Duluth Building Trades Health Fund

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SUMMARY OF MATERIAL MODIFICATIONS – NO. 3

The Summary Plan Description for the Duluth Building Trades Health Fund dated September 1, 2023, is hereby amended as follows:

1. Effective May 1, 2024, on page 8, the Plan's "Initial Eligibility" rules are amended by adding a new section as follows:

Employees Of Signatory Employers First Entering The Plan

When an employer that was previously signatory to a labor contract with a sponsoring union requiring contributions to a different health plan first becomes obligated to contribute to this plan, the following rules apply to the initial eligibility of the bargaining unit employees of the employer. Employees will become eligible on the first of the month after the Fund's receipt of an amount equal to 150 hours multiplied by the then current active employee contribution rate. The payment may be made through a combination of employer contributions, employee self-payments or a transfer from the health plan the employer previously made contributions to. During the employees' first twelve months after their initial eligibility begins, their continuing eligibility requires contributions and/or self-payments based upon 150 hours per month.

2. Effective May 1, 2024, on page 17, add a new section titled Rescission of Coverage following the current section titled When Eligibility Ends, as follows:

Rescission of Coverage

The Fund may rescind your coverage for an act or omission that constitutes fraud or an intentional misrepresentation of a material fact after the Fund provides you with 30 days advance written notice of such recission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud or an intentional misrepresentation of a material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Fund. However, the following situations will not be considered rescissions of coverage and do not require the Fund to give you 30 days advance written notice:

- The Fund terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Fund of your termination of employment;
- The Fund retroactively terminates your coverage because of your failure to timely pay required self-payments or contributions for your coverage; and,
- The Fund retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Fund when you should not have been covered, the Fund will cancel your coverage prospectively – for the

future – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Fund to give you 30 days advance written notice.

3. Effective May 1, 2024, on page 34, under the heading "Covered Medical Expenses" amend #2 to state as follows:

2. Charges for Midwives: The Plan covers expenses incurred by the mother for services of a licensed traditional midwife or a nurse midwife. The services of a licensed traditional midwife or nurse midwife are not payable in connection with a delivery unless performed in a hospital or birthing center;

4. Effective May 1, 2024, on page 56, add a new section titled Worker Wellness Program Benefit as follows:

WORKER WELLNESS PROGRAM BENEFIT

Effective May 1, 2024, the Plan established a Worker Wellness Program ("WWP") which provides eligible employees with a wage replacement payment when they take a day off from work for a Qualifying Leave. This benefit is only available to employees performing work under a collective bargaining agreement requiring contributions to the Plan for the WWP Benefit. Consult your applicable collective bargaining agreement to determine if contributions for WWP Benefits are covered by your agreement. The WWP Benefit is taxable.

A. WWP Account and Webpage Access

Various collective bargaining agreements provide that contributing employers will make a WWP contribution for each hour worked by employees covered by those agreements.

The Plan Administrator will establish an individual WWP Benefit Account for each such employee where WWP contributions and benefit payments will be tracked. The Plan will establish an employee's WWP Benefit Account once it receives a WWP Benefit contribution on behalf of an employee. Instructions for requesting payment of a WWP Benefit are set forth below in the section entitled "Claiming Your WWP Benefits."

You will access your WWP Benefit through the Plan's webpage at www.duluthbuildingtradeshealthfund.com. The webpage provides the following information:

- Eligibility status;
- WWP Benefit balance;
- The process to submit claims for WWP benefit payments.
- Steps to self-certify that you have experienced a Qualifying Leave.

You will need to provide a bank account and routing number for the Plan to electronically transfer your WWP Benefit to your bank account. You should receive the electronic transfer of the funds in your account within two to three days. Should you require a manual check for your WWP Benefit, contact Wilson-McShane.

There is no cap on the amount of WWP Benefits you may accrue and the amounts you accrue under the Plan rollover from year-to-year if they go unused. Your benefits will remain in your WWP Benefit Account if you switch to a different job with a contributing employer to this Plan. However, be mindful of the provisions in the "Termination of Eligibility and Forfeiture" section below.

B. Eligibility for WWP Benefits

You are eligible for a WWP Benefit if you meet the following requirements:

- You are eligible for active coverage under the Plan;
- You are covered by a collective bargaining agreement requiring hourly contributions for the WWP Benefit to the Plan; and
- You have a balance in your individual WWP Benefit Account from which to receive reimbursement for a Qualifying Leave.

Retirees and Non-Bargaining Unit Employees participating in the Plan under a participation agreement are ineligible for the WWP Benefit.

