artificial limbs, and artificial eyes;
- Phenylketonuria (PKU) - special dietary treatment for PKU is covered when recommended by a Physician;
- Lenses after surgery for cataracts, aphakia, or keratosis.

Durable Medical Equipment is covered up to the allowed amount to rent or buy the item. Allowable rental charges are limited to the allowed amount to buy the item. If the Plan buys the item and the Plan Administrator determines later that it is no longer Medically Necessary, the Plan has the right to ask you to return the item. Rentals will be approved for a specified period of time.

The following charges are not covered under this benefit:

- Enternal feedings and other nutritional and electrolyte substances;
- Personal and convenience items;
- Air conditioners, humidifiers, dehumidifies, vehicle lifts, waterbeds, heat appliances, exercise cycles and other machines, alcohol swabs, cotton balls, incontinence liners and pads, Q-tips, adhesives, and informational material;
- Eyeglasses, contact lenses and other optical devices or professional services to fit or supply them (some of which are covered under the Plan's Vision Benefit - see page 55);
- Internal, external or implantable hearing aids or devices, and related fitting or adjustment (the Plan does, however, cover cochlear implants and related fitting or adjustments);
- Duplicates; and
- Services for, or related to, arch supports, foot orthotics, and orthopedic shoes, including but not limited to such related services as biochemical evaluation, range of motion measurements and reports, and negative mold foot impressions.

Emergency Room

Charges for treatment received at a Hospital emergency room, subject to a $100 co-payment. The $100 co-payment will be waived if the Covered Individual is admitted to the Hospital.

Home Health Care

Covered charges include:

- Skilled care ordered in writing by a Physician and provided by the following Medicare-certified home health agency employees:

  → Registered nurse;
  → Licensed registered physical therapist;
  → Master's level clinical social worker
  → Registered occupational therapist;
  → Certified speech and language pathologist;
  → Medical technologist;
  → Registered dietician;
  → Home health aid;

Limitations:

- Coverage is limited to 180 visits per Calendar Year (a home health care visit means intermittent care up to two hours and/or extended care up to eight hours);

- Benefits for prescription drugs used during home health care are listed under the Prescription Drug benefit section.

- Benefits for home infusion therapy and related home health care are listed under the Home Infusion Therapy section.

The following are not covered:

- Home health care and supplies for ventilator-dependent individuals;

- Custodial or non-skilled care;

- Services of a non-medical nature.

Home Infusion Therapy

Covered charges include the following when ordered by a Physician:

- Solutions and pharmaceutical additives;

- Pharmacy compounding and dispensing services;

- Durable Medical Equipment;
- Ancillary medical supplies;
- Nursing services to train you or your caregiver and to monitor the home infusion therapy;
- Collection, analysis and reporting of lab tests to monitor response to home infusion therapy;
- Other eligible home health services and supplies provided during the course of home infusion therapy.

The following charges are not covered under this benefit:

- Home infusion services or supplies not specifically listed as covered services;
- Nursing services to administer therapy that you or another caregiver can be successfully trained to administer;
- Services that do not involve direct patient contact, such as delivery charges and record keeping.

Infertility

Covered charges include:

- Outpatient Hospital services;
- Inpatient services;
- Prescription drugs for infertility treatment and related supplies and services;
- Artificial insemination or intrauterine insemination and related supplies and services (except for charges for donor sperm);
- In-vitro fertilization (subject to the provisions below).

Limitations:

- Benefits are limited to six cycles per patient per lifetime or per pregnancy, whichever occurs first (The six-cycle limit will be renewed if successful

pregnancy is attained. Pregnancy must be confirmed by an ultrasound, a miscarriage documented by a pathology report, or by a live birth.);

- If the patient abandons a treatment regimen before the cycle is complete, the patient may count the partial cycle as one of the six eligible cycles or assume all charges for that cycle in order to preserve benefits for six complete cycles;

- All covered courses of in vitro fertilization must be pre-authorized by a case manager designated by the Plan. You must contact the Plan Administrator before undergoing these treatments;

- Charges for in vitro fertilization will be payable only when the patient suffers from infertility which cannot be surgically repaired;

- This in vitro fertilization benefit is subject to a $7,000 lifetime maximum.

The following are not covered charges:

- Reversal of voluntary sterilization;

- Sperm banking;

- Charges related to freezing one or more embryos or charges incurred for the use of a surrogate mother; these charges are specifically excluded under the provisions of this Plan;

- Charges for donor ova or sperm for purposes of artificial insemination;

- Services for or related to assisted reproductive technology (ART) procedures, including but not limited to in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote charges for donor ova or sperm, except as specifically described above as a covered charge.

Inpatient Hospital

Covered charges include:

- Hospital daily Room and Board at the Hospital's semi-private room rate;

- General duty nursing care;

- Intensive care and other special care units;

- Operating, recovery and treatment rooms;
- Anesthesia;
- Prescription drugs and supplies used during a covered admission;
- Lab and x-ray; and
- Hospital services and supplies.

Maternity Expenses

Covered charges include charges for professional services for delivery and postnatal care.

The following charges are not covered under the Plan:

- Charges for surrogate pregnancy;
- Adoption.

This Plan may not, under Federal law, restrict benefits for any Hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a provider obtain authorization from the Plan for the periods provided above. 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 her newborn earlier than 48 hours following a normal vaginal delivery or 96 hours following a caesarean section.

When pregnancy causes the Covered Individual to incur expense while this coverage is in effect as to such individual, the Plan will consider the Reasonable and Customary expense actually incurred in the same manner as any other Sickness or accidental bodily Injury. As used herein, "Pregnancy" includes spontaneous abortion, miscarriage, normal childbirth, cesarean section, extra-uterine pregnancy or any complications arising from such occurrences and conditions.

Mental Health Care

Covered charges include:

- Outpatient treatment.
  - → Family therapy is covered if recommended by a Provider treating a minor child.

→ For Group Therapy.

→ The Plan will pay 80% (after the Deductible is satisfied).

- Inpatient treatment.

  → Charges for emotionally handicapped children are covered if treatment is performed in a residential treatment program for emotionally handicapped children.

  → Day treatment is covered provided it replaces or follows an admission.

The following charges are not covered:

- Services for mental illness not listed in the most recent edition of International Classification of Diseases;
- Services for mental illness which the Claims Administrator determines cannot be improved with treatment;
- Services for marital, family or other counseling, or for training services;
- Custodial care and supportive care; and
- Court ordered services that are not Medically Necessary.

Outpatient Hospital

Covered charges include charges for:

- Emergency care;
- Outpatient services;
- Scheduled surgery and anesthesia;
- Radiation and chemotherapy;
- Kidney dialysis;
- Lab and x-ray; and
- Preadmission tests.

Physical Examinations

Covered charges include charges for one routine physical examination (performed by a Physician) each Calendar Year, including charges for the examination, x-rays and laboratory tests.

Physician Services

Covered charges include charges for Physicians, including:

- Office visits for illness;
- Inpatient visits during a covered Hospital admission;
- Anesthesia by a Provider other than the operating, delivering or assisting Provider;
- Lab and x-ray;
- Allergy testing, serum, and injections;
- Surgery, including circumcision and sterilization;
- Assistant surgeon when Medically Necessary;
- Kidney and cornea transplants; and
- Cancer screening.

The following charges are not covered:

- Preventive care, local tests, public health tests, routine screening tests, physical exams and immunizations and vaccinations (except when otherwise covered under this Plan);
- Separate charges for pre and post-operative care for surgery;
- Cosmetic surgery to repair a physical defect; and
- Repairs of scars and blemishes on skin surfaces.

Reconstructive Surgery

Covered charges include charges for:

- Surgery to repair a defect caused by an accidental Injury;
- Reconstructive surgery related to or following surgery that was needed because of an Illness of that part of the body;
- Reconstructive surgery to repair a physical functional defect (other than a developmental defect) for a Dependent child under age 16;
- Cosmetic surgery to correct a child's birth defect (other than a developmental defect) for a Dependent child under age 16;
- Cleft lip and palate; and
- Surgery to reconstruct a breast following a mastectomy procedure on the affected breast and any surgical procedure on the non-affected breast which is intended to provide a symmetrical appearance; any costs for prostheses related to the mastectomy procedure (i.e., implants, special bras); and the treatment of any physical complications associated with the mastectomy procedure.

The following charges are not covered:

- Charges for cosmetic health services or reconstructive surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, other than that which is specifically described above.
- Separate charges for pre and post-operative care for surgery;
- Repairs of scars and blemishes on skin surfaces.

Rehabilitation Services

Covered charges include charges for:

- Physical, speech and occupational therapy;
- Chiropractic care (You are limited to 15 services for spinal manipulation, manual muscle stimulations or other conjunctive or manipulative therapy if you use a Non-Participating Provider).

The following charges are not covered:

- Services primarily educational in nature;
- Vocational rehabilitation services;
- Developmental delay services;
- Self-care and self-help training (non-medical);
- Health clubs and spas;
- Services for learning disabilities and disorders;
- Recreational therapy services;
- Rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time.

Skilled Nursing Facilities Benefit

Covered charges include charges for:

- Skilled care ordered by a Physician;
- Semiprivate Room and Board;
- General nursing care;
- Prescription drugs used during a covered admission.

Coverage is limited to 120 days per Calendar Year. The services must start within 14 consecutive days of a confinement of at least three consecutive days in a Hospital for the same or related Illness.

The following charges are not covered:

- Custodial or non-skilled care;
- Services of a non-medical nature.

Ventilator-Dependent Communication Services

Covered charges include charges for communication services of a personal care assistant during the first 120 hours of a Hospital admission.

Covered charges are limited to 120 hours per Hospital admission.

Charges for communication services provided on an outpatient basis or in the home are not covered.

Special Medical Programs Sponsored by the Plan

The Plan provides child health services benefits, prenatal care benefits, prescription drug benefits, vision benefits and organ and bone marrow transplant coverage benefits as indicated in the Summary of Benefits and below. These benefits are not provided under the Plan's major medical benefit. They are provided separately. As a result, they are not subject to the major medical deductible. Also, any coinsurance you pay for these benefits will not count towards satisfying the annual major medical out-of-pocket maximum or against the lifetime major medical benefit maximum.

Child Health Services

Covered charges include preventive services, immunizations, developmental assessments, and laboratory services for Dependent children under age 6.

The Plan will pay 100% of these charges.

Excluded from this benefit are:

- Routine preventive care charges for a child age six or older;
- Charges that exceed the Reasonable and Customary amount when you use a Non-Participating Provider.

Prenatal Care

Covered charges include professional services for prenatal care. The Plan will pay 100% of the Reasonable and Customary charges for these services if you use a Participating Provider. If you use a Non-Participating Provider, you will be responsible for all charges that exceed the Reasonable and Customary amount.

Prescription Drug Benefit

The Plan provides Prescription Drug Coverage through CVS/caremark. The Prescription Drug Benefit provides as follows:

	RETAIL PHARMACY	MAIL SERVICE PHARMACY
	For immediate drug needs or short-term medicine	For maintenance or long-term medicine
You Will Pay:	• 20% co-payment ($5 minimum) for each generic prescription • 30% copayment ($10 minimum) for each brand name prescription	• 20% co-payment ($5 minimum) for each genetic prescription • 30% copayment ($10 minimum) for each brand name prescription
Day / Supply Limitation:	34 day or 100 unit supply, whichever is greater	90 day or 100 unit supply, whichever is greater
Refill Limitation:	None	None

Covered charges include charges for prescriptions and insulin.

The following charges are not covered:

- The cost of administering drugs;
- Drugs the federal government has not approved for sale;
- Drugs that can be purchased without a prescription;
- Appetite suppressants, yocon (yohimbine), nystatin powder or rogaine;
- Non-prescription supplies such as alcohol, cotton balls, lancets, and blood letting devices.

Limitations:

- A prescription is limited to a 34 day supply or 100 units for retail pharmacy, whichever is greater, a 90-day or 100 unit supply for mail service, whichever is greater, or a 3-cycle supply of birth control pills.
- Please also see the Inpatient Hospital section of this booklet for additional provisions applicable to drugs dispensed and used during a Hospital admission.

This list of exclusions and limitations is not an all-inclusive list of exclusions and limitations applicable to the prescription drug benefit.

The Plan has a contract with CVS/caremark to provide prescription drugs at discounted prices. If you use a CVS/caremark provider, the provider will automatically file a claim with the Plan Administrator for you. When you visit a CVS/caremark pharmacy, you will need to show your Plan identification card. If you would like to find out if a particular pharmacy is a CVS/caremark pharmacy, call CVS/caremark at 1-866-212-4750 or visit CVS/caremark's website at www.caremark.com.

