MO-KAN SHEET METAL WORKERS WELFARE FUND

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2018

TABLE OF CONTENTS

MO-KAN SHEET METAL WORKERS WELFARE FUND OFFICE

(Administrative Office of the Board of Trustees)
P.O. Box 300019
Kansas City, MO 64130-0019
Telephone: (816) 531-0334 or Toll-Free (866) 531-5488
www.mokansheetmetal.org

PARTICIPATING LOCALS

Local No. 2	Kansas City, Missouri
Local No. 3	Omaha, Nebraska
Local No. 29	Wichita, Kansas
Local No. 36B	Columbia, Missouri
Local No. 36C	Springfield, Missouri

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To All Plan Participants:

As Trustees of your Welfare Plan, we take pleasure in providing you with this revised booklet. Since you received the last booklet, many changes have been made in the benefits available to eligible participants and their Dependents. This booklet is up-to-date as of January 1, 2018, and includes a description of all benefits for employees for whom contributions to the Welfare Fund are required as a result of written agreements.

Since this booklet describes the procedures to be followed for filing a claim, in addition to the benefits provided by the Plan, we urge you to read this booklet and keep it in a safe place. If after reading the booklet you have any questions which are unanswered, the Fund Office will be happy to be of assistance.

Sincerely,

BOARD OF TRUSTEES

Effective Date: January 1, 2018

ATTENTION

This booklet provides a general description, written in non-technical language, of the important provisions of this Plan as expressed in the insurance contracts and administrative rules and regulation of this Plan. However, this is not just a summary of the Plan, but the actual Plan document written so that it can be used by Participants and the Trustees in administering the Plan. All provisions for any insured benefits are subject to the terms and conditions of the group policies issued by the Company.

WHENEVER A PRONOUN IS USED IN THE MASCULINE, IT ALSO INCLUDES THE FEMININE UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE.

Under the documents creating the Fund (and the terms of the Plan), the Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, determine those benefits to be in compliance with the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming benefits under the Plan. If the Plan makes any inadvertent, mistaken, excessive, erroneous or fraudulent payment of benefits, the Trustees or their representative shall have the right to recover these types of payments. The Trustees reserve the right to change, modify or discontinue all or part of the benefits described in this booklet at any time by action or amendment.

SECTION 1. SUMMARY PLAN DESCRIPTION

1. **Name of Plan.** This Plan is known as the Mo-Kan Sheet Metal Workers Welfare Fund.

2. **Board of Trustees.** A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employers and Union representatives, selected by the Employers and the Local Unions which have entered into collective bargaining agreements which relate to this Plan. If you wish to contact the Board of Trustees, you may use the following resources:

Board of Trustees
Mo-Kan Sheet Metal Workers Welfare Fund
P.O. Box 300019
Kansas City, Missouri 64130-0019

(This address is sometimes referred to as the "Fund Office")
Telephone: (816) 531-0334 or Toll Free (866) 531-5488
www.mokansheetmetal.org

The Trustees of this Plan are:

Union Trustees	**Employer Trustees**
Mr. Doug Piant Local 36 Business Agent PO Box 471 Fulton, Missouri 65251	**Mr. Justin Gunter** Metro Air Conditioning Company 10035 Lackman Road Lenexa, Kansas 66219
Mr. Greg Chastain Business Agent Sheet Metal Workers Local Union No. 2 2902 Blue Ridge Boulevard PO Box 300378 Kansas City, Missouri 64130-0378	**Mr. James J. Hausman** Hausman Metal Workers 1229 S. 15th Street Post Office Box 1256 St. Joseph, Missouri 64502
Mr. Allen J. Lind Sheet Metal Workers Local Union No. 2 2902 Blue Ridge Boulevard P.O. Box 300378 Kansas City, Missouri 64130-0378	**Mr. Jerry Schaefer** A2MG, Inc. 4715 W. 40 Hwy Blue Springs, MO 64015
Mr. Darryl Oberholtz US Engineering 4134 Front Street Kansas City, Missouri 64120	**Mr. Robert Roach** The Fagan Company 3125 Brinkerhoff Kansas City, Kansas 66115

3. **Plan Sponsor and Administrator.** The Board of Trustees is both the Plan Sponsor and the Plan Administrator. The Plan is administered by the Plan Sponsor.