C. Qualifying Leave

WWP Benefits are payable for an eligible Qualifying Leave. An eligible Qualifying Leave day is defined as a day (or days) on which you are unable to work a normally scheduled day of work due to reasons such as:

- Your physical or mental illness, treatment or preventive care;
- A Family Member's physical or mental illness, treatment or preventive care;
- Closure of your workplace or a Family Member's school due to weather or public emergency; or
- Any other reason for which you did not work on a normally scheduled day of work.

For purposes of this Plan, the term "Family Member" means the participant's spouse, as well as any dependent child or qualifying relative of the participant as defined under IRS Code Section 152(a).

D. Claiming Your WWP Benefits

An employee that experiences a Qualifying Leave may submit a claim for WWP Benefits. To submit a claim you must:

- Submit the amount of WWP Benefits you are claiming. The gross amount of the cash payment will be the lesser of: 1) the current value of your WWP Account; or 2) an amount that is equal to your Applicable Hourly Wage times eight hours for each day or if less than a full day, the actual number of hours of your Qualified Leave. From the gross amount of the payment, the Plan will deduct and pay applicable State and Federal payroll taxes and income tax withholding. The amount paid to you will be the net amount after deductions for taxes. If you do not have an account set-up to accept an electronic payment, the minimal payment is four hours. The "Applicable Hourly Wage" is the amount of your base wages under the collective bargaining agreement providing for contributions to the Fund.; and

- Self-certify that you experienced a Qualifying Leave for the month for which you are seeking WWP Benefits;

For example:

- Bill's spouse has surgery and requires his assistance post-surgery.
- Due to the surgery Bill takes one day off to care for his spouse.
- Bill is eligible for active coverage, has $1,000 in his WWP Benefit Account and his "Applicable Hourly Wage" is $40.00 per hour.
- Bill has experienced a Qualifying Leave and his WWP Account Balance is sufficient to satisfy his WWP Benefit claim of $320.00 (8 hours x $40.00 per hour).

You must submit a claim for work you missed in any calendar year no later than January 15th of the following calendar year. If you fail to timely submit a claim with respect to a period of missed work, you will not be able to make a claim for that missed time. However, your unused WWP Benefit Account balance carries forward into the following calendar year.

WWP Benefits are taxable income to you. The Plan will issue you an annual IRS Form W-2 detailing the amount of WWP Benefits you received in a calendar year and the amounts of taxes that were withheld from your WWP Benefit payments.

E. Termination of Eligibility

Once you become eligible for a WWP Benefit, you remain eligible until your eligibility is terminated under the provisions below.

Your eligibility terminates for WWP Benefits upon the earliest of the following:

- The date the Health Plan is terminated.
- The date you begin working for an employer in an industry covered by the Plan that is not a Contributing Employer.
- You are deceased though your unused WWP balance (if any) will be paid to your estate.
- The date on which a) you are not eligible for active benefits under the Plan and b) the Plan has not received contributions on your behalf during the preceding thirty-six (36) months.
- Within thirty-six (36) month after you have: a) filed your retirement paperwork with the Plan Administrator, and b) no longer have active coverage under the Plan (active coverage includes coverage via a drawing down of your hours bank and making self-payments).

When your eligibility terminates, you may regain eligibility only by meeting the requirements for Eligibility for WWP Benefits. The amounts remaining in your account when your eligibility originally terminated due to one of the above noted events are reduced to zero and those amounts will not be reinstated if you re-establish eligibility.

5. Effective May 1, 2024, on page 65-66, the Second Level Appeal ("External Review") of the Claim Appeal Procedures is amended by adding a new paragraph 2 and renumbering the remaining paragraphs as follows:

Second Level Appeal ("External Review")

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2. Scope of Claims Eligible for External Review:

External review is not available for all denied claims. The only claims that are eligible for external review include:

a) Claims that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, or experimental or investigational nature of the treatment);

b) A rescission of coverage; and,

c) Any adverse benefit determination that involves or relates to the requirements of the No Surprises Act.

6. Effective May 1, 2024, on page 82, add a new definition for Birthing Center as follows:

Birthing Center- A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and licensed by the regulatory authority having responsibility for the licensing under the laws of jurisdiction in which it is located.

7. Effective May 1, 2024, on page 86, revise the definition of Physician or Surgeon as follows:

Physician Or Surgeon: Any individual, including a psychiatrist, consulting psychologist, psychologist, chiropractor, osteopath, podiatrist, optometrist, doctor of dental surgery, licensed traditional midwife and nurse midwife, who is licensed to practice by the governmental authority having jurisdiction over such licensure, and who is acting within the usual scope of the individual's practice.