SUMMARY OF MATERIAL MODIFICATIONS
TO THE
COMBINED MASTER PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
(Restated April 1, 2021)
of the
HEAT AND FROST INSULATORS LOCAL 34
HEALTH AND WELFARE PLAN

The Combined Master Plan Document and Summary Plan Description (that is, the Plan Booklet dated April 1, 2021) of the Heat and Frost Insulators Local 34 Health and Welfare Plan has been amended effective April 1, 2022.

1. <u>The Plan's Eligibility and Participation provisions are amended to remove the language regarding the Reserve Hours Bank and is replaced with provisions providing for a Dollar Bank</u>.

ELIGIBILITY AND PARTICIPATION

Eligibility For Bargaining Unit Employees

Initial Employee Eligibility – Hourly Dollar Contributions

Contributions on behalf of an Employee are made monthly but based upon the hours worked by those employees in covered employment. The hourly contribution amount is set forth in the applicable collective bargaining agreements.

An Employee becomes initially eligible in the month following the calendar month in which total contributions received on behalf of the Employee exceed the monthly premium amount for coverage as established by the Trustees.

An Employee has a rolling six-month period in which to receive total hourly contributions in an amount sufficient to establish their initial eligibility for a month of Plan coverage.

EXAMPLE:

> The Trustees have established the monthly premium amount for Employees to be $2,000*. Mark works under a collective bargaining agreement requiring employer contributions of $11.75* per hour.
>
> Mark works 130 hours in March, with those contributions ($1,527.50) made in April. Mark then works 120 hours in April, with those contributions ($1,410) made in May.
>
> Mark will be eligible for coverage under the Plan on June 1. That is the first day of the month following the time he first has at least $2,000 of total contributions made to the Plan on his behalf.
>
> This period of initial eligibility will continue through the end of the month (June 30). In subsequent months, Mark will be able to continue coverage under the Plan by satisfying the rules set forth below for Continuation of Employee Eligibility – Dollar Bank.

<u>*Note</u>: The Trustees will set the monthly cost for coverage on an annual basis. The $2,000 monthly premium amount used in the examples in this section is used strictly for purposes of the examples and is

not the Plan's current rate. Additionally, the $11.75 per hour rate is also a rate strictly used for example purposes and is not the current contribution rate.

Continuation of Employee Eligibility – Dollar Bank

Once an Employee is covered under the Plan for one month of coverage, he will remain covered for any succeeding month provided the total dollar amount of employer contributions made by the 15th day of the prior month is equal to or exceeds the monthly premium amount as established by the Trustees. Further, any *excess contributions* beyond what is necessary to pay for a month of coverage under the Plan will be retained in the Employee's Dollar Bank to be used for continuing their eligibility.

EXAMPLE:

> As in the example above, the Trustees have established the monthly premium amount for Plan coverage is $2,000. Mark works under a collective bargaining agreement requiring employer contributions of $11.75 per hour.
>
> Mark earned enough total contributions due to his work in March and April to gain coverage in June. After the cost of June coverage was paid, he still had $937.50 left to pay for future coverage under the Plan. In May, Mark worked 105 hours. The corresponding contribution of $1,233.75 was made by his employer prior to the June 15th deadline.
>
> Under this set of facts, Mark will continue to be eligible for coverage during the month of July. He is eligible because he had $2,171.25 of total contributions available to pay for that coverage once contributions for the May work month were received. Once the $2,000 cost for July Plan coverage is deducted, Mark would have $171.25 in his Dollar Bank.

Dollar Bank – Contributions and Deductions

Once established, any excess contributions over and above what is necessary to pay for a month of Plan coverage will be recorded in the Employee's Dollar Bank.

A deduction will automatically be made from an Employee's Dollar Bank to provide coverage in any month in which employer contributions are insufficient to maintain eligibility.

EXAMPLE:

> Mark has built a dollar bank balance of $2,400. The required monthly premium is $2,000. Mark works 60 hours in September, and thus his employer contributes $705 on his behalf in October. This $705 contribution is insufficient for Mark to maintain eligibility in November.
>
> The Plan will automatically deduct the necessary amount ($1,295) from Mark's Dollar Bank to provide eligibility for November. This will leave Mark with a Dollar Bank balance of $1,105.

Dollar Bank Maximum

The maximum balance of the Dollar Bank will be equivalent to nine (9) times the current monthly premium amount. For example, if the monthly premium is $2,000, the maximum Dollar Bank balance an Employee

could accrue would be $18,000. Should the monthly cost of coverage increase, a corresponding increase to the maximum Dollar Bank will be made.

Note that the Dollar Bank is not a vested benefit. For small unused balances (i.e. those less than enough for a month of coverage), if you do not make a self-payment to continue coverage or regain eligibility based on employer contributions within twelve-months of losing coverage under the Plan, any unused Dollar Bank balance will be forfeited. If you have retired, when you reach age 65, any remaining dollar bank balance will be forfeited to the Plan.