If you do not use a CVS/caremark provider, you must pay the full price of the prescription up front and request reimbursement by filing the claim with the Plan Administrator yourself. You will not benefit from any discounts negotiated by the Plan with CVS/caremark providers.

If you would like to take advantage of the Plan's mail order prescription benefit, contact the Plan Administrator for an application form.

Vision Care

Covered charges include up to $200 per two (2) consecutive Calendar Years for frames, lenses and contact lenses.

Organ And Bone Marrow Transplant Coverage

The Plan will pay for 100% of the Reasonable and Customary charges for services, supplies, drugs and related aftercare for the following human organ and bone marrow transplant and stem cell support procedures:

- Allogeneic and syngeneic bone marrow for:

  → Acute leukemia and chronic myelogenous leukemia;
  → Myelodysplasis;
  → Aplastic anemia
  → Wiskott-Aldrich syndrome;
  → Cartilage-hair hypoplasia;
  → Kostmann's syndrome;
  → Infantile osteopetrosis;
  → Neuroblastoma;
  → Primary granulocyte dysfunction syndrome;
  → Thalassemia major;
  → Chronic granulomatous disease;
  → Severe mucopolysaccharidosis;
  → Hodgkin's and non-Hodgkin's lymphoma;
  → Severe combined immunodeficiency disease;
  → Mucolipidosis; and

- → Myelodysplastic syndrome.

- Autologous bone marrow and autologous peripheral stem cell support for:

  - → Acute lymphocytic or non-lymphocytic leukemia;
  - → Advanced Hodgkin's lymphoma;
  - → Advanced non-Hodgkin's lymphoma;
  - → Advanced neuroblastoma; and
  - → Testicular, mediastinal, retroperitoneal, ovarian germ cell tumors, and breast cancer.

- Heart

- Heart-lung

- Liver

- Lung (single or double)

- Pancreas transplant for:

  - → A diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative session; or

  - → A medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

- Kidney and cornea transplants are eligible procedures that are covered on the same basis as any other eligible service and are not subject to the special requirements for organ and bone marrow transplants listed below. Please refer to the Physician Services and Inpatient Hospital sections of this booklet (pages 50 and 47).

Definitions applicable to this Section.

- "Participating transplant center" means a Hospital or other institution that has contracted with Blue Cross and Blue Shield of Minnesota to provide organ or bone marrow transplant or stem cell support and all related services and aftercare.

- "Transplant payment allowance" means the amount Blue Cross and Blue Shield of Minnesota pays for covered services to a participating transplant center for services, chemotherapy, supplies, drugs, and aftercare for or

related to an organ or bone marrow transplant or stem cell support in the agreement with that participating transplant center.

Notes:

- To determine eligibility information and benefit determination, call the Plan Administrator at 952-854-0795 or 1-800-535-6373.

- Prior authorization is required for all transplant and stem cell support procedures. All requests for prior authorization on Organ and Bone Marrow Transplants must be submitted in writing to:

  Blue Cross and Blue Shield of Minnesota
  Transplant Coordinator
  P.O. Box 64653
  St. Paul, MN 55164

- If you have specific questions regarding Organ and Bone Marrow Transplant Coverage, please call the Transplant Coordinator of Blue Cross and Blue Shield of Minnesota, Monday through Friday, from 8:00 a.m. to 4:30 p.m. (CST) at 651-456-1624 or 1-800-382-2000, extension 1624.

- All transplants and stem cell support procedures must be performed by a participating transplant center unless the recipient is a non-Minnesota resident and the services are received from a provider located closer to the residence of the recipient than the closest participating transplant centers, and are subject to all other terms of coverage, including deductibles, copays, coinsurance, and lifetime maximums. Benefits for covered services of any provider will not exceed the transplant payment allowance payable to a participating transplant center for the same procedure.

Limitations:

- Coverage is limited to two transplant procedures for the same condition per person per lifetime.

- Coverage for the above transplant procedures is limited to a period of 371 consecutive days beginning five days before the day of the initial infusion of bone marrow or stem cells or commencement of the transplant surgical procedure. No other benefit period may commence during this period.

The following are not covered under this benefit:

- Organ and bone marrow transplant and stem cell support procedures not specifically listed above as covered.

- Services, chemotherapy, supplies, drugs, and aftercare for or related to human organ transplants not specifically listed above as covered.

- Services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs, and aftercare for or related to bone marrow transplant, stem cell support or peripheral stem cell support procedures for a condition not specifically listed above as covered. Conditions specifically excluded from coverage in connection with the preceding sentence include but are not limited to: multiple myeloma, malignant melanoma and other skin cancer, lung cancer, prostate cancer, brain tumors, uterine and cervical cancer, epithelial cell tumors of the ovary, colon cancer and other gastrointestinal tract cancers including the pancreas.

- Living donor transplants of the liver, lung or any other organ, such as selective islet cell transplants of the pancreas.

- Retransplant of organ or bone marrow during the 365 days period following the transplant procedure.

Doctors on Demand

Doctor On Demand (DOD) is an online service available that allows a covered person to visit a doctor using a computer, smartphone or tablet, with a front facing camera. Medical care is available on-demand from 7 am-11pm in all time zones, 365 days a year or by appointment 24-hours a day, 7 days a week. DOD provides access to online care (including prescriptions, when appropriate) by appointment or on-demand from board certified physicians in 47 states (not available in Alaska, Arkansas, Louisiana).The Plan provides coverage for this benefit at 100%. There is no coinsurance or copayment required.

The DOD app works with any smartphone, tablet or computer with a front-facing camera. You can download the app from the App Store or Google Play, or access DOD via the website: DoctorOnDemand.com/bluecrossmn.

Once a participant has connected, they will speak with a doctor and can discuss an array of medical conditions such as sinus or ear infections, pink eye, cold or flu symptoms, allergies, depression or anxiety, rashes, urinary tract infections and other medical conditions.

DENTAL BENEFITS

Eligibility for Benefits

The Plan offers dental benefits as described below to certain groups of participating Employees. Eligibility for these benefits depends upon whether you are employed in a class of Employees for whom coverage is provided. That coverage is provided because the contribution rates for those Employees are greater than the rates for classes of Employees who are not provided this coverage.

You and your Dependents will be eligible for all Dental Benefits described below (Coverages A, B1, B2, C1, and C2) if you are:

- Eligible under the Plan as an actively employed Plasterer;
- Eligible under the Plan as Plasterer through application of the Hours Bank and/or Self-Pay provisions of the Plan;
- Eligible under the Plan as a former Plasterer currently eligible under COBRA, or;
- Eligible under the Plan as a Non-Bargaining Unit Member.

If you are not a member of one of these classes of Employees (for example, if you are a Cabinet Maker/Industrial Carpenter or a retired Plasterer) you and your Dependents are eligible for Coverage A, only.

Preferred Provider Organization

The Plan's benefits are offered through a Dental Preferred Provider Organization (PPO) established by Delta Dental of Minnesota. This PPO is a network of Dentists and dental clinics with whom the Plan has contracted to provide discounted dental services.

Summary of Dental Benefits

The Plan pays for the following percentages of applicable Allowable Charges for covered dental treatment, based on whether the treating Dentist is a Delta Premier Dentist, Delta Choice Dentist, or not a member of Delta Dental's Preferred Provider Organization:

	Delta Premier Dentist	Delta Choice Dentist	Non-Participating Dentist
COVERAGE A - Diagnostic and Preventive Services	100%	100%	90%

A non-participating Dentist has the right to bill you directly for the percentage of Allowable Charges not covered by the Plan and for any amount that is not considered to be an Allowable Charge.

	Delta Premier Dentist	Delta Choice Dentist
COVERAGE B1a - Basic Services	80%	90%
COVERAGE B1b - Endodontics	80%	90%
COVERAGE B1c - Periodontics	80%	90%
COVERAGE B1d - Oral Surgery	80%	90%
COVERAGE B2 - Major Restorative Services	50%	55%
COVERAGE C1 - Prosthetic Repairs and Adjustments	50%	55%
COVERAGE C2 - Prosthetics	50%	55%

For services B1a through C2 provided by a non-participating Dentist, see the Section below entitled Claims Payment to determine the amount of benefit coverage.

Benefit Maximums

The Plan pays up to a maximum of $2,000 for each Covered Individual each Calendar Year for Coverages A, B1, B2, C1 and C2. The $2,000 maximum does not apply to Dependents under age 19.

Deductible

There is a $50.00 deductible per Covered Individual each Calendar Year not to exceed three (3) times the deductible (i.e., $150.00) per family for Coverages B1, B2, C1 and C2.

The deductible does not apply to Coverage A.

Description of the Covered Procedures

The Plan covers the following dental procedures when they are performed by a licensed Dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under the Plan will be provided whether the dental procedures are performed by a duly licensed Physician or duly licensed Dentist, if otherwise covered under this portion of the Plan, provided the dental procedures can be lawfully performed within the scope of a duly licensed Dentist.

As a condition to approving claim payments, the Plan is entitled to request and receive, to the extent lawful, from any attending or examining Dentist, or from Hospitals in which a Dentist's care is provided, information and records relating to a Covered Individual as may be required to pay claims. Also, the Plan may require the Covered Individual to be examined by a dental consultant retained by the Plan in or near the Covered Individual's place of residence. The Plan will hold such information and records confidential.

Only those services listed below are covered and only so long as they are not otherwise excluded under the "Exclusions and Limitations for Dental Benefits" or the "Plan Conditions, Limitations, and Exclusions" section of this booklet.

COVERAGE A - Diagnostic and Preventive Services

Oral examinations (including emergency exams and specialist exams) at six (6) month intervals, including bitewing x-rays at twelve (12) month intervals.

Full mouth x-rays or panorex once in any three (3) year interval.

Dental or periodontal prophylaxis (cleaning of teeth) as prescribed by the Dentist, but not more than once every six (6) months.

Topical fluoride applications as prescribed by the Dentist, but not more than once in any twelve (12) month interval and then only for Covered Individuals under the age of nineteen (19) years.

Oral hygiene instruction as prescribed by the Dentist, but not more than once per lifetime for each Covered Individual.

Space maintainers for extracted posterior primary teeth on covered Dependent children.

COVERAGE B1a - Basic Services

Emergency treatment for relief of pain (minor procedures).

Restoration of lost tooth structure as a result of tooth decay or fracture, when restored with amalgams (silver fillings), preformed crowns for Dependent children or resin (white fillings) restorations on anterior teeth.

Sealants: Coverage is limited to once per lifetime for permanent first and second molars of covered Dependent children under the age of sixteen (16) years.

COVERAGE B1b - Endodontics

Includes pulpotomies on primary teeth for covered Dependent children and root canal therapy on permanent teeth. No coverage is provided for retreatment.

COVERAGE B1c - Periodontics

Nonsurgical periodontics: procedures necessary for the treatment of diseases of the gingiva (gums).*

LIMITATION: Benefit for the repeat of any nonsurgical periodontal treatment will be provided only after a two (2) year period has elapsed.

Surgical periodontics: the surgical procedures necessary for the treatment of diseases of the gingiva (gums) and bone supporting the teeth.*

LIMITATION: Benefit for the repeat of any surgical periodontal treatment will be provided only after a three (3) year period has elapsed. Procedures designed to enable prosthetic or restorative service to be performed, such as crown lengthening, are not covered benefits.

COVERAGE B1d - Oral Surgery

Routine oral surgery, provides for tooth removal (including alveolectomy, where indicated), including pre- and post-operative care.

All other oral surgery, such as alveoplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and treatment of compound and simple fractures.

Surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder subject to the provision of the Coordination of Benefits section of this Plan.*

COVERAGE B2 - Major Restorative Services

Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture.

Crowns, inlays or onlays when the amount of lost tooth structure does not enable the placement of a filling material. If inlays are placed, benefits will be limited to the same number of surfaces and allowances for amalgam (silver filling).*

LIMITATION: Benefit for the replacement of a crown, inlay or onlay will be provided only after a five (5) year period measured from the date on which the procedure was last benefited.

Resin (white filling) restorations for posterior teeth.

LIMITATIONS: (A) Posterior teeth will have a resin restoration maximum of three (3) surfaces;

(B) Coverage for replacement of a resin restoration or further restoration by any other procedure will be provided only after a two (2) year period has elapsed.