4. **Identification Number.** The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 44-0567087.

5. **Agent for Service of Legal Process.** The agent for service of legal process is the Fund Administrator at the Fund Office. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon the Fund Administrator. Also, service of legal process may be made on the Board of Trustees or a Trustee.

6. **Source of Contributions.** Contributions to the Fund are made by Employers in accordance with written Collective Bargaining Agreements or Participation Agreements. Such Employers have entered into Collective Bargaining Agreements with Local Unions of the Sheet Metal Workers International Association. The amount of the Employer contribution and Employees on whose behalf contributions are made are determined by the terms of the Collective Bargaining Agreements.

   Contributing Employers may enter into Participation Agreements with the Welfare Fund in order to provide contributions to the Fund for Non-Bargaining Employees. The amount and manner of such contribution is established from time to time by the Board of Trustees in accordance with applicable law.

   The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement and information as to whether a particular Employer is contributing to the Fund on behalf of Participants working under the Collective Bargaining Agreements.

   The Fund also provides, under certain circumstances for an Employee whose eligibility is about to terminate, the option to continue coverage by making self-payments directly to the Fund. See SPECIAL CONTINUATION RULES, Section 4-4.

   Eligible Retirees make self-payments directly to the Fund. The amount and manner of such contribution is established from time to time by the Board of Trustees in accordance with applicable law.

7. **Trust Fund.** All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Insurance premiums, if any, are paid from the Trust Fund.

8. **Plan Year.** The records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1 and ends on December 31.

9. **Type of Plan.** This Plan is maintained for the purpose of providing Medical, Dental, Hearing Aide, Vision, Life Insurance, Loss of Time, and Accidental Death and Dismemberment benefits in the event of death, sickness or accident. The Comprehensive Major Medical, Dental, Hearing Aide, Vision, Life Insurance, Accidental Death and

Dismemberment, and Loss of Time Benefits of the Plan are provided by the Fund on a self-funded basis. The Plan also provides Laboratory and X-Ray and Supplemental Accident on a self-funded basis. These Plan benefits are shown in BENEFIT SUMMARIES, Section 2, for Employees and Retirees.

10. **Eligibility.** The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any insured or self-insured Benefits are fully described in ELIGIBILITY RULES, Section 4.

11. **Claim Procedure.** The procedures to follow for filing a claim for Benefits are set forth in CLAIMS PROCEDURES, Section 16. If your claim is denied or partly denied, please refer to Section 16-5 of this booklet, How to Appeal a Denial of Claim. If you have any questions about an Appeal, please contact the Fund Office.

12. **Plan Administration.** The third-party administrator for the Plan is BlueCross BlueShield of Kansas City ("BCBSKC").

SECTION 2. BENEFIT SUMMARY

Benefit	In-Network	Out-of-Network
Deductible	$670/$1340	$670/$1340
Calendar Year Out-of-Pocket maximum (includes deductible)	$1700/$3400	$2700/$5400
Co-insurance	80%	60%
Individual Lifetime Max	Unlimited	Unlimited
Office Visits	80% after deductible	60% after deductible
Telehealth Visit	$39 copay	60% after deductible
Co-Payments		
Inpatient (waived if admitted twice in six months)	$400 co-pay and 80% after deductible	$800 co-pay and 60% after deductible
Emergency Room	$130 co-pay and 80% after deductible	$130 co-pay and 60% after deductible
Routine Physical Exam (newborn to adult)	100% up to $500 then 80% after deductible	100% up to $500 then 60% after deductible
Routine Immunizations	Covered for children to age 26 and certain CDC recommended for adults at 100%	60% after deductible
Mammogram	One annual routine exam after age 35 covered at 100%	60% after deductible
Cervical Cancer Screening	One test per year, covered at 100%	60% after deductible
Prostate Exam & PSA Test	One test per year covered at 100%	60% after deductible
Preventive Colonoscopy	100%	60% after deductible
Prescription Drugs	**Generic co-pay applies to OTC smoking cessation, Allergy, Ant-acids, Anti-fungal, Asthma, and Decongestants. Retail co-pay applies to smoking cessation prescription medications.**	Member pays out of pocket and then sends receipts to WellDyne/Rx West for reimbursement. Only reimbursed contracted amount.
Retail Generic (30 days)	$15 co-pay	Member pays out of pocket and then sends receipts to WellDyne/Rx West for reimbursement. Only reimbursed contracted amount.
Retail Brand (30 days)	50% up to $65	
Mail Order Generic(90 days)	$25 co-pay	
Mail Order Brand (90 days)	50% up to $130	
Smoking Cessation Benefit One treatment per cycle per calendar year, $2000 lifetime maximum. Does not apply to RX out of pocket maximum.	$15OTC 50% up to $65 for RX Both require a prescription	
OTC program Examples: Prilosec, Claritin	$15.00 generic $20.00 mail order	
Out of Pocket Max for RX	$1340 Ind. $2680 family	
Laboratory and X-Ray	First $150 of Lab and X-Ray covered at 100% then 80% after deductible	First $150 of Lab and X-Ray covered at 100% then 60% after deductible