Self-Paying for Continued Coverage if Dollar Bank Balance is Insufficient

If hourly contributions and the balance, if any, in an Employee's Dollar Bank are insufficient to provide for a month's coverage, a Participant may continue their coverage under the Plan pursuant to the following rules:

- Self-paying the difference between the amount of employer contributions made on their behalf plus any Dollar Bank dollars the Participant has available and the required monthly premium contribution; or

- Electing COBRA.

EXAMPLE:

Mark has received $822.50 in employer contributions for the month of March, which is applied to pay for May coverage. He has $900 in his Dollar Bank. The monthly premium for coverage is $2,000. To continue his coverage in May, Mark may self-pay the difference of $277.50 to continue his coverage ($822.50 in employer contributions + $900 in the Dollar Bank + $277.50 self-payment = $2,000 monthly premium contribution required for coverage).

If no employer contributions are made in the month in question, the Participant may continue their coverage only by electing COBRA. The Employee must continue on COBRA until they receive sufficient employer contributions to their Dollar Bank to provide for a full month of coverage under the Plan and once again be covered as an active Participant in the Plan.

EXAMPLE:

Mark has received no employer contributions for the month of March, has $0 in his Dollar Bank and therefore has had no dollars available for May coverage. To continue his coverage in May and beyond, Mark cannot self-pay for coverage and instead must elect COBRA. Mark must then remain on COBRA until he receives sufficient in contributions to his Dollar Bank to once again pay for a month of coverage as an active Participant under the Plan.

2. <u>The Plan's provisions regarding the Medicare Supplemental Reimbursement Benefit and specifically Benefit Expiration are amended to provide as follows</u>:

Medicare Supplemental Reimbursement Benefit (post-65 coverage)

<u>Benefit Eligibility</u>: Effective on and after April 1, 2021, former bargaining unit employees will be eligible to receive this reimbursement benefit if they:

1. Have eighteen (18) total years of coverage under the Plan: and

Have five (5) consecutive years of coverage under the Plan immediately prior to retirement.

If you do not meet both the above service requirements, you are ineligible for this reimbursement benefit.

To receive the reimbursement benefit, you must be enrolled in Medicare and in a Medicare Supplemental Plan as further described below.

<u>Benefit expiration</u>: As of April 1, 2021, recipients will have their reimbursement benefit expire under the following terms or their death, whichever is earliest:

1. For recipients who, as of April 1, 2021, are age 74 or older, the reimbursement benefits will terminate on March 31, 2022;

2. For recipients who, as of April 1, 2021, are age 71 but less than age 74, the reimbursement benefit will terminate as of December 31, 2022;

3. For current and future recipients as of April 1, 2021, who are not yet age 71, the reimbursement benefit will terminate as of the end of the month as of the earlier of (1) your attainment of age 72, or seven (7) years of coverage under the Medicare Supplemental Reimbursement Benefit. However, if you were both (a) under the age of 65, and (b) disabled as of June 1, 2018, your benefits will terminate as of May 31, 2025.

3. <u>The Plan is amended to add an HRA Plan that provides as follows</u>:

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Establishment of HRA feature to the Plan

The Board of Trustees for the Heat and Frost Insulators Local 34 Health & Welfare Plan (the "Plan") established this Health Reimbursement Arrangement (HRA) as a feature of the Plan, effective April 1, 2022 (the "Effective Date") for claims first incurred on and after January 1, 2022. Capitalized terms used in this Appendix, if not otherwise defined in the combined Plan Document and Summary Plan Description (the "SPD"), will have the meanings set forth in Section 2 below.

The HRA is intended to permit a Covered Individual to obtain reimbursement of Medical Care Expenses on a non-taxable basis from the HRA Account. This Plan will be available to active Eligible Employees and Retirees who meet the eligibility requirements found below.

Legal Status

This HRA Plan feature is intended to qualify as an employer-provided medical reimbursement arrangement under Internal Revenue Code (the "Code") §§ 105 and 106 and regulations issued thereunder, and as a

Health Reimbursement Arrangement as defined under IRS Notice 2002-45 and will be interpreted to accomplish that objective.

The Medical Care Expenses reimbursed under the HRA Plan are intended to be eligible for exclusion from gross income under Code § 105(b).

Definitions Applicable to the HRA Plan

Benefits. The reimbursement benefits for Medical Care Expenses as defined below.

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

Covered Individual. An Eligible Employee, Retiree, and Spouse and Dependent of those individuals.

Dependent. As defined in the Definitions section of the SPD.

Employee or Eligible Employee. An Employee or Retiree eligible to participate in this portion of the Plan, as provided in the Eligibility to Participate Section below.

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

HRA Account. The HRA Account described in the Establishment of Account Section.

Medical Care Expenses. Expenses as defined in the Eligible Medical Expenses Section.

Period of Coverage. The HRA Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it will mean the portion of the Plan Year following the date participation commences, as described in Eligibility Section; and (b) for Employees who terminate participation, it will mean the portion of the Plan Year prior to the date the Eligible Employee's participation in the Plan terminates.