COVERAGE C1 - Prosthetic Repairs and Adjustments

Prosthetics: provides for repairs and adjustments to prosthetic appliances when they are servicing as the permanent prosthetic appliance.

COVERAGE C2 - Prosthetics: Removable and Fixed

Prosthetics: provides bridges, standard partial dentures and full dentures for the replacement of fully extracted permanent teeth. Benefits are limited to the commonly performed method of tooth replacement.*

EXCLUSION: Coverage is NOT provided for the replacement of teeth congenitally missing.

*IMPORTANT: Refer to the Pre-statement of Costs.

Replacement benefits for a given prosthetic appliance for the purpose of replacing an existing appliance will be provided only after five (5) years have elapsed from when last benefited and then only in the event that the existing appliance is not, and cannot be, made satisfactory. EXCLUSION: Coverage is NOT provided for the replacement of misplaced, lost or stolen dental prosthetic appliances.

Replacement benefits for Fixed Prosthetics: None of the individual units of the bridge may have been benefits previously as a crown or cast restoration during the prior five (5) year period. The fabrication of the bridge due to the loss of an existing permanent tooth does not set aside the five-year exclusion on cast restorations.

Service which is necessary to make an appliance satisfactory will be provided.

Exclusions and Limitations for Dental Benefits

No payment will be made under this Plan for any loss, expenses, or charge for:

1. Services of anesthesiologists.

2. New or experimental dental techniques or procedures, which may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

3. Dental procedures performed other than by a licensed Dentist and his or her employees or agents.

4. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting and gnathologic recordings.

5. Direct diagnostic, surgical or nonsurgical treatment procedures applied to body joints or muscles, except as provided under oral surgery.

6. Any artificial material implanted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.

7. Veneers (bonding of coverings to teeth).

8. Orthodontic treatment procedures.

9. Consultations and office visits.

10. Temporary procedures.

11. Correction of congenital conditions.

12. Athletic mouthguards.

13. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment.

14. Removable unilateral dentures.

15. Charges exceeding the least costly commonly performed course of treatment, in any case where there are alternative treatment plans carrying different costs.

LIMITATIONS:

1. Alternative Treatment Plans - in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Individual and the Dentist; however, the benefits payable under the Plan will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Individual.

2. Reconstructive Surgery - Benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from Injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician, to the extent required by Minnesota Statutes, section 62A.25; provided, however, that such procedures are dental reconstructive surgical procedures.

3. Benefits for impatient or outpatient expenses arising from dental treatment up to age eighteen (18), including oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Orthodontic treatment is not covered under this Dental Benefit.

Pre-statement of Costs (Estimate of Benefits)

IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS OR PROSTHETICS (SEE THE DESCRIPTION OF COVERAGES), A PRESTATEMENT OF COSTS MUST BE SUBMITTED TO THE PLAN ADMINISTRATOR BEFORE TREATMENT.

After the examination, your Dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics or prosthetics, a participating Dentist will submit a claim form to the Plan Administrator outlining the proposed treatment. The Plan Administrator will determine if the treatment proposed is covered by the Dental Benefit section of the Plan and estimate the amount of the payment.

A statement will be sent to your Dentist estimating the amount of the payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the Plan. If claims for other completed dental services are received and processed before the completion date of the proposed treatment, this may reduce the Plan's estimated payment for the proposed treatment and increase your obligation to the Dentist.

If your Dentist does not submit a Pre-statement of Costs before performing the treatment, you will be responsible for payment of any dental treatment not approved by the Plan.

Dental Benefit Payments

Covered Fees

Under the Plan's dental benefit program, you are free to go to the Dentist of your choice. You may have additional out-of-pocket costs if your Dentist is not a Delta Choice Dentist, due to the enhancements in the benefits. There may also be a difference in the payment amount if your Dentist is not a participating Dentist of Delta

Dental. This payment difference could result in some financial liability to you beyond the usual features of the Plan. The amount depends upon the non-participating Dentist's usual fees in relation to the Table of Allowances determined by Delta.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER PARTICIPATION STATUS WITH DELTA CHOICE BEFORE YOU RECEIVE DENTAL CARE.

Claim Payments

Delta Choice Dentists:

Claim payments are based on the Delta Choice maximum allowable fee or the actual charge, whichever is less. The payment percentages may be increased as shown in the Summary of Dental Benefits at the beginning of this section. Claim payments are sent directly to the Delta Choice Dentist. If a claim is submitted for dental services provided by a Delta Choice Dentist, the "Allowable Charges" are the lesser of:

1. The Delta Choice maximum allowable fees as determined by Delta Dental;

2. The actual charge; or

3. The amount actually accepted as payment in full by the Dentist, regardless of the amount charged.

Participating Dentists:

Claim payments are based on the Dentist's usual pre-filed fees, the actual charge, the amount accepted by the Dentist as payment in full or Delta's maximum customary fee, whichever is less. Claim payments are sent directly to the participating Dentist.

Non-participating Dentists:

Claim payments are based on the treating Dentist's usual fees or the Table of Allowances established solely by Delta Dental, whichever is less.

Claim payments are sent directly to the Covered Individual.

THE COVERED INDIVIDUAL IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NON-PARTICIPATING DENTIST.

Claim payments for participating and non-participating Dentists are based on the "Allowable Charges" which are the lesser of:

1. The usual, customary and reasonable fees of participating Dentists;

2. The Table of Allowances as determined by Delta as to non-participating Dentists;

or, as to Delta Choice, participating and non-participating Dentists,

1. The fees actually charged to the Covered Individual;

2. The fees regularly offered to patients; or

3. The amount actually accepted as payment in full by the Dentist regardless of the amount charged.

Benefit payments are made only when the covered dental procedures have been completed.

FAMILY ASSISTANCE PROGRAM THROUGH BLUE CROSS BLUE SHIELD OF MINNESOTA (BCBS-MN)

From time to time, we all deal with personal problems, both large and small. Sometimes we need help to resolve our problems. Your Family Assistance Program, provided through BCBS-MN, is a confidential assessment, counseling, and referral service for you and your family to help resolve personal problems which may be affecting your life at work and at home. This program is also available to Retirees.

Skilled counselors are available 24 hours a day, every day of the year, to talk with you in confidence about your problems. Your BCBS-MN counselor can help you with:

- Family and marriage problems
- Alcohol or controlled substance dependency
- Financial concerns
- Emotional problems
- Legal referrals
- Medical concerns
- Work-related problems

For example, your counselor can help you find a nursing home for your father, recommend a new Physician, counsel a chemically dependent person in your family, locate a marriage counselor for long-term counseling, or find a financial counselor to help you plan your budget. Talking to a professional about your problems can often help you gain a fresh prospective.

How to Use Your Family Assistance Program

If you need help with a problem, just dial the confidential hotline at **1-800-432-5155 or you may go to www.bluecrossmn.com/eap**. Some problems can be resolved with a counselor in just a few minutes over the phone.

At the first meeting which lasts about one hour, your counselor will discuss your problems with you and determine the type of assistance you need. More meetings with your same counselor can be made, or, if you and the counselor decide that long-term counseling or treatment is needed, your counselor will refer you to an appropriate agency. Your counselor will follow up to make sure that you were satisfied with the service received and that your problem is being resolved.

The assessment, short-term counseling, and referral services are fully paid for by the Plan. If you are referred for long-term counseling or treatment, you are responsible for the cost of these services. The Plan may cover some of the long-term counseling and treatment costs associated with the care of chemical dependency, alcoholism and mental and nervous disorders. Please refer to page 48 of this booklet for a description of the Plan's Mental Health Benefits.

PLAN CONDITIONS, LIMITATIONS AND EXCLUSIONS

SUMMARY

This Plan is designed to pay for only certain types of benefits. This section contains a list of various conditions and exclusions which apply. The list is provided only as an example: there may be other exclusions, conditions and limitations that apply. The Plan Administrator's office can provide you with more information about the payment of claims.

No payment will be made under this Benefit Plan for any loss, expense or charge:

1. Incurred as the result of any accidental bodily Injury, Sickness, disease, Mental or Nervous Disorder sustained while the individual was performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

2. Any charges or losses which are: (a) covered under any workers' compensation law or similar law; or (b) for which coverage was required to have been provided under this law even if it was not actually provided; or (c) for which coverage could have been elected under this law even if it was not actually elected by the person who could have done so (even if that person was not the Covered Individual); or (d) otherwise arose out of or in the course of any occupation, employment or activity for wage or profit.

3. Incurred for services rendered while the individual is confined in a Hospital operated by the United States Government or an agency of the United States Government, provided, however, that if such charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law, and subject to all the requirements of this Plan, such charges will be considered Covered Medical Expenses.

4. Incurred for which the Eligible Employee, Eligible Retiree or the Eligible Dependent is not legally required to pay.

5. Incurred for education, training, or Room and Board while the individual is confined in an institution which is primarily a school or other institution for learning or training.

6. Incurred while an individual is confined for purposes of Custodial Care in an institution which is primarily a place of rest, a place for the aged or a nursing home.

7. Incurred for any type of Custodial Care (care that is designed primarily to assist an individual in meeting the activities of daily living, i.e., milieu therapy), regardless of what the care is called.

8. Incurred for any services or treatments not prescribed by a Physician. This exclusion applies to items such as vitamins, cough medicine, aspirin, cosmetics, soap, toothpaste, etc.

9. Incurred for any treatment or surgical procedure or service that is of an elective nature or for any non-emergency plastic or cosmetic surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue.

   Exception: This exclusion will not apply to charges covered under the Reconstructive Surgery benefit (see page 51).

10. Incurred for a gastric bypass procedure or for any services, treatments, or surgical procedures rendered in connection with an overweight condition or a condition of obesity or morbid obesity, including diet plans and visits to a Physician related to such a condition.

11. Incurred for any services or supplies which are not recommended or approved by the attending Physician.

12. Incurred for services or supplies received from a physician who does not meet this Plan's definition of a Physician or from a hospital which does not meet this Plan's definition of a Hospital as specified in the Plan's "Definitions".

13. Incurred for services, supplies, treatments or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational accidental bodily Injury or Sickness unless such charges are specifically identified as being Covered Expenses or Covered Medical Expenses under the Plan.

14. Incurred as a result of treatment or consultation with a marriage counselor, or as a result of treatment or consultation with a social worker, **except** as provided for in the Plan's Mental Health Benefits provisions, contained on page 48, or as may be specifically authorized by the Plan's Family Assistance Program, through Blue Cross Blue Shield of Minnesota.

15. Incurred for care or treatment provided by a person who is a relative in any way to the Eligible Employee, to the Eligible Retiree, or to the Dependent who is receiving the care, or who ordinarily lives in the Employee's or Retiree's home or in the home of the Dependent who is receiving the care.

16. Incurred for physical therapy or any other type of therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement.

17. Incurred for any procedure, prescription, supply or device considered to be not in the best interest of the Covered Individual and as approved by the Board of Trustees.

18. Incurred for speech therapy, **except** when it is Medically Necessary because of physical impairment caused by disease or Injury.

19. Incurred for any special education rendered to any individual, regardless of the type of education, the purpose of the education, **except** for a single nutritional consultation session recommended by the attending Physician.

20. Incurred for radial keratotomy, eye refractions, eyeglasses, or contact lenses **except** for the first pair of contact lenses required following cataract surgery, or dental prosthetic appliances, including any charges made for the fitting of any of these appliances, **except** when the service or supply was rendered as a result of non-occupational accidental bodily Injury; provided, the service or supply is made promptly following the Injury and within six (6) months from the date of the Injury, or when charges incurred for the service or supply are otherwise specified as payable under the provisions of this Plan.

21. Incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

22. Incurred for nursery care beyond the joint confinement of the mother and child or after the end of the period that either the mother or newborn child is no longer medically required to remain in the Hospital. In determining a mother's maximum period of medically required confinement, the period of a normal maternity confinement will be used. In the event of termination of nursery charges for a newborn child, benefits will be payable for the newborn child only if all other eligibility rules of the Plan have been met for such child.

23. Incurred for birth control medications **except** when specifically covered as a "Covered Medical Expense" under this Plan or when they are prescribed by a Physician for therapeutic treatment of a specific Sickness.

24. Incurred for contraceptive devices or any other method of contraception **except** when specifically covered as a "Covered Medical Expense."

25. Incurred by Dependent children for vasectomies or other sterilization procedures unless recommended by a Physician for therapeutic purposes of the patient.

26. Incurred for any operation or treatment in connection with sex transformations.

27. Incurred to treat any bodily Injury, disease, or Sickness incurred in, or aggravated during, performance of service with the uniformed services; **except** as may otherwise be provided for under this Plan.

