INTERNATIONAL MASONRY TRAINING AND EDUCATION FOUNDATION
MATERNITY DISABILITY BENEFIT

SUMMARY PLAN DESCRIPTION

EFFECTIVE JUNE 1, 2022

Dear Participant:

The Board of Trustees of the International Masonry Training and Education Foundation (IMTEF) is pleased to provide you with this booklet describing certain features of the IMTEF Maternity Disability Benefit. The Trustees of the Fund have established this Plan to provide eligible members with valuable pregnancy- and maternity- related short-term disability benefits.

This booklet serves as both the Plan Document and the Summary Plan Description ("SPD" or "Plan") of the IMTEF Maternity Disability Benefit. This booklet has been written in simple, straightforward language. When this booklet refers to "you," it assumes that you are an eligible Participant covered by this Plan. This document describes how you become and remain eligible to receive benefits, how to apply for benefits, how to appeal a benefit decision, and the rights you and other participants are given by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Board of Trustees has full discretionary authority to interpret the Plan and decide all issues pertaining to the terms of this document and coverages available. The Board of Trustees may also, in its sole discretion, modify, amend or terminate the Plan and any of its provisions. As the Plan is amended from time to time, the Plan Administrator will send you information explaining the changes. Please be sure to read all Plan communications and keep them with this booklet.

In solidarity,

BOARD OF TRUSTEES

Contents

Plan Identifying Information

Name of the Plan	International Masonry Training and Education Foundation Maternity Disability Benefit
Type of Plan	Welfare Plan providing pregnancy- and maternity-related short-term disability benefits.
Funding Medium and Type of Plan Administration	This Plan is funded by Participating employer contributions pursuant to Collective Bargaining Agreements between the Union and participating employers or Other Written Agreements.
Address of Plan	IMTEF Board of Trustees c/o 17101 Science Drive Bowie, MD 20715
Third-Party Administrator	**Amalgamated Employee Benefits Administrators (AEBA)** **Disability Benefits Claim Dep't** **P.O. Box 5453,** **White Plains, NY 10602-5453** **Toll-Free: 1-866-975-4091** **Fax: 1-914-367-4114**
Agent for Service of Legal Process	Caryn A. Halifax President, IMTEF 17101 Science Drive Bowie, MD 20715
Plan Sponsor	The Board of Trustees of the International Masonry Training and Education Foundation

Employer Identification Number (EIN)	27-1494284
Plan Effective Date	June 1, 2022
Plan Year	January 1-December 31
Plan Administrator	**Board of Trustees:** Union Trustees Timothy Driscoll (Co-Chair) Robert Arnold Jeremiah Sullivan Charles Raso Employer Trustees Michael Schmerbeck (Co-Chair) Gregory Hess Robert Hoover Daniel Kwiatkowski John Trendell

-Remainder of page left intentionally blank-

I. DEFINITIONS

Appeals Committee. The committee created for the purpose of reviewing those disability claims that were initially denied by the Initial Review Committee and whose denial was properly appealed. The Appeals Committee shall consist of two Trustees, including one Employer Trustee and one Union Trustee, who do not participate in the initial review of the disability claim.

Collective Bargaining Agreement. The current written agreement in effect between an Employer and the Union, or an affiliated local union or district council of the Union, which governs the working conditions, wages, and other related matters, and which calls for contributions to IMI or to IMTEF.

Contributing Employer. An Employer that is bound to a Collective Bargaining Agreement or Other Written Agreement requiring contributions to IMI or IMTEF.

Coverage. Applicability of Benefits to Plan Participants.

Covered Employment. Work under a Collective Bargaining Agreement or Other Written Agreement for which contributions must be paid to IMI or to IMTEF.

Disability or Disabled. A pregnancy-related physical illness or condition that makes an Employee unable to perform the full-time duties of her regular trade as certified by a Physician.

Employee. Individual who is covered by a Collective Bargaining Agreement or Other Written Agreement that requires an Employer to make contributions to IMI or to IMTEF on her behalf.

Employee Retirement Income Security Act of 1974 (ERISA). The federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer Contributions. The payment an Employer is obligated to make for service performed by an Employee, according to the terms of the Collective Bargaining Agreement or Other Written Agreement between the Union (or affiliate of Union) and an Employer or the Board of Trustees of the Trust and an Employer.