Plan. The Heat and Frost Insulators Local 34 Health & Welfare Plan, as set forth herein and as amended from time to time, including this HRA Section.

Plan Administrator. The Plan has contracted with HealthPartners to administer the HRA Account Plan. HealthPartners has full discretionary authority to act on behalf of the Board of Trustees, except with respect to appeals, for which the Board of Trustees has the full authority to act, as described in the SPD.

Retiree. An eligible Retiree who is covered under the Plan's Limited Retiree Coverage and has a balance in their HRA Account.

HRA Plan Year. The calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short Plan Year representing the initial Plan Year or where the Plan Year is being changed. In such case, the Plan Year will be the entire short Plan Year.

Eligibility to Participate in HRA Plan

A Covered Individual is eligible to participate in this feature of the Plan if they are:

- An Eligible Employee who is member of Local 34 or has previously been an Eligible Employee and have any funds available in their HRA Account that have not otherwise been forfeited.
- A Non-Bargaining Unit Employee if their Employer has signed a Participation Agreement requiring HRA contributions.
- A Retiree is eligible to participate in this HRA Plan if:
    - They are currently a Retiree covered under the Retiree Coverage provisions of the Plan, and
    - They have an HRA Account balance.

Establishment of Account

The Plan Administrator will establish and maintain an HRA Account with respect to each Eligible Employee but will not create a separate fund or otherwise segregate assets for any individual participant for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts from the Trust.

- *Crediting of Accounts.* An Employee's HRA Account will be credited at the end of each month with an amount equal to the applicable rate specified in the Contributing Employers collective bargaining agreement or Participation Agreement with the Plan, which has been actually received by the Plan.

- *Debiting of Accounts*. An Employee's or Retiree's HRA Account will be debited during each Period of Coverage for all applicable reimbursements, recordkeeping expenses and those other plan administrative expenses charged to the account by the Board of Trustees.

- *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Employee's or Retiree's HRA Account reduced by prior reimbursements and deductions for administrative expenses.

Carryover of Accounts

Any unused amounts in an Employee's or Retiree's HRA Account can be carried over from one HRA Plan Year to the next.

Termination of Participation – Eligible Employee

An Employee will cease to be an Eligible Employee in this HRA Plan upon the earlier of:
- The termination of this HRA Plan and/or the Plan in general; or
- The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA Coverage as provided below or under the Plan's Limited Retiree Coverage provisions.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Reimbursement after Termination Section (relating to a run-out period for submitting claims incurred prior to termination, relating to COBRA and reimbursement for Excepted Health Benefits).

Forfeiture of HRA Account Balance

An Eligible Employee will forfeit his HRA Account Balance (Active or Retiree) if the Employee suffers a break in coverage under this Plan of more than one year. A break in coverage for purposes of forfeiture of

an HRA Account Balance means the Employee has no coverage of any kind (Active, Self-Pay, COBRA or Retiree) under the Plan for a year or more.

Termination of Participation – Retiree

A Retiree will cease to be an eligible Retiree in this HRA Plan upon the earlier of:

- The termination of this HRA Plan and/or the Plan in general; or
- The date on which the Retiree exhausts his balance in his HRA Account.

Retirees will be able to spend-down the HRA Account they accrued after they reach age 65 as long as they maintain a balance sufficient to pay any administrative expenses.

FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if an Eligible Employee goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Plan will continue to maintain the Eligible Employee's Benefits on the same terms and conditions as if the Eligible Employee were still an active Employee.

Benefits Offered

When an Employee becomes covered in accordance with the terms of the Plan, and if the applicable collective bargaining agreement requires contributions to the HRA portion of the Plan, an HRA Account will be established for such Employee to receive Benefits in the form of reimbursements for Medical Care Expenses.

In no event will Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

An Employee will have the option to use his HRA Account for reimbursement of his eligible Medical Care Expenses while he is either an Eligible Employee or an eligible Retiree, as long as he also continues to have a positive HRA Account balance and covers all administrative expenses.

Employer Contributions Only

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

- *No Funding under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions over which an Employee exercises control (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or such employer contribution be treated as Employer contributions to the HRA feature of the Plan.

Funding This HRA Plan Feature

All the amounts payable under this HRA Plan will be paid from the general assets of the Trust. Nothing herein will be construed to require the Board of Trustees to maintain any fund or to segregate any amount for the benefit of any Employee, and no Employee or other person will have any claim against, right to, or

security or other interest in any fund, account or asset of the Trust from which any payment under this Plan may be made, except for benefits properly payable during the existence of the HRA plan feature. The HRA accounts are not vested benefits. HRA accounts are subject to revision or elimination by the Board of Trustees.

Eligible Medical Care Expenses

Under the HRA Account, a Covered Individual may receive reimbursement for Medical Care Expenses that are incurred under either this Plan during a Period of Coverage or, if not Incurred while a Participant in this Plan, are Incurred while covered under another form of group medical insurance.

- *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is paid by the Covered Individual. Medical Care Expenses incurred before a Covered Individual first becomes covered by the Plan are not eligible.