28. Incurred for dental services and supplies rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, **except** when covered as a "Covered Medical Expense."

29. Incurred for travel, whether or not recommended by a Physician, **except** as specified in the "Covered Medical Expenses" provisions of this Plan.

30. Incurred for services, supplies or procedures that are Experimental or Investigative in nature. Although some uses of a treatment may be non-Experimental or non-Investigative or are approved by the Food and Drug Administration, a particular use which is Experimental or Investigative or which is not approved by the Food and Drug Administration is excluded. Furthermore, treatments that relate to Experimental or Investigative treatments or to treatments unapproved by the Food and Drug Administration, which would not be performed but for the excluded treatment are excluded. Any medical or surgical complications resulting from excluded treatments are also excluded.

31. Incurred which exceed the maximum benefit payable by this Plan are normally provided under this Plan once the individual has already received Plan benefits aggregating the Maximum Benefit for that type of care and treatment as specified on the Summary of Benefits.

32. Incurred for any treatment, care, procedures, services or supplies which are not Medically Necessary, **except** where this Plan specifically provides otherwise (i.e. routine physical examinations, routine immunizations)

33. Any amount of an incurred charge that is determined to be in excess of a Reasonable and Customary Charge.

34. Incurred for the rental or purchase of any Durable Medical Equipment or other equipment that is not used solely for therapeutic treatment of a single individual's Injury or sickness and subject to the limitations on coverage as explained on page 43.

35. Incurred for any of the following list of items, regardless of intended use, including but not limited to: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, de-humidifiers, allergy-free pillows, blankets or mattress covers, electric heating units, orthopedic mattresses, exercising equipment, gravity lumbar reduction chairs, vibratory equipment, pre-fabricated orthotic devices, elevators or stair lifts, stethoscopes, clinical thermometers, or scales with the exception of elastic bandages or stockings, and devices or surgical implantations simulating natural body contours, as specified in this Plan.

36. Incurred for any in-Hospital items such as telephones, televisions, cosmetics, magazines, newspapers, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not Medically Necessary.

37. Incurred for any confinement in a nursing facility other than as provided under this Plan.

38. Incurred for patent medicines or drugs, or medicines not legally dispensed by a registered pharmacist according to the written prescription of a Physician.

39. Incurred for any type of service or supply provided in connection with tobacco use cessation.

40. Incurred for hypnosis.

41. Incurred for services or supplies which are furnished, paid for or otherwise provided due to past or present service of any individual in the armed forces **except** as otherwise provided for under this Plan.

42. Incurred for confinement and services at a halfway house or group home.

43. Charges that would not have been made if this Plan did not exist.

44. Incurred in connection with any Injury or Sickness for which the individual is not under the regular care of a Physician.

45. Hospital charges incurred in connection with an in-patient Hospital confinement for the purpose of dental treatment for which there exists no

written certification by an M.D. that the in-patient confinement is Medically Necessary for such treatment.

46. Drugs or medicines prescribed by a Physician which are available as over-the-counter purchases, e.g., aspirin, cough medicine, or vitamin supplements.

47. Charges for Sickness or Injury resulting from engaging in illegal acts. "Illegal acts" will mean any gross misdemeanor or felony for which a Covered Individual may or has been convicted under any state or federal law.

48. Charges or benefits that are provided for or paid for by a program of the Federal, State or City Government, including Medicare, CHAMPUS, TRICARE, Medicaid and statutory disability benefits.

49. Charges for any Injury or condition that results from an incident occurring on any property where Lessee or Lessor or Owner of said property is responsible for Injury or Illness or which is otherwise covered under Homeowner's insurance. However, the Plan will consider the charges only if no insurance or other form of compensation is available to the victim providing the Eligible Employee and/or Eligible Dependent (the individual responsible for payment of expenses) signs an acknowledgment of the Plan's first priority right to subrogation and reimbursement.

50. Any loss, expense or charge arising from the maintenance or use of an automobile where (a) the Covered Individual fails to maintain the statutory minimum level of no-fault automobile insurance protection in the jurisdiction in which they reside (this exclusion will apply only up to the amount of no-fault automobile insurance required); (b) the Covered Individual fails to apply for any available no-fault automobile insurance; (c) the no-fault insurer has determined that charges are not Medically Necessary, Reasonable or Customary; or (d) in states without a no-fault automobile insurance statute, the Covered Individual does not first exhaust any medical payment coverage on the vehicle(s) involved.

51. Charges incurred in connection with acupuncture unless performed by a Doctor of Medicine (M.D.).

52. Charges for injections prescribed or administered by a Chiropractor.

53. Charges incurred for the treatment of compulsive gambling or other lifestyle changes **except** as treatment may be offered through Mental Health Benefit.

54. Charges for or related to membership in a health or fitness club/facility, work-hardening program, therapeutic exercise programs, and all related materials and products related to these programs.

55. Charges for or related to genetic engineering and testing.

56. Charges for special home construction to accommodate a disabled individual.

57. Charges for telephone conversations/telephone consultations, unless otherwise covered under a Plan provision.

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

59. Any loss, expense or charge arising out of or relating to an Injury, occurrence, condition, or circumstance for which either (a) recovery subject to the Plan's right of subrogation or reimbursement rights has been received (whether before or after the submission of claims to or payment of claims by the Plan), (b) the Plan deems it likely that recovery will be received, or (c) a claim for a loss, expense or charge has not been submitted before resolution of the third party claim.

    At the discretion of the Trustees, losses, expenses or charges excluded by this section may be paid subject to the Plan's rights of subrogation and reimbursement. The amount of the loss, expense or charge excluded by this section will be the total of amounts that the Plan would otherwise pay (not the amount charged by the provider or claimed by the Covered Individual) up to the full amount of the recovery. This exclusion applies notwithstanding any allocation or apportionment that purports to characterize any recovery or part of a recovery as in any way not subject to the rights of subrogation or reimbursement, including but not limited to, any apportionment to a spouse for loss of consortium.

60. Any loss, expense or charge incurred by an individual at the time the individual owes payment to the Plan because of benefit overpayments or

benefit payments made in reliance upon incorrect, misleading or fraudulent statements or representations by the person, or where the person or other Eligible Family Member has failed to honor the Plan's rights of subrogation or reimbursement, or otherwise failed to cooperate with the Plan. The Plan has the right to deny future related and unrelated benefit payments for charges excluded under this paragraph.

61. Private-duty nursing.

62. Artificial organs, and devices or systems, whose purpose is to assist or replace a natural body organ, and any charges for the implantation, attachment or use of such organ device, or system, including follow-up care. This exclusion does not apply to kidney dialysis or pacemakers.

63. Bariatric surgery and related expenses, including complications.

64. Chemotherapy and the related course of treatment, drugs, supplies and aftercare when the initial treatment plan includes or anticipates autologous bone marrow rescue, stem cell rescue or bioengineered drug therapy, unless the condition is eligible for coverage under the Organ and Bone Marrow Transplant procedures section of this booklet.

65. Services for, or related to, any treatment, equipment, drug, and/or device that the Plan Administrator determines does not meet the generally accepted standards of practice in the medical community for cancer and/or allergy testing and/or treatment. The Plan does not cover chelation therapy services that the Claims Administrator determines are not Medically Necessary, or services for or related to systemic candidiasis, homeopathy, or immunoaugmentative therapy.

66. Services that are prohibited by law or regulation.

67. Autopsies.

68. Any diagnostic admission for diagnostic tests that can be performed on an outpatient basis.

69. Services for, or related to, gene therapy as a treatment for inherited or acquired disorders. Services for, or related to, DNA analysis for non-Medically Necessary conditions. The Plan will, however, pay for DNA analysis if there is a documented presence of specific clinical symptoms related to a clearly established disease, and the results of the testing will help to establish a definitive diagnosis that will assist in developing a specific clinical treatment plan.

70. Service for, or related to, growth hormone, except for persons with documented hormone deficiency due to pituitary origin only.

71. Services for, or related to, fetal tissue transplantation.

72. Services which have been paid by another insurance plan.

73. Services for, or related to, functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.

The above listing is not an all-inclusive listing of services not covered by the Plan. It is only representative of the types of services and supplies for which no payment is made by the Plan.

PAYMENT OF BENEFITS

SUMMARY

The next few sections of the document describe many general rules that apply to all types of benefits you may receive under the Plan. Some of the more important rules are listed below.

- The Trustees of the Plan, or anyone they may delegate, have the sole authority to interpret this document, and any other documents concerning the Plan.

- Similarly, the Trustees may amend or modify the Plan at any time. No benefits or conditions of the Plan are promised or guaranteed to continue.

- Your claims for benefits must be filed within certain time limits described in these sections.

- If someone else is legally responsible to pay for an Injury they have caused you the Plan may recover the amount of benefits it has paid as a result of that Injury. This is called "subrogation".

Quite often a person may be covered under more than one health care plan. For instance, a husband may be covered under this Plan as an employee, and covered under his wife's plan as a dependent. The Trustees of this Plan have adopted rules that determine which plan(s) must pay for benefits, and in what order. Those "coordination of benefits rules" are described in this section.

This section of the document also describes the claims appeal procedures that you and the Trustees must follow if your claim for benefits is partially or totally denied. You may appeal a denial to the Board of Trustees. If the Trustees deny your claim, you may appeal that decision to an arbitrator.

Rules Governing Payment of Benefits

The following rules affect the payment of benefits from this Plan:

1. Benefits payable for any loss will be paid upon timely receipt by the Trustees, or their duly appointed representatives, of written proof of loss covering the occurrence, character and extent of the event for which claim is made.

2. Benefits are payable to the Eligible Employee or Eligible Retiree whose Injury or Sickness, or whose Eligible Dependent's Injury or Sickness, is the basis of claim under this Plan, unless benefits are assigned according to the provisions described below, provided, however, that payments for services furnished to a Dependent child whose parents are divorced and such child is not a member of the Employee's or Retiree's household may

be paid directly to the service provider(s), at the discretion of the Plan Administrator, whether or not benefits are assigned.

3. The provisions governing assignments will be:

   a. No assignment of any present or future right, interest, or benefit under this Plan will bind the Trustees without their written consent thereto.

   b. Assignment of Hospital expenses and expenses for medical care and treatment will be automatic when care is provided through a PPO, and no assignment will be required to be signed by the Employee or Retiree.

   c. The Trustees may, at their option, accept validly executed assignments of benefits made by the Eligible Employee or the Eligible Retiree when the assignments are executed in favor of any other provider of medical services providing medical services covered by this Plan. In that case, benefits will be paid to the assignee instead of the Eligible Employee or Retiree.

   d. Assignments made by an Eligible Employee's spouse or an Eligible Retiree's spouse will be considered valid assignments.

   e. No assignment of benefits will assign more than the assignor's right to payment of benefits and will not be deemed to assign any other right or interest that the assignor has under the Plan, including, but not limited to, the right to appeal or seek review of a benefit denial.

   f. Except as otherwise prescribed by law, no payments will be subject to the debts, contracts or engagements of any Covered Individual, or to any judicial process to levy upon or attach benefits for payment of a Covered Individual's debts.

   g. Any unpaid medical benefits due and owing at the time of the Employee's death may be paid, at the Plan's option, to a Beneficiary or the Employee's estate.

4. Subject to proof of loss, benefits payable for any loss for which this Plan provides periodic payments will be paid not less often than semi-monthly during the continuance of the period for which there is coverage and any balance remaining unpaid upon termination of coverage under the Plan will be paid immediately upon receipt of proof of loss.

5. If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been

appointed for such individual, the Trustees may, at their option, assign benefits to the provider(s), which assignment will constitute a complete discharge of the Plan's obligations to provide benefits.

6. A charge for any service, supply, or treatment will be considered to have been incurred on the date on which the service or treatment was rendered or on which the supply was provided.

7. Benefits will be payable by the Plan up to but not to exceed any Maximum Benefit or other benefit limitation specified on the Summary of Benefits beginning on page 5. For each Covered Individual, whether or not there has been an interruption in the continuity of eligibility, the maximum amount of benefits available during any specified period of time will be equal to the amount by which the Maximum Benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on the Eligible Employee's account during that period of time.

8. Benefits will be payable only for expenses incurred by persons who are Covered Under the Plan at the time the expenses are incurred.

9. Benefits will be payable for expenses incurred by a Covered Individual only if the expenses are incurred within any applicable time limitations specified on the Summary of Benefits or in any other applicable provision of this Plan Document.