Initial Review Committee. The committee created for the purpose of determining whether claims are covered by the Plan. The Initial Review Committee shall be Amalgamated Employee Benefits Administrators (AEBA).

Masonry Industry. Any and all types of work covered by collective bargaining agreements to which the Union and/or any Local, District Council or State Conference are a party; or under the trade jurisdiction of the Union as that trade jurisdiction is described in the International Union's Constitution; or in a related building trade; or any other work to which a craftworker has been assigned, referred, or can perform because of her skills and training. The term "Masonry Industry" shall not include employment which is on referral by and authorized by the Union.

Noncovered Masonry Employment. Employment or self-employment in the Masonry Industry on or after June 1, 1988, either for an employer that does not have or which is not otherwise covered by a collective bargaining agreement with the Union or a Union affiliate.

Other Written Agreement. Agreement between the Trustees of this Plan and an employer that requires the employer to make contributions to this Plan.

Participant. An individual who meets the eligibility requirements specified in the Plan, as described under Eligibility above. A Participant must live and/or work in the United States.

Physician. An individual who is operating within the scope of her/ his medical license and is licensed to prescribe and administer prescription drugs or to perform surgery. Any nurse practitioner, midwife, nurse midwife or other qualified provider who acts within the scope of his or her license will be considered on the same basis as a Physician.

Plan. The plan of short-term disability benefits and the Rules and Regulations governing the eligibility of Employees for the benefits of this IMTEF Maternity Disability Benefit, as described in this document as amended from time to time.

Plan Administrator. International Masonry Training and Education Foundation or its designee.

Plan Sponsor. The Board of Trustees of the International Masonry Training and Education Foundation.

Union. The International Union of Bricklayers and Allied Craftworkers ("BAC"). An "affiliate" of the Union is any local union, district council or state conference affiliated with BAC.

II. ELIGIBILITY FOR COVERAGE

How do I become eligible to receive coverage?

If you are a BAC craftworker currently employed by, or seeking work from a Contributing Employer, you are eligible to receive Coverage if you meet the following minimum hours requirement:

1. You have worked at least 1,000 hours in Covered Employment in the 12 months immediately preceding your claim; and
2. Your Employer has made sufficient contributions to the IMI on your behalf and in accordance with the Collective Bargaining Agreement or Other Written Agreement and the terms of this Plan.

If you work the required hours to qualify for Coverage but your employer fails to make sufficient contributions to meet the tests described above, you will not receive Coverage.

Eligibility will be measured again using the requirements above with respect to any future claims related to future pregnancies.

Am I eligible to receive Coverage for a Pregnancy that arose or a baby that was born before June 1, 2022?

Eligibility requires 1,000 paid hours of "Covered Work" in the 12-month period immediately prior to the onset of the pregnancy-related disability or birth for which benefits are claimed. However, the amount of the benefit, if any, will be determined relative to the effective date of the Plan, as described below.

When does my eligibility for coverage end?

Your Eligibility for coverage ends at the end of the benefit period for which you have applied.

Your Eligibility for coverage and any payments thereof will also end if either of the following events occur:

1. If you become employed in the Masonry Industry and such employment is not covered by a collective bargaining agreement between the employer and the Union ("Non-Covered Masonry Employment"), your coverage under the IMTEF Maternity Disability Benefit will be terminated as of the date of that employment; or
2. If this plan is terminated, your coverage will end immediately.

III. BENEFITS PROVIDED

As specified in more detail below, if you are eligible for coverage, you may be eligible to receive Short-term Disability Benefits upon satisfying each of the following requirements:

You are suffering a pregnancy- or maternity-related physical Disability;

and

You provide proof that you are under the continuous care of a Physician with the Physician recommendation that you should not work as a result of such Disability for a defined period of time.

What is the amount of the benefit?

The benefit is $600 per week, for a maximum cumulative period of twenty-six (26) weeks for Pregnancy- and Maternity-related disability as set forth below. After 26 weeks, the benefit payments will stop regardless of whether you are able to return to work or not. In the event that an additional claim relates to the same pregnancy, the maximum benefit period of 26 weeks combines any claims related to the same pregnancy.