- *Medical Care Expenses Generally.* "Medical Care Expenses" means expenses incurred by a Covered Individual for medical care, as defined in Code § 213(d) (including, for example, amounts for certain Hospital bills, doctor and dental bills and prescription drugs). Reimbursements paid for Medical Care Expenses incurred by a Covered Individual will be charged against the Employee's or Retiree's HRA Account. See the examples of benefits eligible and ineligible for reimbursement at the end of this HRA Plan section.

- *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Covered Individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through other insurance, including any other accident or health plan (see below if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements for reimbursement.

Reimbursement Procedures with HealthPartners

HealthPartners administers the HRA Account. You must submit for reimbursement to HealthPartners by following the procedures listed below.

- *Manual Submission of Claims*. Eligible Employees can submit their claims for reimbursement manually through the following methods:
    - From their phone via the **myHP** mobile app;
    - You can log onto your account at www.healthpartners.com and submit your claim online; or
    - You can submit a claim for reimbursement using a reimbursement request form. Completed forms can be sent by mail or fax to the address and number on the bottom of the form. Reimbursement request forms can be found at www.healthpartners.com.

- *Claims Substantiation*. An Eligible Employee must substantiate their claims when submitted via one of the above noted options. The substantiation must set forth:
    - The person or persons on whose behalf Medical Care Expenses have been incurred;
    - The nature and date of the Medical Care Expenses so incurred;
    - The amount of the requested reimbursement; and
    - A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application will be accompanied by copies of bills, invoices, or other statements showing that the Medical Care Expenses have been incurred, and the amounts of such Medical Care Expenses, together with any additional documentation that HealthPartners may request.

- *Timing of Reimbursement*. HealthPartners reimburses substantiated claims on a weekly basis. Claims submitted by 11:00 a.m. on Thursday will be reimbursed the next week. Claims submitted after 11:00 a.m. on Thursday will be reimbursed within two weeks.

- *Claims Denied*. Refer to the appeals procedures described in the SPD (page 48) for information about reimbursement of claims that are denied.

Reimbursements after Termination; COBRA

When an Eligible Employee ceases to be a Participant, the Employee will not be able to receive reimbursements for Medical Care Expenses incurred after his participation terminates (with the exception of the Employee retiring and having an HRA balance available). However, such Employee (or the Employee's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Employee (or the Employee's estate) files a claim within twelve months of the termination of their participation.

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

Coordination of Benefits; Health FSA to Reimburse First

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source will pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Employee's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims will be administered in accordance with the claim procedure set forth in the SPD. The Board of Trustees acts on behalf of the Plan with respect to appeals.

Reliance on Covered Individual

The Board of Trustees may rely upon the information submitted by a Covered Individual as being proper

under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by a Covered Individual.

GENERAL PROVISIONS

Expenses

The Plan will pay the expenses of administering the HRA Plan via an annual January deduction from each Eligible Employees HRA Account to cover the coming calendar year's administrative expenses. As of adoption of the HRA Plan, the monthly administrative fee is $4.75 per month providing for an annual administrative fee of $57.00. The trustees reserve to increase or decrease the monthly administrative fee should they deem it necessary. If Eligible Employees do not have a sufficient balance in January to cover the coming calendar year expenses, their account balance will go negative until such time as incoming contributions are first sufficient to pay the outstanding administrative fee.

No Guarantee of Tax Consequences

Neither the Board of Trustees nor the Employers makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee or Retiree under this Plan will be excludable from the Employee's or Retiree's gross income for federal state or local income tax purposes. It will be the obligation of the Employee or Retiree to determine when each payment under this Plan is excludable from the Employee's or Retiree's gross income for federal, state and local income tax purposes, and to notify the Board of Trustees if the Employee or Retiree has any reason to believe that such payment is not so excludable.

Indemnification of Trust and Plan

If any Employee or Retiree receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Employee or Retiree will indemnify and reimburse the Trust for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes form such payments or reimbursements.

Non-Assignability of Rights

The right of any Employee or Retiree to receive any reimbursement under this Plan will not be alienable by the Employee or Retiree by assignment or any other method and will not be subject to claims by the Employee's or Retiree's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Eligible HRA Benefits

The HRA will reimburse any qualified medical care expense under IRS Code §213(d) incurred during a period of coverage. The following expenses are eligible for reimbursement in accordance with the rules and procedures in this HRA Plan. However, this is not intended to be an all-inclusive list. Other expenses not listed here may be reimbursable.