10. Benefits will be payable only for expenses which are specified as Covered Expenses or Covered Medical Expenses or which are specified as payable in any other applicable provision of this Plan of Benefits, subject to any applicable limitations or exclusions governing such expenses.

11. Medical benefits will be payable only for expenses incurred as the result of care and treatment provided to a Covered Individual solely as the result of a non-occupational Injury or Sickness unless a particular type of expense which would normally be excluded by this provision is specifically included as a Covered Expense or is specified as payable in any other applicable provision of this Plan of Benefits.

12. Medical benefits will be payable only for expenses which are Medically Necessary and which are required in connection with the care and treatment of a Covered Individual as a result of non-occupational Injury or Sickness.

13. Medical benefits will be payable only for expenses which are incurred upon the recommendation of, or with the approval of, a Physician who is acting within the scope of the Physician's license.

14. Benefits will be payable only for expenses which are actually incurred.

15. The self-funded (self-insured) benefits payable under this Plan are limited to the Plan assets available for such purposes regardless of accumulated eligibility.

16. Expenses incurred by a female Employee, by a female Retiree, by a Dependent spouse of a male Employee, by a Dependent spouse of a male Retiree or by a Dependent Child of an Employee as the result of a pregnancy or a pregnancy-related condition will be treated the same as expenses incurred for a Sickness or non-occupational Injury. Payment for such expenses will be made in accordance with the provisions and conditions of each benefit.

17. Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment. Other provisions governing the payment of benefits and/or the limiting or exclusion of benefits are specifically set forth in the various provisions of this Plan of Benefits.

18. Benefits for medical expense will be paid as follows:

    a. For benefits charges incurred with participating providers, the Plan will pay a discounted amount. These providers have agreed to accept payment from the Plan as payment in full, except for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan;

    b. For benefits charges incurred with non-participating providers within the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network, the Plan will pay the Reasonable and Customary Charge, or if applicable, a separately negotiated amount to the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit limitations or other similar limitations under the Plan and may be balance billed by the non-participating provider;

    c. Benefits charges incurred with non-participating providers outside the geographic area of the Blue Cross Blue Shield Minnesota AWARE Network will come through Blue Cross' Blue Card program. The Plan will pay the Reasonable and Customary Charge as provided by the Blue Card Host Plan in the Blue Card system or, if applicable, an amount separately negotiated with the non-participating provider. You will be responsible for applicable co-payments, deductibles, coinsurance, maximum benefit

limitations or other similar limitations under the Plan and may be balance billed by the non-participating provider.

There are conditions, limitations and exclusions which apply to certain types of charges. Refer to the "Exclusions and Limitations" section of this document for more information. You will also want to check the "Definitions" section which defines important terms of the Plan.

Payments to those Eligible for Medical Assistance

Payment of benefits under the Plan with respect to any Plan participant will be made in accordance with any assignment of rights made by or on behalf of such participant or a Beneficiary of the participant as required by any applicable state plan for medical assistance which is approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling an individual as a participant or Beneficiary or in determining or making any payment of benefits for or on behalf of an individual as a participant or Beneficiary in the Plan, the Plan will not take in to account the fact that such individual is eligible for or is provided medical assistance under an applicable state plan for medical assistance which has been approved under Title XIX of the Social Security Act. In any case in which the Plan has a legal liability to make payments of benefits for or on behalf of a participant or Beneficiary for items or services as to which payment has legally been made under any applicable state plan for medical assistance approved under Title XIX of the Social Security Act, such payment by the Plan will be made in accordance with any applicable state law which provides that the state has acquired a right to payment for such items or services with respect to the participant or Beneficiary.

Coordination of Benefits

If you and your spouse or children are covered by this Plan and another plan providing medical or dental benefits (including, for example, a plan or policy of homeowner's insurance) they will be coordinated between the two plans. This provision is commonly called "coordination of benefits" or C.O.B. and limits total benefits payable under this Plan and other plans to 100% of eligible charges.

When there are medical expenses for a family member that are covered by two different group plans, you should file the claim with both plans. Make sure you provide all requested information to both plans. Then the claim departments will decide which plan is "primary" (pays benefits first) and which plan is "secondary" (pays eligible benefits not paid by the primary plan).

Definitions Applicable to the Coordination of Benefits Provisions

The term **"Other Plan" and "Another Plan"** as used in these "Coordination of Benefits" provisions, means any plan providing benefits or services for or by reason of medical care or dental care or treatment or healing which benefits or services are provided by:

1. Group, blanket, franchise, or any other arrangement for coverage of persons in a group whether on an insured or non-insured basis.

2. Group Blue Cross Blue Shield, or other prepayment coverage provided on a group basis.

3. Group-Type Contracts other than individual insurance issued on a franchise basis. "Group-Type Contract" is a contract which is not available to the general public and can only be obtained and maintained through membership or affiliation with a particular organization or group.

4. Any coverage, group or group-type, and individual automobile "no-fault" and traditional automobile "Fault" type contracts.

5. Any coverage for students which is sponsored by or provided through a school or other education institution which cover grammar, high school, and college students for accidents including athletic injuries either on a 24-hour basis or on a "to and from school" basis.

6. Any coverage under federal or state or other governmental programs, except Medicare, and any coverage required or provided by statute.

7. Coverage under a labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan.

8. Medicare. For the purposes of this Article, the definition of Medicare will include both Part A and Part B of Medicare, whether or not the Covered Individual is enrolled for both parts.

The term **"Other Plan" and "Another Plan"** will not mean:

1. A state plan under Medicaid.

2. Benefits under a law or plan when, by law, its benefits are excess to those of any private insurance plan.

3. Individual or family coverage except those plans described above.

4. Group Hospital Indemnity Plan of $100.00 per day or less.

The term **"Plan"** will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not. Notwithstanding the foregoing, the term "Plan" is deemed to include any Plan which is paid for entirely by an Employee, Retiree or Dependent only if such Plan contains a provision coordinating its benefits with This Plan.

The term **"This Plan"** as used in these "Coordination of Benefits" provisions, means that portion of the Plasterers and Cabinet Makers Health Fund which provides the medical and dental benefits subject to these "Coordination of Benefits" provisions.

The term **"Allowable Expense."** as used in these "Coordination of Benefits" provisions, means any necessary, Reasonable and Customary item of expense at least a portion of which is covered under at least one of the Plans covering the person with respect to whom a claim is made. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished will be deemed to be both an Allowable Expense and a benefit paid. The Trustees will not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan shall be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer or Employee or any insurance company or other organization or person.

The term **"Claim Determination Period"** as used in these "Coordination of Benefits" provisions, means a period of one year commencing with January 1.

Circumstances Under Which Coordination of Benefits will be Applied

Coordination of Benefits will be applied if the Covered Individual has duplicate coverage with respect to the payment of part or all of a claim for benefits under any Other Plan.

Order of Benefit Payments

To administer this provision properly, and to determine whether the Plan Administrator will reduce its regular benefit, it is necessary to determine the order in which the various plans will pay benefits. This will be determined as follows:

> **Dependent/Non-Dependent.** The benefits of a Plan which covers the person other than as a dependent will be determined before the benefits of a Plan which covers such person as a Dependent.
>
> **Employee/Non-Employee.** The benefits of a Plan which covers the person as an employee will be determined before the benefits of a Plan which covers such person *other than* as an employee.

Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is not retired or laid-off (or as that employee's dependent) will be determined before those of a Plan which covers that person as a retired or laid-off employee (or as that employee's dependent). If the Other Plan does not contain this rule, this rule will be ignored.

Dependent Children. With respect to establishing the order of benefit determination on claims filed on behalf of a Dependent child, the following rules apply:

1. Parents Not Legally Separated or Divorced. With respect to claims filed on behalf of a dependent child of parents who are not divorced or legally separated:

    a. Birthday Rule. The benefits of a Plan which covers the person as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year.

    b. Same Calendar Day Date of Birth. The benefits of a Plan which covers the person as a dependent of person whose date of birth, excluding year of birth, occurs on the same calendar day, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other person for a shorter period of time.

    c. If the other Plan does not have the provisions of Subparagraph 1(a) above regarding order of benefit determination for dependent children which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of Subparagraphs 1(a) above will not apply, and the rule set forth in the Plan which does not have the provisions of Subparagraph 1(a) above will determine the order of benefits.

2. Divorced or Legally Separated. With respect to claims filed on behalf of a dependent child of parents who are divorced or legally separated:

    a. Court Decree. If there is a court decree (QMCSO) which establishes financial responsibility for medical and health care expenses for a dependent child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of a Plan which covers the child as a dependent of the parent without such financial responsibility. The Plan has adopted procedures for determining

whether a decree or order meets the requirements to be a QMCSO. A copy of these procedures is available, free of charge, from the Plan Administrator.

b. Parental Custody Without Remarriage. In the absence of a court decree establishing financial responsibility for the medical and health care expenses of a dependent child, and if the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

c. Parental Custody With Remarriage. In the absence of a court decree establishing financial responsibility for the medical and health care expenses of a dependent child, and if the parent with custody of the child has remarried:

i. The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers the child as a dependent of the stepparent; and

ii. The benefits of a Plan which covers a child as a dependent of a stepparent will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

Longer/Shorter Length of Coverage. As to Plans for which the factors listed above do not establish an order of benefit determination, the benefits of the Plan which has covered the person for the longer period of time will be determined before the benefits of a Plan which has covered such person the shorter period of time.

The Plan Administrator has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Coordination of Benefits with Other Types of Insurance

This Plan is not in lieu of and does not affect the requirement for coverage under any plan of no-fault automobile insurance or other automotive insurance which provides medical coverage. That type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile. The Plan may require you to arbitrate any discontinuance or non-payment of no-fault benefits before a claim will be considered under this Plan.

Coverage under this Plan is deemed to be secondary coverage to any plan or policy of insurance which may pay medical expenses for a specific risk, including but not limited

to, for example, any automobile policy, homeowner's policy or premises insurance policy.

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

Coordination of Benefits with Automobile Insurance

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

1. Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides. That type of insurance is deemed to be primary for any claims arising out of the maintenance or use of an automobile.

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

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

4. An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must arbitrate any notice of discontinuance of no-fault automobile insurance or no benefits for said injuries will be payable under this Plan.

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

Excess Coverage Limitation

Regardless of any other rule stating otherwise, all benefits payable under this Plan will be limited to being in excess of the benefits which are payable by any other plan or

group insurance policy which is or purports to be an “excess policy” or an “excess plan” paying benefits only in excess of benefits provided by any other plan or policy.

If an entity or insurer of such other group “excess plan” or group “excess policy” agrees to pay benefits as if it were not an excess plan or policy, this Plan’s benefits will be payable without regard to the provisions of the previous paragraph, subject to the Coordination of Benefit provisions.

Coverage will not be changed at any time when your Employer’s compliance with federal law requires this Plan’s benefits for an individual to be determined before benefits are available under Medicare.

Filing for Medical and Weekly Disability Benefits

When you have a medical or weekly disability claim, follow these steps:

Step 1: File a medical claim as soon as you or your Dependent incurs medical expenses. When medical care is provided by a Participating Provider, the Provider will generally file the claim on your behalf. You should check with your Provider to determine whether the Provider will file the claim on your behalf.

File your claim for Weekly Disability Benefits as soon as you miss work due to the disability.

Step 2: Obtain the necessary claim forms from the Plan Administrator.

Step 3: For Weekly Disability Benefit claims, have your doctor complete his or her sections of the Claim Form and return the form to the Plan Administrator.

Step 4: Make sure you have all the itemized bills relating to the claim such as prescription drug bills and Physician’s bills. Each bill must show the name of the patient, the date and the charge for each service rendered and the Sickness or Injury for which each item of expense was incurred. Bills for prescription drugs must include the patient’s name, drug name, date, amount of charge, prescribing Physician’s name and prescription receipt. Be sure that your full name, address and Social Security number are on the bills. If the claim is for a Dependent, add the Dependent’s name, Social Security Number and birth date.

Step 5: Send the itemized bills and claim forms to:

Wilson-McShane Corporation
3001 Metro Drive
Suite 500
Bloomington, MN 55425

Before any claims can be paid for a Dependent spouse, a certified copy of your marriage certificate may be required to be on file at the Plan Administrator's office.

Claims Filing and Appeals Procedures

Deadlines for Filing Claims

Medical and Disability Claims - The deadline for filing a claim for medical or disability benefits is 15 months after the date you incurred the claim.

Prescription Drug Claims - All bills for prescription drugs must be filed no later than 15 months following the month in which the charge was incurred. Failure to do so will result in non-payment by the Plan.