This benefit is taxable. The Plan will deduct from your benefit the amount required to be withheld by the Internal Revenue Service (IRS) for FICA (Federal Insurance Contributions Act) taxes and income taxes. You are paid the benefit net of any taxes withheld.

What is the Pregnancy (pre-Delivery/Birth) benefit?

This benefit is available for periods you have been certified by your physician to be unable to work due to physical limitations arising from your pregnancy, but not sooner than the 4th month of pregnancy. You may be required to provide re-certifications by your physician of continued inability to work from time to time during the pregnancy.

Note: Unless the doctor's certification eliminates sitting in a classroom, Apprentices are expected to continue their classroom training.

What is the Maternity benefit?

This benefit is available for periods you are disabled due to the birth of your own child (or children), as follows:

a. Up to six (6) weeks immediately following traditional delivery
b. Up to eight (8) weeks immediately following Cesarean delivery
c. For avoidance of doubt, the Maternity benefit is not available for
    - Surrogate related pregnancies
    - Adoptions
    - Foster care

When will my benefits begin?

Benefits begin with the first (1st) day of Disability due to Pregnancy or the date of the birth, but in no event prior to the date of the first treatment of the Participant by a Physician. Benefit payments cannot extend beyond the date of treatment by the Physician. The cumulative twenty-six (26) week limit benefit applies to each instance of pregnancy by a participant and any resulting birth(s).

Can I take the benefit intermittently?

The pregnancy- and maternity-related benefit may not exceed twenty-six (26) weeks total. You may take the benefit for intermittent periods during your pregnancy if your physician certification supports it. For benefit periods separated by two or more weeks of continuous, full-time active work, a new physician certification will be required.

The Maternity benefit must be taken in consecutive weeks immediately following the birth.

Can I receive benefits for a pregnancy that arose or a baby that was born before the Plan was in effect?

Yes, but only for the period of pre- or post-delivery benefit on and after the effective date of the Plan, and only if you meet the eligibility requirements of the Plan. Benefits will not be retroactively available for any period before June 1, 2022.

How will this benefit affect, or be affected by, any other public, collectively-bargained, or other pregnancy- or maternity-related benefits I am entitled to?

This benefit will not be offset for any other benefits you may be entitled to. To determine whether receipt of this benefit affects your entitlement to any of those other benefits, you should contact the relevant plan administrator or government program for each of those other benefits.

In situations where the Family and Medical Leave Act applies, paid benefits under this policy will run concurrently with FMLA leave.

Can this benefit be changed after I become pregnant?

This is not a vested benefit, and there is no guarantee that you will receive any benefit. The Board of Trustees expects to continue the Plan indefinitely, but it reserves the exclusive right to interpret this policy and/or modify any terms and conditions of this policy and to alter/ modify or discontinue the Plan in whole or in part, at any time and for any reason, at its sole determination.

IV. EXCLUSIONS

Regardless of whether you meet other Plan criteria, you will not receive a benefit for any period during which:

- You are not an active Participant (for example, you are a retiree, owner, operator of a contributing employer, officer or employee of the local union, or spouse or dependent);
- You are no longer disabled or you fail to provide any required proof that you are disabled;
- You are no longer under the direct care and treatment of a Physician for your disability;
- You are working for wage or profit;
- You do not meet the Plan's claim filing requirements (below);
- You already have received the maximum cumulative amount of benefits (26 weeks);
- You are a dependent of a member, but not a member yourself; or
- You die

V. FILING A CLAIM FOR BENEFITS

How do I file a Claim for benefits?

You must submit a disability claims form required by the Trustees. The form must be completed by you and your Physician and must contain a certification of your disability from your physician, and a statement that you are both under their care for your disability and that your disability directly prevents you from working or earning wage or profit. You also will be required to sign a HIPAA-compliant authorization(s) to permit the Plan

to obtain medical records from your Physician. The claims and authorization forms may be obtained from the plan administrator (AEBA) by calling **1-866-975-4091** or by visiting AEBA's website www.amalgamatedbenefits.com/AEBA/IMTEF. The completed forms should then be submitted to AEBA for consideration.

When must I file my claim?