• Acupuncture	• Oxygen and Oxygen Equipment
• Ambulance	• Physiotherapist Services
• Artificial Limb	• Podiatrist Services
• Bandages	• Postnatal Treatments

• Birth Control Pills	• Practical Nurse Medical Services
• Braille Books and Magazines	• Pregnancy Test Kit
• Contact Lenses	• Prescription Medicines
• Crutches	• Prosthesis
• Dental Treatment	• Psychiatrist, Psychoanalyst, Psychologist Services
• Dental X-rays	• Psychotherapy
• Dentures	• Qualified Long-Term Care Insurance Premiums (up to certain limits)
• Diagnostic Devices	• Registered Nurse Services
• Eyeglasses and Surgery	• Special School Costs for the Handicapped
• Fertility Enhancement	• Stop Smoking Programs
• Guide Dog	• Telephone or TV Equipment to Assist the Hard-of-Hearing
• Hearing Aids and Batteries	• Therapy Equipment
• Hospital Bills	• Transportation Expenses (relative to health care)
• Hydrotherapy	• Vaccines
• Insurance premiums for COBRA, Medicare or self-payments for coverage	• Vasectomy
• Lodging (away from home for outpatient care)	• Vitamins (if prescribed)
• Obstetrician Services	• Weight-Loss Program
• Ophthalmologist, Optician, Optometrist Services	• Wig
• Oral Surgery	• Wheelchair
• Orthopedic Shoes	• X-rays
• Over-the-Counter Medications (if prescribed by a Physician, doctor or surgeon)	

Non-Reimbursable HRA Expenses

"Qualified Medical Care Expenses" will not include the following expenses (not an exhaustive list):

• Athletic, Fitness, or Health Club Membership (unless prescribed by a physician)	• Maternity Clothes
• Automobile Insurance Premium (allocable to medical coverage)	• Medicare Supplemental Insurance Coverage Premiums
• Boarding School Fees	• Premiums for health insurance for individual or group policies other than the Plan
• Bottled Water	• Scientology Counseling
• Commuting Expenses of a Disabled Person	• Social Activities
• Cosmetic Surgery and Procedures	• Special Foods or Beverages
• Cosmetics, Hygiene Products, and Similar Items	• Specially Designed Car for the Handicapped (other than an autoette or special equipment)
• Diaper Service	• Swimming Pool
• Domestic Help	• Travel (for general health improvement)
• Funeral, Cremation, or Burial Expenses	• Voluntary Abortion Expenses
• Health Programs offed by Resort Hotel, Health Clubs, and Gyms	• Weight Loss Programs (for general health)
• Illegal Operations and Treatments	• Any item not considered “Medical Care” under IRC Section 213
• Massage Therapy (unless prescribed)	

PLEASE KEEP THIS NOTICE WITH YOUR PLAN BOOKLET.

IF YOU HAVE QUESTIONS REGARDING THE PLAN, PLEASE CONTACT THE PLAN ADMINISTRATOR AT (952) 851-5948.

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The Combined Master Plan Document and Summary Plan Description (that is, the Plan Booklet dated April 1, 2021) of the Heat and Frost Insulators Local 34 Health and Welfare Plan has been amended effective immediately for the coverage of At-Home Covid-19 Test Kits.

1. Plan Coverage of At-Home Covid-19 Test Kits

Pursuant to recent U.S. Department of Labor guidance, the Plan will provide coverage for at-home Covid-19 tests subject to the following provisions.

- **When was coverage of at-home Covid-19 tests effective?** Covid-19 tests are covered if purchased on and after January 15, 2022, and through the end of the declared public health emergency related to Covid-19.

- **What is the best way to purchase the tests?** The best way for you to purchase a test is at your ProAct in-network pharmacy. Be sure to purchase the tests at the pharmacy window (rather than the main checkout) so that the claims can be properly processed by ProAct.

    - **Please note that there are free at-home Covid-19 Tests available from the federal government:** Every home in the U.S. is eligible to order 4 free at-home Covid-19 tests. Go to www.COVIDtests.gov to order your free at-home Covid-19 tests.

- **How many tests are covered?** Coverage is provided for up to eight (8) tests per covered individual in a 30-day period. Coverage is provided through the Plan's prescription drug benefit program administered by ProAct.

    - For example, a family of four covered under the Plan, may receive at no cost up to 32 tests (8 per covered person) in a 30-day period if purchased at an in-network provider.

- **What kind of tests are covered?** Only FDA-approved tests will be covered under this program. Go to www.fda.gov to learn which tests are currently FDA approved or check the packaging on the test before purchasing.

- **Do I have to pay anything for the tests if I buy them in-network?** No. The Plan will cover the cost of at-home Covid-19 tests without cost-sharing (no deductible or coinsurance) for tests purchased directly or online at a ProAct in-network pharmacy.

- **What if I purchased the tests out-of-network?** If you purchase tests from an out-of-network pharmacy, your reimbursement will be the actual amount you paid per test or $12 per test, *whichever is less*. If you purchased at-home Covid-19 tests at an out-of-network pharmacy, you must submit for reimbursement of your expenses through ProAct in the method listed below under *"What if I already bought and paid for tests before receiving this notice or if I purchased tests from a non-network provider?"*

- **What if I already bought and paid for tests before receiving this notice or if I purchased tests from a non-network provider?** If you purchased tests previously, or purchased them from a non-network provider and have your receipts for the purchase, you can submit for reimbursement through ProAct via use of the ProAct Direct Member Reimbursement Form.