Incomplete Claims

If you send a claim to the Plan Administrator and it cannot be processed because information is missing, you will receive a notice stating why the claim cannot be completed and what additional information is needed. It is your responsibility to send this information to the Plan Administrator. Approval or denial of a claim will be made within time frames listed below.

Pre-Service Claims

If the Plan states that a procedure requires pre-authorization before it will be treated as a covered expense, you must submit the claim or the suggested course of treatment to the Plan well in advance of the service or treatment being performed. When you submit a claim for which pre-authorization is required, the Plan will notify you if the claim is authorized within 15 days of the Plan receiving the claim from you. If the Plan needs additional time in which to determine whether the claim is a covered charge, it can extend its determination for up to an additional 15 days as long as the Plan notifies you of its need for an extension within 15 days of the Plan receiving the claim. If the Plan's need for the extension is due to your failure to provide the Plan with all the information it needs to process the claim, you will have 45 days after the Plan asks for additional information in order to give the additional information to the Plan. If you failed to follow the Plan's procedures for filing the claim, the Plan will notify you of this failure within 5 days of it receiving the claim.

Pre-Service Claims are those claims for which your receipt of a benefit from the Plan is conditioned, in whole or in part, on approval from the Plan prior to you receiving the medical care.

The Plan will waive its pre-authorization requirements if you have emergency services performed that would otherwise be covered under the Plan (this is also known as "urgent care"). You or the Provider, however, must notify the Plan as soon as reasonably possible after the services are performed. You will not be penalized for failing to obtain a pre-authorization in an emergency situation, but the Plan will only

pay the Reasonable and Customary Charge for services that are determined to be Medically Necessary.

An emergency (or urgent care) claim is a claim which (a) involves a procedure that requires preauthorization under the Plan either in a pre-service situation or for an extension of care in a concurrent care situation and (b) applying the pre-authorization time frames for determining the claim could seriously jeopardize the life or health of the Covered Person, seriously jeopardize the ability of the Covered Person to regain maximum function, or would subject the Covered Person to severe pain without the treatment that is the subject of the claim.

All Other Medical Claims

If the Plan denies coverage for a medical claim, it will do so within 30 days of the Plan's receipt of the claim from you or your provider. In certain situations, the Plan may extend this by an additional 15 days; if it does, it will notify you of the extension within the original 30 days and will tell you the reasons for the extension and when the Plan expects to make a decision on your claim. If the extension is needed because you failed to submit the necessary information to the Plan, the Plan will tell you of the information it needs and will give you 45 days to provide the needed information to the Plan.

Claim Denials

If your claim is denied, the Plan will notify you within the time frames stated above. The Plan will also:

1. Provide you the specific reasons your claim was denied;

2. Refer to the specific Plan provision(s) on which the determination was based;

3. Describe any additional material or information for you to complete the claim and an explanation of why the material or information is necessary;

4. Describe the Plan's review procedures and the time limits for these procedures (which are also stated below), plus a statement concerning your rights under federal law if your claim is denied;

5. If an internal rule was relied upon by the Plan in making the decision, either give you a description of the rule or a notice that you can request a copy of the rule from the Plan;

6. If the claim decision was based on a Medical Necessity or experimental treatment exclusion, either give you an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request; and

7. If the claim is an urgent care claim, give you a description of the review process applicable to urgent claims (which is also discussed above).

Claim Appeal Procedure

If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim. The procedures for appealing a claim decision are:

1. Compose a claim appeal which explains why you believe your claim should be reviewed.

2. Attach any additional information you think will help a favorable decision to be made on your claim.

3. Return your completed appeal, along with any additional information you are submitting, to the Plan Administrator:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Your claim appeal must be filed in writing at the Plan Administrator's office within 180 days of the date the claim denial was mailed to you.

When appealing a claim, you have certain rights under federal law. These include:

1. You will have the opportunity to submit written comments, documents, records and other information relating to the claim.

2. You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

3. The review by the Plan will take into account all comments, documents, records, and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination.

Applicable Time Frames for Deciding Claim Appeals

Pre-Service Claims - If your appeal is for a denial of a claim requiring pre-authorization, the Plan will notify you of its decision on appeal within 30 days of the Plan's receipt of your appeal.

All Other Claims - For all other claims, the Board of Trustees will review your appeal at its next regularly scheduled meeting; however, if your appeal was received by the Plan within 30 days of the Board of Trustees meeting, the your appeal will be reviewed at the

Board's second regularly scheduled meeting following the Plan's receipt of your claim appeal. If special circumstances require, such as the need to hold a hearing, the review of your appeal may be delayed until the Board's third meeting following your request for an appeal. If this extension is required, the Plan will notify you of the extension and of the special circumstances requiring the extension.

After a decision is made concerning your appeal, you will be notified of the decision by the Plan within 5 days of the decision being made.

Circumstances Resulting In Denial or Loss of Benefits

The Trustees or their representatives are authorized to deny payment of a claim. The reason for denial may include one or more of the following:

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred.

2. You did not file the claim within the Plan's time limits.

3. The expenses are not Covered Under the Plan or the expenses for which you filed the claim were not actually incurred.

4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.

5. No payment or a reduced payment was made because some or all of the expenses for which the claim was filed were applied against a deductible.

6. A third party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expense and you or your Dependent, whether or not a minor, did not comply with the subrogation provisions of this Plan, beginning on page 96.

7. Another plan was primarily responsible for paying benefits for the expenses (refer to "Coordination of Benefits" section in this booklet).

8. The Trustees amended the Plan eligibility rules or reduced Plan benefits.

9. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf.

10. Your Employer terminated Contributions to the Plan, either because your employer did not enter into a successor Collective Bargaining Agreement

requiring Contributions to the Plan, or because the Participation Agreement providing for Contributions to the Plan was terminated.

11. You or your Dependents failed to make any required Self-Contribution.

12. The Plan was terminated.

13. You or your Eligible Family Member do not meet the regular eligibility requirements of the Plan.

The above list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances that might cause the denial of benefits for your claim. If you have any questions about a denied claim, contact the Plan Administrator's office.

TERMINATION OF COVERAGE

Employees

For Employees who are employed by a Contributing Employer, coverage will terminate:

1. Upon termination of the Plan.

2. Upon termination of Contributions on behalf of the Employee.

3. Upon the date on which the Employee fails to meet the Plan's eligibility requirements.

4. When the Employee elects not to make a Self-Contribution for Continuation Coverage.

5. The date on which the Employee is no longer eligible for benefits under the Continuation Coverage provisions of COBRA.

Dependents

A Dependent's coverage will terminate at the earliest to occur of the following:

1. The date the Trustees terminate Dependent Benefits under the Plan.

2. The date the Employee ceases to be eligible for coverage under the Plan unless Self-Contributions for Continuation Coverage are made by or on behalf of the Dependent.

3. The date on which the Dependent no longer meets the Plan's definition of Dependent.

4. The date on which the Dependent is no longer eligible for benefits under the Continuation Coverage provisions of COBRA.

Certificate of Creditable Coverage

Upon termination of coverage of a Covered Individual, the Plan will provide him or her with a Certificate of Creditable Coverage (by first class mail), which will state the length of time that he or she was Covered Under The Plan, excluding periods of time before a significant break in coverage (a significant break in coverage is a continuous 63 day period without group health care coverage).

You should retain this Certificate in your personal files and submit it to any future employer who sponsors a group health care plan. The Certificate may entitled you to a reduction in the waiting period for coverage of pre-existing condition under a new

employer's group health care plan if that plan includes a waiting period for the coverage of such conditions.

GENERAL PLAN PROVISIONS

Beneficiaries

You may designate or change your Beneficiary by filing a written request to the Plan Administrator. Ask the Plan Administrator for the necessary forms. The designation or change will be effective as of the date you execute the request, but the Plan will be completely discharged of its obligations to the extent of any payment made before receiving your request at the Plan Administrator.

Physical Examinations

The Trustees have the right to have a Physician examine a person for whom benefits are being claimed and to ask for an autopsy in the case of death. They also have the right to examine any and all hospital or medical records relating to a claim.

Free Choice of Doctor

You are free to choose any Physician you wish who meets the Plan's definition of a legally qualified Physician. However, significant savings will be obtained by both you and the Plan by using In-Network Physicians (i.e., Participating Providers).

Governing Law

All questions pertaining to the validity or interpretation of the Trust Agreement or the Plan or any question concerning the acts and transaction of the Trustees or any other matter that affects the Plan will be determined under federal law, where applicable federal law exists. If there is no applicable federal law, then the laws of the State of Minnesota will apply.

Subrogation And Reimbursement

Introduction

The Plan has a first priority subrogation and reimbursement right if it provides benefits resulting from or related to an Injury, occurrence or condition for which the Covered Individual has a right of redress against any third-party.

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

For example, the subrogation and reimbursement right may apply if a Covered Individual is injured at work, in an automobile accident, at a home or business, in an assault or in any other way for which a third-party has or may have responsibility. If a

recovery is obtained from a third-party, such as an insurance company, the Plan will be paid first and to the full extent of the benefits it paid. The Covered Individual receives payment only after the Plan is fully reimbursed.

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

Subrogation and Reimbursement – Rules for the Plan

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

(a) Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the Covered Individual agrees that the Plan has the subrogation and reimbursement rights as described in this Subrogation and Reimbursement section. Further, the Covered Individual will sign a form acknowledging the Plan's subrogation and reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the Covered Individual refuses to sign the acknowledgment. The Plan's subrogation and reimbursement rights to benefits paid prior to Plan notice of a subrogation and reimbursement right, are not impacted if the Covered Individual refuses to sign the acknowledgment.

(b) Constructive Trust or Equitable Lien: The Plan's subrogation and reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the Covered Individual from a third-party, whether by settlement, judgment or otherwise. When a recovery is obtained, the recovery proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovery proceeds and is paid to the full extent of its equitable subrogation and reimbursement rights. If the Covered Individual fails to hold the recovery proceeds in trust or in any other way prejudices or adversely impacts the Plan's subrogation and reimbursement rights, the Plan reserves the right to, among other things, pursue all available equitable action and offset any future benefits payable to the Covered Individual under the Plan.

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

Covered Individual may have received or may be entitled to receive from the third-party.

(d) Right to Take Action: The Plan's right of subrogation and reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any other Covered Individual can bring an action (including in the Covered Individual's name) for specific performance, injunction or any other equitable action necessary to protect its rights in the cause of action, right of recovery or recovery by a Covered Individual. The Plan will commence any action it deems appropriate against a Covered Individual, an attorney or any third-party to protect its subrogation and reimbursement rights. The subrogation and reimbursement right applies to claims of Eligible Dependents covered by the Plan regardless of whether such Dependent is legally obligated for expenses of treatment.

(e) Applies to All Rights of Recovery or Causes of Action: The Plan's subrogation and reimbursement rights apply to any and all rights of recovery or causes of action the Covered Individual has or may have against any third-party.

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

(g) Full Cooperation: The Covered Individual will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's subrogation and reimbursement rights. Benefits will be denied if the Covered Individual does not cooperate with the Plan.

(h) Notification to the Plan: The Covered Individual must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the member for their injuries, sickness, or death.

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

(j) Apportionment, Comparative Fault, Contributory Negligence, Make-Whole and Common-Fund Doctrines Do Not Apply: The Plan's subrogation and reimbursement rights include all portions of the Covered Individual's

claims regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's subrogation and reimbursement rights are not affected, reduced or eliminated by comparative fault, contributory negligence, the make-whole and common-fund doctrines or any other equitable defenses.

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

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

Plan Discontinuance or Termination

This Plan may be discontinued or terminated under certain circumstances, for example, if future Collective Bargaining Agreements and participation agreements do not require Employer Contributions to the Plan. In such an event, benefits for Covered Expenses incurred before the termination date will be paid to eligible members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. Benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement, or the assets may be turned over to another employee benefit trust fund providing similar benefits. However, any use of such assets will be made only for the benefit of Plan participants who were Covered Under the Plan at the time of the Plan termination.

Release of Information

You must provide the Plan Administrator with any required verbal or written authorization for the release of necessary information relating to any claim you have filed.

Severability Clause

If any provision or amendment to the Trust Agreement or the Plan should be determined or judged to be unlawful, such an illegality will apply only to the provision in question. It will not apply to any other provision of the Trust Agreement or the Plan unless such illegality would make it impractical or impossible for the Trust Agreement or the Plan to function.