You must file your completed claim form with the Plan Administrator (AEBA) not later than ninety (90) days following the start of your Disability. Your claim form shall be deemed filed with the Plan when it is received by AEBA. Any claim filed later than ninety (90) days shall be denied except in those instances where you are unable to file claim due to the nature of the disability. In this instance, a completed claim form must be filed within one hundred eighty (180) days following the commencement of the Disability.

Claims filed after this time period will be permanently denied.

When will my claim be paid?

Once benefits are approved, Short Term Disability Benefits will be paid on a weekly basis with the first payment adjusted in the event of any payments owed prior to the first payment. Unless you set up an electronic ACH account, you will receive a check from the Plan Administrator.

VI. CLAIMS REVIEW AND APPEALS

How long will it take to approve my claim?

All claims filed with the Plan will be reviewed anonymously to determine if they are covered by the Plan. Claims will first be reviewed by the Initial Review Committee who will review claims and provide notification of denials no later than forty-five (45) days after filing the claim for Disability benefits. If the Initial Review Committee requires an extension of time to make a decision due to matters beyond the Plan's control, a thirty (30) day extension, plus a second thirty (30) day extension, if needed, may be requested if notice of extension is given before the end of initial response period. The Plan may also request additional or missing information from the Employee within forty-five (45) days of receipt of the claim for benefits. The Employee will be given a minimum of forty-five (45) days to respond to the Plan's request for information. For an extension of time involving a claim that is due to an Employee's failure to submit information necessary to decide the claim, the time frame for the Plan to respond will be suspended (or tolled) from the date the notice of extension is given to the Employee until the date of response or, if earlier, the deadline to respond.

What if my claim is denied?

If the claim is denied in whole or part, the Plan will provide a written notice of determination which will include the following information:

1. The specific reason(s) for the determination;
2. Reference to the specific Plan provisions on which the determination is based;
3. A description of any additional information or material necessary to perfect the claim and the reasons why it is needed;
4. A copy of the Plan's Claims Review Procedure including the time periods to appeal the initial determination;
5. A statement of rights to bring a lawsuit under ERISA if benefits are denied after review; and,
6. A statement that (a) the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; (b) details the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were used in denying the claim, or a statement that none were used; and (c) contains a discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

What if I disagree with the claim decision?

If your claim is denied, reduced or terminated, or otherwise not fully paid, you have the right to have the initial decision reviewed by filing an appeal with the Plan within one hundred-eighty (180) days of the denial. If a written request for appeal is not timely, the initial decision on the claim will be final. If an appeal of the Plan's denial is timely filed, the appeal will be reviewed anonymously by the Appeals Committee. You or your authorized representative may make a written request for review to the Trustees.

If your appeal is timely, you may submit written comments, documents, records and other information relating to the claim. You may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim and identification of any medical or vocational experts whose advice was obtained by the Plan. A document, record or other information is "relevant" to the claim if (1) it was relied upon in making the determination or was submitted, considered or generated in the course of making the determination; or (2) it relates to administrative processes and safeguards used to ensure and verify that claim determinations are consistent with the Plan and that the Plan is consistently applied to similarly situated claimants; or (3) it is a statement of Plan policy or guidance concerning the denied benefit without regard to whether it was relied upon.

No deference shall be given to the initial determination. If the initial determination is based in whole or part on medical judgment, the Trustees shall consult with a health care professional, with appropriate medical training and experience, who was not consulted in

connection with the initial determination and who is not a subordinate of any individual who was consulted. The review on appeal shall take into account all comments, documents, records and other information submitted by the claimant and relating to the claim, without regard to whether it was submitted or considered in the initial determination. A decision denying benefits on appeal which is based on new or additional evidence, or rationales, not included when the benefit claim was denied at the claims stage will not be made without the claimant being given notice and a fair opportunity to respond.

A final determination of the claim on appeal shall be made at the next meeting of the Appeals Committee after the appeal is filed or, if filed within thirty (30) days of meeting, the second meeting thereafter. After the decision is made, you will be notified within 5 days of Plan decision.

What if my appeal is denied?