  You may submit this form in the following ways:

  - Mail: ProAct, Inc., 1230 HWY 11, Gouvernor, NY 13642, Attn: DMR Dept.
  - Fax: (315) 287-7864
  - Email: dmr@proactrx.com

  You can access the Direct Member Reimbursement Form at the Plan's website: www.insulators34benefits.com.

  If you have questions about coverage through the prescription drug program as administered by ProAct, please contact ProAct at: 1-877-635-9545.

- **Important note:** Covered at-home Covid-19 tests include only those for at-home medical use by you or your covered household family members. Tests for employment purposes, resale, or travel requirements will not be covered or reimbursed under this program.

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Heat and Frost Insulators Local 34
Fringe Benefit Funds
3001 Metro Drive, Suite 500
Bloomington, MN 55425
P: 952·851·5948
F: 952·854·1632

To: Participants of the Heat & Frost Insulators Local 34 Health and Welfare Plan

From: Board of Trustees

Re: New Plan Document and Summary Plan Description Effective April 1, 2021

Date: February 1, 2021

The Board of Trustees for the Heat and Frost Insulators Local 34 Health and Welfare Plan (the "Plan") are pleased to distribute to you a new Plan Document and Summary Plan Description (SPD) for the Plan effective April 1, 2021.

In preparing this new SPD for you, the trustees have also made a number of changes to the Plan that are also effective April 1, 2021. These changes have been made with the future financial security of the Plan in mind.

The remainder of this notice outlines those changes to the Plan effective April 1, 2021. All the changes below are also reflected in the new SPD.

MEDICAL BENEFITS

The Trustees have made the following changes to the Schedule of Medical Benefits for the Plan.

Annual Individual and Family Deductible	
Benefit Changes effective on and after April 1, 2021	**Benefits Prior to April 1, 2021**
Annual Deductible for In-Network Services: Individual: $400 Family: $800	Annual Deductible for In-Network Services: Individual: $200 Family: $400
Annual Deductible for Out-of-Network Services: Individual: $800 Family: $1,600	Annual Deductible for Out-of-Network Services: Individual: $200 Family: $400

Deductible Example

The deductible is determined on a calendar year basis. At the start of the 2021 calendar year, the individual in-network deductible is $200. On April 1, 2021, the individual in-network deductible will increase to $400 per calendar year (the out-of-network individual deductible will increase to $800 per calendar year).

If prior to April 1, 2021 you have met the $200 individual in-network deductible, after April 1, 2021, you will have to meet the $400 in-network individual deductible. This means you will have to pay another $200 out of pocket before the Plan will pay benefits.

The same conversion will occur for the out-of-network deductible as well.

Individual and Family Out-of-Pocket Maximum	
Benefit Changes effective on and after April 1, 2021	**Benefits Prior to April 1, 2021**
In-Network Out-of-Pocket Maximum Each Calendar Year: Individual: $2,400 Family: $4,800	In-Network Out-of-Pocket Maximum Each Calendar Year: Individual: $1,200 Family: $2,400
Out-of-Network Out-of-Pocket Maximum Each Calendar Year: Individual: $4,800 Family: $9,600	Out-of-Network Out-of-Pocket Maximum Each Calendar Year: Individual: $1,200 Family: $2,400

Out-of-Pocket Maximum Example

The out-of-pocket maximum is determined on a calendar year basis. At the start of the 2021 calendar year, the individual in-network out-of-pocket maximum is $1,200. On April 1, 2021, the individual in-network out-of-pocket maximum will increase to $2,400.

If prior to April 1, 2021 you have met the $1,200 individual in-network out-of-pocket maximum, after April 1, 2021, you will have to meet the $2,400 in-network individual deductible. This means you will have to pay another $1,200 out of pocket before you will meet the individual out-of-pocket maximum for 2021.

The same conversion would occur for the out-of-network maximum out-of-pocket benefit as well.

Benefit Changes effective on and after April 1, 2021	**Benefits Prior to April 1, 2021**
Covered Percentage of Expenses (Coinsurance)	**Covered Percentage of Expenses (Coinsurance)**
In-Network: After Deductible, 80% of most eligible services. Out-of-Network: After Deductible, 70% of most eligible services.	In-Network: After Deductible, 90% of most eligible services. Out-of-Network: After Deductible, 80% of most eligible services.
Preventive Care: In-Network: 100% Out-of-Network: 70% after Deductible	**Preventive Care:** In-Network: $20 copay; then 100% Out-of-Network: 80% after Deductible
Emergency Room: $100 copay/visit, then 100% coverage (In or Out-of-Network)	**Emergency Room:** $60 copay/visit, then 100% coverage (In or Out-of-Network)
Physical Speech and Therapy: In-Network: $30 copay/visit; then Plan pays 100% Out-of-Network: 70% after the Deductible	**Physical Speech and Therapy:** In-Network: $20 copay/visit; then Plan pays 100% Out-of-Network: 80% after the Deductible