Trustee Interpretation, Authority and Rights

The Trustees have the authority to determine eligibility for benefits and construe the terms of the Plan and all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that such decisions are to be upheld unless it is determined to be arbitrary or capricious.

The Trustees have the authority to change the eligibility rules and other provisions of the Plan, to amend, increase, decrease or eliminate benefits, and to terminate the Plan, in whole or in part. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

The right to change or eliminate any and all aspects of benefits provided for Retired Employees is a right specifically reserved to the Trustees, since the retiree coverage is not an "accrued" benefit. The Trustees may reduce Retiree benefits, increase Self-Contributions for the benefits or completely terminate such benefits at any time. Such a change will be effective even though an Employee has already become a Retiree. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate in the exercise of their fiduciary duty, and they may change these rules and procedures at any time.

Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation law, Occupational Diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you did not file a claim for benefits under the rules of these laws.

Coverage Under Another Health Care Plan

You must advise the Plan Administrator's office if you have coverage under any other health care plan. If this Plan pays primary benefits but subsequently discovers that another plan should be responsible for paying primary benefits (and this Plan should be secondary), this Plan has the right to recover those benefits from you.

INFORMATION ABOUT THE PLAN

Name of Plan/Fund

Plasterers and Cabinet Makers Health Fund

Plan Sponsorship and Administration

Your Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees appointed by the Union and by Trustees appointed by Contributing Employers.

The names and addresses of the Trustees are shown in the front of this booklet. Claims are administered by Wilson-McShane Corporation under a contract with the Plan. The address and telephone number of Wilson-McShane Corporation is:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795 or 1-800-535-6373

Service of Legal Process

The name and address of the person who is designated as agent for service of process for the Plan is:

Mr. Matt Winkel
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
952-854-0795 or 1-800-535-6373

Service of process may also be made upon any of the Trustees of the Plan (listed in the front of this booklet).

Type of Plan

The Plan is an employee welfare benefit plan that provides hospital, medical, life, accidental death and dismemberment, and loss of time benefits.

Source of Contributions/Plan Participation

The Plan receives Contributions from Employers who have entered into Collective Bargaining Agreements with local Unions affiliated with the Union and are required to make Contributions to the Plan. Also included are Employers who have Participation Agreements with the Trustees to provide coverage for their employees. Contributions are made monthly to the Plan and enable employees working under such agreements to participate in the Plan. A copy of the Collective Bargaining Agreements may be

obtained by Plan participants and Beneficiaries upon written request to the Plan Administrator. They are also available for examination.

Employees are entitled to participate in this Plan if they work under one of the Collective Bargaining Agreements or participating agreements and if their Employers make the required Contributions to the Plan on their behalf.

The Plan also receives Contributions from Employees, Retirees, and Dependents for the purpose of continuing coverage under the Plan.

Plan participants and Beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

Accumulation of Assets/Payment of Benefits

Employer Contributions and Employee, Retiree and Dependent Self-Contributions are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses.

The Plan provides medical, life, dental, accidental death and dismemberment and loss of time benefits. These benefits are self-insured. This means the benefits are paid directly from the Plan to you or the provider of services. The self-insured benefits payable by the Plan are limited to the Plan's assets available for such purposes.

Organizations through which Benefits are Insured

Life Benefits and Accidental Death and Dismemberment Benefits are insured and administered by:

USAble Life
P.O. Box 204678
Dallas, TX 75320
Group Policy Number: 10013286

Stop Loss Insurance is insured by:

H.C.C. Life Insurance Company
P.O. Box 402032
Atlanta, GA 30384-2032

Plan/Fund Year

The Plan's fiscal year is April 1 through March 31.

Plan/Fund Identification Number

The employer identification number (EIN) assigned to this Plan by the Internal Revenue Service is 41-6039051.

Plan Number

The Plan number assigned by the Plan Sponsor is 501.

YOUR RIGHTS UNDER ERISA

As a participant in the Plasterers and Cabinet Makers Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as the 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 in the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date for coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your

employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning a Qualified Medical Child Support Order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file a suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

DEFINITIONS

BENEFICIARY - An individual who is not and was not an Employee or former Employee or Retiree, but who is or may in the future, by reason of the individual's relationship to an Employee or Retiree, be eligible for benefits under the Plan.

BENEFIT PLAN; PLAN; PLAN OF BENEFITS - The self-funded program of health and welfare benefits provided by the Plasterers and Cabinet Makers Health Fund, established by, and as it may be amended from time to time, the Board of Trustees pursuant to the provisions of the Trust Agreement.

CALENDAR YEAR - The 12-month period starting on January 1 of any year and ending on December 31 of that year.

CHEMICAL DEPENDENCY - Alcohol or drug dependence as defined in the most recent edition of International Classification of Diseases.

COLLECTIVE BARGAINING AGREEMENT(S) - The Collective Bargaining Agreements in force and effect between the Union and a Contributing Employer which requires the Employer to make Contributions to the Plan on behalf of their Employees for work performed within the jurisdiction of the Union, together with any modifications or amendments of such Collective Bargaining Agreements.

CONTRIBUTIONS -

1. Payments made to the Plan by Employers pursuant to a Collective Bargaining Agreement on behalf of their Employees for hours worked by their Employees and also Employee payments to the Plan as required by such Agreements; and

2. Self-Contributions.

COVERED EXPENSES; COVERED MEDICAL EXPENSES - The Reasonable and Customary Charges incurred by a Covered Individual upon the recommendation and approval of the attending Physician for services and supplies required for treatment of the individual as a result of a non-occupational accidental bodily Injury or Sickness and for which Plan benefits are payable.

COVERED INDIVIDUAL - An Eligible Employee, an Eligible Retiree or an Eligible Dependent. Under the BlueCard program, an Eligible Employee or Eligible Retiree would be known as a "Subscriber", while an Eligible Dependent would be known as a "Member."

COVERED UNDER THE PLAN - An individual who is eligible to receive the Plan benefits which are applicable to his or her eligibility status as an Eligible Employee, Eligible Retiree or Eligible Dependent.

CUSTODIAL CARE - Care which is designed to help a person in the activities of daily living including preparation of special diets, supervision over medication that can be self-administered, and assisting the person in and out of bed, to walk, bathe, dress, eat, etc.

DENTIST - A person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry.

DEPENDENT -

1. A person who is:

    a. The **spouse** of an Eligible Employee or Eligible Retiree who is a legal resident of the same country in which the Eligible Employee resides. The Plan may require that an Employee or Retiree provide a certified copy of his or her marriage certificate before any benefits are paid for a Dependent spouse.

    b. An Eligible Employee's or Eligible Retiree's **child** who is less than 26 years of age.

    c. An Eligible Employee's or Eligible Retiree's **child** age 19 or older who is handicapped due to mental retardation or physical handicap. The coverage of such handicapped child will be continued for as long as the Employee or Retiree is Covered Under the Plan, provided that all of the following requirements are met:

        i. The child must meet the definition of a child (see subpart b, below) except for age:

        ii. The child must have become so handicapped and incapable while a Dependent.

        iii. The child must remain handicapped due to mental retardation or physical handicap child must be incapable of self-sustaining employment and continue to be incapable of such employment.

        iv. The child must be Covered Under the Plan prior to the attainment of age 19.

        v. The child must be dependent upon the Eligible Employee or Eligible Retiree for the major portion of the child's support and maintenance (except to the extent the child is supported by another parent, is receiving governmental aid or

assistance or is the beneficiary of another trust) and must be domiciled with the parent.

vi. At the time the first claim is filed on behalf of the child, the Eligible Employee or Eligible Retiree must furnish proof that the child was so handicapped while a Dependent. If the required proof is not received by the Plan, the child will not be considered an Eligible Dependent beyond the date he or she attains age 19, even though such child continues to be handicapped.

vii. Such mental retardation or physical handicap will be considered to have been established only if proof of such incapacity is furnished at least thirty-one (31) days prior to the date coverage would otherwise terminate. The Plan Administrator or its designee may require, at reasonable intervals, subsequent proof of the child's disability and dependency. The Plan Administrator will have the right to have a Physician of its choice examine the child periodically as a condition of continuing such child's status as an eligible child.

viii. The child must be eligible to be claimed as a Dependent on the Eligible Employee's federal income tax return.

d. A **child of a Dependent child** described in paragraphs b or d above. The child and the Dependent child must both reside with and rely upon the Eligible Employee or Eligible Retiree for a major portion of their support and maintenance. Effective September 1, 2011, new children of Dependent children will not be eligible for coverage under the Plan. Any child of a Dependent child covered on or before September 1, 2011 remains eligible for coverage.

2. For purposes of the definition of a Dependent, the term "child" means:

a. Any natural born child born of an Eligible Employee or Eligible Retiree.

b. Any child placed for adoption with or legally adopted by an Eligible Employee or Eligible Retiree. Placement for adoption means the assumption and retention by an Eligible Employee or Eligible Retiree of a legal obligation for total or partial support of a child in

anticipation of the legal adoption of such child by the full-time Eligible Employee or Eligible Retiree. Placement for adoption will terminate upon the termination of such legal obligation.

c. Any natural child of an Eligible Employee or Eligible Retiree not covered in No. 1 above, who does not live with the Eligible Employee or Eligible Retiree, provided the Eligible Employee or Eligible Retiree is responsible for providing health care coverage for the child pursuant to the terms of a Qualified Medical Child Support Order ("QMCSO"). A copy of the QMCSO and the child's birth certificate will be required by the Plan Administrator's office before claims for such a child will be considered for payment. Alternatively, a Participant may apply to cover a natural child through completion of an election form to provide coverage that certifies and provides:

   i. A copy of the child's birth certificate;

   ii. Certifies that the child is the Participant's natural Dependent child;

   iii. Acknowledgement that no other individual is required to provide coverage; and

   iv. That should it be determined that the child is not in fact the Participant's natural child, the Participant will be required to reimburse the Plan for any claims paid on the child.

d. For purposes of this definition, the term "stepchild" will mean any child of the spouse of an Eligible Employee or Eligible Retiree, born to such spouse, placed for adoption with or legally adopted by such spouse. Any stepchild of an Eligible Employee or Eligible Retiree provided that:

   i. Such stepchild is living in the Eligible Employee's or Eligible Retiree's household;

   ii. Such stepchild's non-custodial natural parent does not have group health benefits available through the non-custodial parent's place of employment; and

   iii. Such stepchild's non-custodial parent is not obligated by any court decree to be responsible for and provide health care for such child.

e. Individuals who were eligible to receive coverage from the Plan due to their status as a "child" on the date immediately preceding the

effective date of this Plan Document will be considered a "child" for purposes of eligibility for benefits until 1) they would no longer be considered a "child" under the previous Plan Document, and 2) they do not satisfy the definition of child and/or Dependent in this Plan Document.

DEPENDENT BENEFITS - The benefits provided under this Plan with respect to Eligible Dependents of Eligible Employees and Eligible Retirees.

DURABLE MEDICAL EQUIPMENT - Medically Necessary equipment that is:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. useful only to a person who is ill;
4. appropriate for use in the patient's home; and
5. prescribed by a Physician.

ELIGIBLE DEPENDENT - Any Dependent who is eligible to receive the Plan benefits provided for Dependents of Eligible Employees and Eligible Retirees.

ELIGIBLE EMPLOYEE - Any Employee who has met the eligibility requirements specified on page 9, and who is therefore entitled to receive the Plan benefits provided for Employees.

ELIGIBLE FAMILY MEMBER - An Eligible Employee or an Eligible Retiree or any person in the Employee's or Retiree's family or household who meets the definition of a Dependent.

ELIGIBLE RETIREE - Any Retiree who has met the eligibility requirements specified on page 19, for being eligible for the Retiree Benefits and who is therefore entitled to receive such Plan benefits.

EMPLOYEE(S) - All those persons who are represented in collective bargaining by the Union and who are employed by an Employer who has agreed to make Contributions to the Plan on their behalf;

EMPLOYER; CONTRIBUTING EMPLOYER -

1. Any person, firm, association, sole proprietorship, partnership or corporation that on the Effective Date of this Plan has entered into a Collective Bargaining Agreement with the Union requiring that Contributions be made to the Plan on behalf of their Employees;

2. Employers who in the future enter into a Collective Bargaining Agreement with the Union requiring that Contributions be made to the Plan on behalf of Employees at the same rate of Contribution as other Employers currently contributing or required to contribute to the Plan;

3. The Union in its capacity as Employer of Employees not covered by a Collective Bargaining Agreement provided that the Union will have in effect a valid Participation Agreement with the Trustees;

ESSENTIAL HEALTH BENEFITS - Items and services covered within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care for Dependents under age 19.