If your claim is denied in whole or part on appeal, the Plan will notify you of its adverse determination, which shall include the following:

1. The specific reasons for the determination, including a reference to the specific Plan provisions on which it is based;
2. A statement of the right, upon request, to examine and to receive copies, free of charge, of all documents, records, and other information relevant to the claim;
3. Information relating to any additional voluntary appeal or alternative dispute resolution options offered by the Plan;
4. A statement that a civil action suit may be filed under ERISA;
5. A statement that:
    a. details the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were used in denying the claim, or a statement that none were used; and
    b. contains a discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
    and,
6. If the determination is based on medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that it is available at no cost upon request.

The determination made on review of the claim following an appeal shall be final and binding on all persons.

VII. TRUSTEES' DISCRETIONARY AUTHORITY

The Board of Trustees shall perform its duties as Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret this Summary Plan Description, and to resolve and interpret any ambiguities that may exist and to make all necessary factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan. Any construction of the terms of this SPD and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Trustees may delegate such duties concerning administration and interpretation of the Plan as they deem necessary or appropriate, including matters involving the exercise of discretion. The Trustees may remove, with or without cause, at any time any person to whom duties are delegated by the Trustees.

VIII. Miscellaneous

What if I receive a benefit in error?

If the Fund makes payment for benefits that are in excess of allowable amounts, due to error (including for example, a clerical error) or fraud in Eligibility for coverage or for any other reason, the Fund reserves the right to recover such overpayment (plus processing fees, administrative charges, interest, any attorneys' fees and all other costs incurred by the Fund to collect such amounts) through whatever means are necessary, including, without limitation, deduction of the amounts from future claims and/or by legal action.

Can I sue the Plan to obtain benefits?

You may not start a lawsuit to obtain benefits with respect to any Claim unless and until you have first timely exhausted all the requirements of the claims filing and claims review procedures under the Plan, or until 90 days have elapsed since you filed an appeal if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

Under no circumstances may any lawsuit be started more than two years after the time any Claim must first be submitted.

Can I ask that my benefit be paid to anyone else?

Generally, benefits payable under this Plan cannot be alienated, transferred, assigned, or otherwise promised to a person or party other than you. This means benefits will only be paid directly to you.

What are the sources of contributions to the Plan?

The Plan is maintained pursuant to a number of Collective Bargaining Agreements or Other Written Agreements. You may obtain a copy of any such agreement that applies to you by submitting a written request to IMTEF Maternity Disability Benefit or you can examine such agreement in person. In either case, the address is 17101 Science Drive, Bowie, MD 20715.

IX. PRIVACY NOTICE

Any medical or personal information that you, your Physician, or other health care provider(s) supply to the Plan will be used strictly for determining your eligibility for Plan benefits and held in the strictest confidence using security safeguards. Such information will be disclosed only to those with a need to know for the purposes of determining your eligibility and Plan benefit. If there is a need to disclose such information to a third party, the Plan will require the third party to appropriately safeguard the privacy of your information. Should the Plan become aware of any breach of your information, the Plan will promptly notify you and inform you of what steps you may need to take to protect yourself.

X. STATEMENT OF PARTICIPANTS RIGHTS UNDER ERISA

As a plan participant in the IMTEF Maternity Disability Benefit, 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:

a. The right to receive information about your plan and benefits including the right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 Employee Benefit Security Administration.
b. The right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
c. The right to receive a summary of the Plan's annual financial report.
d. The right to prudent action by Plan fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the sole 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 receiving benefits under the Plan Benefit or exercising your rights under ERISA.

How to Enforce Your Rights

a. If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a 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.
b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the SPD from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $171 per day, not to exceed $1,173 per request, for 2022 (as adjusted annually for inflation) until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored in whole or in part, and if you have exhausted the claims procedure available under the Plan, you may file suit in a state or federal court. If you feel the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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 in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

XI. AMENDMENT AND RESOLUTION

This Plan Document may be amended or terminated by majority vote of the Trustees. Any changes to the Plan made by resolution require majority vote of the Trustees and shall be set out in a separate signed document.

Should any provision of this document be declared unlawful or unenforceable by a court of competent jurisdiction, unaffected provisions shall remain in effect, unless it becomes impossible or impractical to achieve the purposes of the Plan.

This Plan Document may be executed in counterparts; each counterpart shall be deemed an original.