Benefit Changes effective on and after April 1, 2021	Benefits Prior to April 1, 2021
Prescription Drugs Prescription Drug Out-of-Pocket Maximum per Calendar Year: In-Network: $5,000 per individual; $10,000 per family. Out-of-Network: No Benefit Retail Pharmacy: Participant Copay is 15% subject to the minimums below: $5 – Generic $20 - Brand Name (formulary) $35 – Brand Name (non-formulary) Note: In-Network only. There is no out-of-network prescription drug benefit. Mail Order: Participant Copay is 15% subject to the minimums below: $10 – Generic $40 - Brand Name (formulary) $70 – Brand Name (non-formulary)	**Prescription Drugs** Prescription Drug Out-of-Pocket Maximum per Calendar Year: There was no previous out-of-pocket maximum for prescription drugs. Retail Pharmacy: $5 – Generic $20 - Brand Name (formulary) $35 – Brand Name (non-formulary) Note: In-Network only. There is no out-of-network prescription drug benefit. Mail Order: $10 – Generic $40 - Brand Name (formulary) $70 – Brand Name (non-formulary)

DENTAL BENEFITS

The Trustees have made the following changes to the Schedule of Medical Benefits for the Plan.

Benefit Changes effective on and after April 1, 2021	Benefits Prior to April 1, 2021
Orthodontia Maximum: $1,500 lifetime All other Dental Benefits: $1,500 per calendar year Note: Any participants who started orthodontia treatment prior to April 1, 2021, will remain subject to the prior $2,000 lifetime maximum.	Orthodontia Maximum: $2,000 lifetime All other Dental Benefits: $2,000 per calendar year

EARLY RETIREE ELIGIBILITY FOR BARGAINING UNIT EMPLOYEES – CREDITED SERVICE

Effective April 1, 2021, the Plan has made changes to the thresholds required to earn Credited Services under the Plan, and those changes are dependent upon whether you are age 55 and older as of April 1, 2021 or if you are younger than age 55 as of April 1, 2021, as further detailed below.

Per the Plan, credited service hours are hours for which a participating employer makes contributions to the Trust while you are working either as a permit employee or as a member of Local 34. Your credited hours include reciprocal hours earned on and after January 1, 2017 from another plan when traveling as a member of Local 34. Hours worked as a traveling member of another local union do not count as credited hours. These policies were in place before April 1, 2021 and will continue to be in place after April 1, 2021.

Credited hours also include hours credited during a period of disability according to the terms of the section entitled Continuation Coverage.

For purposes of this Retiree Coverage, the following rules apply with regard to your accumulation of credited service.

Benefit Changes effective on and after April 1, 2021

Participants age 55 and older as of April 1, 2021

For participants who are age 55 and older as of April 1, 2021, one (1) year of credited service equals 1,200 hours under the Plan in a calendar year.

If you are credited with less than 1,200 hours in a calendar year, no credited service will be granted; there will be no partial years of credited service.

Participants younger than age 55 as of April 1, 2021

For participants who are younger than age 55 as of April 1, 2021, credited service is defined as follows:

- 1,400 – 1,499 hours under the Plan in a calendar year will equal 0.5 of a year of credited service;
- 1,500 – 1,599 hours under the Plan in a calendar year will equal 0.75 of year of credited service;
- 1,600 hours or more under the Plan in a calendar year will equal one (1) year of credited service.

If you are younger than age 55 on April 1, 2021 and are credited with less than 1,400 hours in a calendar year, no credited service will be granted.

Benefits Prior to April 1, 2021

Credited Service

For purposes of Retiree Coverage, participants received one (1) year of credited service for each

calendar year in which the participant was credited with at least 1,200 hours under the Plan.

MEDICARE SUPPLEMENTAL REIMBURSEMENT BENEFIT (POST-65 COVERAGE)

Effective April 1, 2021, the Board of Trustees has made a number of changes to the Plan with regard to the Medicare Supplemental Reimbursement Benefit (post-65 coverage) for participants and their spouses. The changes relate to overall eligibility for the Medicare Supplement Reimbursement Benefit, how long Medicare Supplemental Benefits will last and the cost of coverage for your spouse.

Medicare Supplemental Reimbursement Benefit - Participant Eligibility

Benefit Changes effective on and after April 1, 2021

Benefit Eligibility: Effective on and after April 1, 2021, former bargaining unit employees will be eligible to receive this reimbursement benefit if they:

1. Have eighteen (18) total years of coverage under the Plan: and

2. Have five (5) consecutive years of coverage under the Plan immediately prior to retirement.

If you do not meet both the above service requirements, you are ineligible for this reimbursement benefit.

To receive the reimbursement benefit, you must be enrolled in Medicare and in a Medicare Supplemental Plan.

Benefits Prior to April 1, 2021

Former bargaining unit employees who met one of the following criteria were eligible to receive the benefit:

1. The individual was less than 65 years of age, disabled and became entitled to Medicare due to an ongoing Social Security-eligible disability that commenced while covered by the Plan, and had a minimum of 5 consecutive years of coverage under the Plan immediately preceding the onset of the disability.