EXPERIMENTAL AND INVESTIGATIVE - For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedures, facility, drug, equipment, device, or supply) is considered to be Experimental or Investigative if the use if not yet generally recognized as accepted medical practice, or if the use requires federal or other governmental agency approval and the approval has not been granted at the time the service or supply is provided, or if the use is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

1. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty;

2. Has a definite positive effect on health outcomes;

3. Over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh the harmful effects); and

Reliable Evidence includes only:

1. Published reports and articles in authoritative medical and scientific literature;

2. The written investigational or research protocols and/or written informed consent used by the treating facility or of another facility which is studying the same service, supply, or procedure; and

3. Compilations, conclusions, and other information which is available and may be drawn or inferred from (A) or (B), above.

Consideration may be given to whether:

1. The treatment cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the treatment is furnished; or

2. Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trails are under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or

3. Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

4. The mortality rate of the treatment; the cure rate and the survival rate for patients using the treatment for the particular Injury, Sickness or condition as compared with rates for similarly situated patients using no treatment or using existing treatments which are generally accepted by the Food and Drug Administration, and; the number of patients who have received the treatment for the same Injury, Sickness or condition.

The final determination of whether the use of a treatment is Experimental or Investigative will rest solely with the Trustees.

HOSPITAL - A lawfully operating institution which is engaged primarily in providing medical care and treatment to sick and injured individuals on an inpatient basis at the patients' expense and which fully meets every one of the requirements set forth in Paragraphs 1-6 below:

1. It is a Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations;

2. With respect to treatment of Mental or Nervous Disorders, it is a community mental health center or mental health clinic established for the purpose of providing consultation, diagnosis and treatment in connection with a mental Sickness or functional nervous disorder and is approved or licensed by the commissioner of Public Welfare or other authorized state agency;

3. With respect to an Emotionally Handicapped Child, it is a licensed residential treatment facility established for the purpose of treating emotionally handicapped children and approved or licensed by the State in which you live. "Emotionally Handicapped Child" is a child under 19

years of age who, in the judgment of a professional, social worker, psychiatrist, or psychologist, is exhibiting those symptoms or behavior patterns that are determined to be of such a nature that the child needs the care and treatment provided at such facility;

4. With respect to the treatment of alcoholism, chemical dependency or drug addiction, it is confinement in a residential primary treatment program licensed by the state in which you live;

5. It is a Hospital, a psychiatric Hospital, or a tuberculosis Hospital, as those terms are defined in Medicare, which is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; and

6. It is an institution which fully meets all of the following tests:

   a. It provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine;

   b. It provides on the premises 24-hour-a-day nursing services by or under the supervision of Registered Graduate Nurses;

   c. It is operated continuously with organized facilities for operative surgery on the premises; and

   d. It is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing or convalescent home, an extended care facility, a place for Custodial Care, or similar establishment.

ILLNESS - A sickness, injury, disease, pregnancy, mental illness, chemical dependency, or other condition involving a physical disorder that occurs while Covered Under The Plan.

INJURY - Bodily Injury caused by an accident while Covered Under The Plan.

MEDICALLY NECESSARY - Only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat a Covered Individual’s Injury or Sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the Covered Individual’s condition, disease, ailment, or Injury;

2. Are appropriate according to standards of good medical practice;

3. Are not solely for the convenience of the Covered Individual, (including his or her family or care giver) Physician, or Hospital;

4. Are the most appropriate which can be safely provided to the Covered Individual;

5. Are not deemed to be Experimental or Investigative; and

6. Are not furnished in connection with medical or other research.

MEDICARE - The Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may later be amended.

MENTAL OR NERVOUS DISORDER - A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

MOTOR VEHICLE - Any registered or unregistered, licensed or unlicensed, on-road or off-road automobiles, trucks, motorcycles, recreational vehicles, or motor homes.

NURSE MIDWIFE - A licensed registered nurse who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

PHYSICIAN -

1. A legally qualified Physician or surgeon licensed to practice in his or her state who is a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Chiropractic (D.C.), a Doctor of Dentistry (D.D.S., D.M.D.) or a Doctor of Podiatry (D.P.M.) acting within the scope of their license.

2. A Nurse Midwife with respect to treatment, service or care rendered by said Nurse Midwife within the lawful scope of practice of a duly certified Nurse Midwife.

QUALIFIED MEDICAL CHILD SUPPORT ORDER - Any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or a decision from a state administrative body that:

1. Provides for child support payments related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

2. Enforces a state law relating to medical child support payments with respect to the Plan; and

3. Creates or recognizes the right of a child as an alternate recipient who is recognized under the Order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to a full-time Eligible Employee who is a participant in the Plan; and

4. Includes the name and last known address of the participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided, and each plan, including this Plan, to which the order applies; and

5. Does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1980 of the Social Security Act; and

6. Has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan.

REASONABLE AND CUSTOMARY CHARGE; REASONABLE AND CUSTOMARY -

1. A charge that does not exceed the general level of charges being made by providers of similar training and experience when furnishing customary treatment for a similar Sickness, condition, or Injury. The locality where the charge is incurred will also be considered. "Locality" means a county or such greater area as is necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services or supplies for which the charge was made.

2. With respect to medical expenses incurred by a Covered Individual as a result of a non-occupational accidental Injury or Sickness, the Plan's maximum allowable expense for a charge by a Physician or any other provider of medical services or supplies is the applicable percentage as specified under the Plan's, "Summary of Benefits", (beginning on page 5) provided that the Plan may review and compare the charge with the charges made by other Physicians and providers of medical services or supplies for similar services or supplies in the Locality concerned to individuals of similar age, sex, circumstances and medical condition.

3. In no event may the Reasonable and Customary charge exceed the allowed charges for a Participating Provider under the Plan's Preferred Provider network.

4. A Reasonable and Customary Charge will not exceed charges actually incurred.

RETIREE; RETIRED EMPLOYEE - An individual who was an Eligible Employee under this Plan on the day preceding the date of retirement and who is now retired either under the retirement provisions of a pension plan negotiated or sponsored by the Union or under the provision of the Social Security Program, provided that:

1. The Employer of the Employee is a party to the Collective Bargaining Agreement as defined herein at the time the Eligible Employee retires.

2. The Eligible Employee is at least 57 years of age and no longer actively at work in the trade.

3. The Eligible Employee is a member in good standing with a participating Local Union.

4. The Eligible Employee makes the necessary Self-Contributions.

5. The Employee is either:

    a. An Employee who established eligibility for coverage under this Plan while working in employment subject to a Collective Bargaining Agreement as defined herein; or

    b. The Employee established eligibility for participation in this Plan while an Employee of the Union or while an Employee of one of the Employers or while an Employee of any Plan or an agency created pursuant to collective bargaining between the Employer(s) and the Union; or

    c. The Employee established eligibility for coverage in the Plan while an Employee of an Employer subject to a Collective Bargaining Agreement.

ROOM AND BOARD CHARGES - All charges made by a Hospital in its own behalf for room, board, general duty nursing and any other charges by whatever name called which are regularly made by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of Physicians, private duty nurses or charges for intensive nursing care.

SELF-CONTRIBUTIONS –

1. Payments made to the Plan on behalf of Employees of Employers signatory to a Collective Bargaining Agreement for the purpose of maintaining eligibility;

2. Payments made to the Plan by Retirees and surviving spouses of Retirees for the purpose of maintaining eligibility; and

3. Payments made to the Plan for Continuation Coverage under COBRA by Employees, Retirees and Dependents for the purpose of maintaining their coverage under the Plan.

TOTAL DISABILITY; TOTALLY DISABLED -

1. With respect to an Eligible Employee, the complete inability of the Eligible Employee, as a result of an accidental bodily Injury or Sickness, to engage in his or her occupation or employment for wage or profit. The disability must be verified periodically by an attending Physician's statement.

2. With respect to an Eligible Retiree or an Eligible Dependent, the complete inability, as a result of non-occupational accidental bodily Injury or Sickness, of the Retiree or Dependent to engage in the substantial and material activities engaged in prior to the start of the disability.

3. With respect to a Dependent child, as a result of an accidental bodily Injury or Sickness, confinement in a house or Hospital.

4. A disability will be declared a Permanent Total Disability if it continues for a period of at least six (6) months or to the date of death.

TRUST AGREEMENT - The Restated Agreement and Declaration of Trust establishing the Plasterers and Cabinet Makers Health Fund.

TRUST FUND; FUND - The Plasterers and Cabinet Makers Health Fund, the Trust Fund created pursuant to the Agreement and Declaration of Trust (as amended and restated), and consisting generally of all the monies, property and other things of value held by the Trustees under the provisions of the Agreement and Declaration of Trust and any amendments thereto and which comprise corpus and additions, without distinction as to principal and income.

TRUSTEE; TRUSTEES; BOARD OF TRUSTEES - A Trustee or the Trustees designated pursuant to the Trust Agreement together with such Trustee's successor or such Trustees' successors. The term "Employer Trustees" will mean the Trustees appointed by the Employers. The term "Union Trustees" will mean the Trustees appointed by the Union.

UNION - The Plasters Local No. 265 & the Cabinet Makers & Millmen Local No. 1865.

MEDICAL DATA PRIVACY

Introduction

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). While the Plan has always taken care to protect the privacy of your health information, the new regulations require the Plan to adopt more formal procedures and to tell you about these procedures in this booklet. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");

2. Your privacy rights with respect to your PHI;

3. The Plan's duties with respect to your PHI;

4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and

5. The person or office to contact for further information about the Plan's privacy practices.

A. The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information ("PHI") to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations.*

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally

not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, Contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;

2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);

3. Subrogation;

4. Coordination of Benefits;

5. Establishing self-payments by persons Covered Under The Plan;

6. Billing and collection activities;

7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;

8. Obtaining payment under stop-loss or similar reinsurance;

9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;

10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;

11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective reviews;

12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;

3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and

6. Management and general administrative activities of the Plan, including but not limited to:

    a. Managing activities related to implementing and complying with the Privacy Regulations;

    b. Resolving claim appeals and other internal grievances;

    c. Merging or consolidating the Plan with another Plan, including related due diligence; and

    d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

C. Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions.

The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.

2. Ensure that any agents of the Trustees, including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;

6. Make PHI available to an person who is the subject of the information according to the Privacy Regulation’s requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;

8. Make available the PHI required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and

10. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Board of Trustees (including alternate Trustees).

   The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

2. The Trustees' agents, such as the Trustees' staff, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

E. Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

F. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints

concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person.

HIPAA SECURITY

Introduction

Recently, the federal Department of Health and Human Services adopted regulations governing the Plan's obligation to maintain the security of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations work in conjunction with the Medical Data Privacy Regulations ("Privacy Regulations"), which provisions are contained in a previous amendment to the Plan effective April 13, 2003, which added a section entitled "Medical Data Privacy" and is found on pages 119-124 of the Summary Plan Description. While the Plan has always taken care to secure your health information, the new regulations require the Plan, along with the Plan Administrator, to take some additional steps, in addition to those required by the Privacy Regulations, to maintain the electronic, physical and technical security of your protected health information. The information below outlines the additional steps the Plan has taken to secure your health information in compliance with the HIPAA Security Regulations.

A. Policies to Protect PHI in Electronic Form

The Plan, in conjunction with the Plan Administrator, has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI) in electronic form (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these regulations) that they create, receive, maintain or transmit on behalf of the Plan. The Trustees will report to the Plan any security incident of which they become aware.

B. Business Associates

The Plan will enter into agreements with other entities known as "Business Associates" to perform functions as part of the administration of the Plan. The Plan's agreements with its Business Associates will require that the electronic, physical and technical security of your electronic PHI be maintained.

C. Access to PHI in Electronic Form for Plan Administrative Functions

As indicated in the section of the Summary Plan Description covering the Privacy Regulations, the Plan will give access to PHI to the Board of Trustees and their staff's as necessary and reasonable to assist the Trustees in fulfilling their duties. Any such disclosures of your protected health information in electronic form to the above noted personnel are supported by reasonable and appropriate security measures. If any of the above noted personnel fail to comply with these provisions, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions as appropriate.

D. If You Have Any Questions

The Plan Administrator is largely responsible for maintaining the security of your PHI in electronic form. The Plan Administrator has appointed a Security Officer for purposes of Security Regulations compliance. If you have questions regarding the security of your PHI in electronic form, you may contact the Security Officer through the Plan Administrator.

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