2. The individual elected early retirement on or after the age of 52 under the Plan's Early Retirement benefit and continued that coverage until becoming entitled to Medicare at age 65.

3. The individual retired at age 65, had a minimum of 5 consecutive years of coverage under the Plan immediately preceding retirement, and is entitled to Medicare benefits.

4. If an individual did not satisfy the eligibility requirements of subparagraphs 2 or 3, immediately above, they were still eligible for the Medicare Supplement benefit if they had twenty (20) years of Credited Service under the Plan. However, if an individual only satisfied the eligibility provisions of this subparagraph 4 (and not subparagraphs 2 or 3), that individual's spouse who had not yet attained Medicare eligible age was not be eligible for coverage on the same basis as the spouse of an active Employee.

Medicare Supplemental Reimbursement Benefit – The Date a Participant's Receipt of the Benefit Expires

Effective April 1, 2021, there will be an expiration date on the receipt of the Medicare Supplemental Reimbursement Benefit.

What this means is the Plan, as further detailed below, will no longer provide the Medicare Supplemental Benefit after you reach a certain threshold. This does not mean that you cannot continue your Medicare Supplemental coverage. You may do so, but you must pay the full premium. The Plan will no longer provide a subsidy.

Benefit Changes effective on and after April 1, 2021	**Benefits Prior to April 1, 2021**
Benefit expiration: As of April 1, 2021, recipients will have their reimbursement benefit expire under the following terms or their death, whichever is earliest: • For recipients who, as of April 1, 2021, are age 74 or older, the reimbursement benefit will terminate on March 31, 2022; • For recipients who, as of April 1, 2021, are age 71 but less than age 74, the reimbursement benefit will terminate as of the end of the month you attain age 75; • For current and future recipients as of April 1, 2021 who are not yet age 71, the reimbursement benefit will terminate as of the end of the month you attain age 72. • While the benefit from the Plan will cease on the above noted dates, you may continue to maintain Medicare Supplemental Coverage at your own cost.	Previously, the Medicare Supplemental Reimbursement Benefit continued until the retiree's death.

Medicare Supplemental Reimbursement Benefit - Cost of Spouse Coverage

Effective April 1, 2021, the Plan has adopted changes to its provisions regarding the eligibility of a retiree's spouse when the retiree reaches age 65 and their spouse has not reached that age. The spouse's coverage and the cost for coverage will be subject to new rules as provided below:

Benefit Changes effective on and after April 1, 2021
Spousal Eligibility: In the case of a **retiree** eligible for coverage under this reimbursement benefit, but whose spouse has not yet reached the age of 65, such spouse will continue to be eligible for Plan coverage per the following premium schedule: • Non-Medicare eligible spouses covered *as of* April 1, 2021: For a non-Medicare spouse covered by the Plan as of April 1, 2021, the cost of coverage will be 75% of the applicable monthly retiree premium that would apply to a participant who was under age 62 (regardless of the participant's or spouse's actual age), enrolled in Retiree Coverage under this Plan, and had the same number of years of Credited Service. • Non-Medicare eligible spouses of participants who become eligible for Medicare *on and after* April 1, 2021: For non-Medicare spouses of participants who become eligible for Medicare on and after April 1, 2021, the monthly cost of coverage for such non-Medicare covered spouse will be 100% of the applicable retiree premium that would apply to a participant who was under age 62 (regardless of the participant's or spouse's actual age), enrolled in Retiree Coverage under this Plan, and had the same number of years of Credited Service. This spousal coverage under the Plan terminates on the first day of the month in which the spouse reaches age 65.
Benefits Prior to April 1, 2021
• Previously, a spouse of the participant who has not yet reached the age of 65 continued to be eligible under the Plan on the same basis as the spouse of an active Employee. • The monthly cost for this spousal coverage was equal to 50% of the monthly retiree premium that would apply to a participant who was under age 62 (regardless of the participant's or spouse's actual age), enrolled in Retiree Coverage under this Plan, and had the same number of years of Credited Service.

EXTERNAL REVIEW OF CLAIM APPEALS

Effective April 1, 2021, the Plan has added provisions providing for an additional level of appeal. Specifically, should the Board of Trustees for the Plan deny your claim appeal under the procedures contained in the Plan, you will now have one additional level of appeal. This appeal will be to an outside third-party Independent Review Organization (IRO). The procedures for you to access the external review are detailed in the new Plan Document and Summary Plan Description.

EXCLUSION FOR SEX TRANSFORMATION BENEFITS

For legal compliance purposes, the Plan is amended to remove its exclusion of charges incurred for any operation or treatment in connection with sex transformations or any type of sexual dysfunction, including any complications arising therefrom.

IF YOU HAVE QUESTIONS REGARDING THE PLAN, PLEASE CONTACT THE PLAN ADMINISTRATOR AT (952) 851-5948.

Sincerely,

Board of Trustees – Heat and Frost Insulators Local 34 Health and Welfare Plan

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