Benefit	In-Network	Out-of-Network
Lab	100% benefit if collected and tested at a Quest facility	60% after deductible
Supplemental Accident This benefit pays the first $300 of an accident claim.	$300 per calendar year	$300 per calendar year
Mental Illness/ Chemical Dependency		
Inpatient (waived if admitted twice in six months)	$400 co-pay and 80% after deductible	$800 co-pay and 60% after deductible
Outpatient	80% after deductible	60% after deductible
Chiropractic Treatment 40 visits per calendar year (includes x-rays)	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Bereavement Counseling (maximum 8 visits in 12 months)	Not covered under Medical- Provided without co-pay through Employee Assistance Program ("EAP")	Not covered
Nutritional Counseling	100%	100%
All other covered services	80% after deductible	60% after deductible
Dental (Calendar Year maximum for Preventive, Basic and Restorative is $1600 for non-pediatric; Pediatric dental—child up to 20th birthday has no dollar maximum.)	**Dental Preferred Care available for Kansas City area.**	DNOA available for outside the Kansas City area
Dental Deductible	$25	$25
Dental Coinsurance	80%	80%
Dental Preventative	100%	100%
Dental Basic (Class II)	80% after deductible	80% after deductible
Dental Major (Class III)	80% after deductible	80% after deductible
Orthodontia (Class IV) ($1,800 lifetime maximum)	50% after deductible	50% after deductible
Routine Vision (can be used for Lasik if after 20th birthday or Medically Necessary)	$350 per person, per year	$350 per person, per year
Pediatric Vision	One routine eye exam and two pairs of glasses (select frames) and contacts (up to a one-year supply) with no dollar maximum	One routine eye exam and two pairs of glasses (select frames) and contacts (up to a one-year supply) with no dollar maximum
Safety Glasses Frames and lenses once per calendar year.	50% up to $70 Benefit payable only to actively working Participants.	50% up t6o $70 Benefit payable only to actively working Participants.
Hearing Aid Benefit	80% after deductible. One set per 3 consecutive year period. Unlimited adjustments at 80%	60% after deductible. One set per 3 consecutive year period.

Benefit	In-Network	Out-of-Network
	after deductible	
Life Insurance Benefit	Active: $10,000 Basic Retiree: $2,000 Long-term Retiree: $3,000	
Loss of Time Member must be totally Disabled and unable to perform any amount of work	Weekly Benefit…$300.00 Waiting Period: Injury…….None Illness or Pregnancy …..7 Days Maximum Period of Benefits Per Any Continuous Twelve Month Period is 26 weeks	
Wellness Program Opportunity to earn up to $375 in WBA credit		

PROVIDER AND BENEFIT INFORMATION

GENERAL INFORMATION

To access information about benefits provided by the Fund, please visit the Fund website at www.mokansheetmetal.org. You will find information about providers, benefits summaries, claim forms, COBRA continuation coverage, wellness program and Wellness Benefit Account ("WBA") Program, Employee Assistance Program ("EAP") benefits, the prenatal program, retiree information, and other information about the Fund.

LIST OF PROVIDERS

To access a list of providers, go to www.mokansheetmetal.org, and click on the tab labeled "Benefits" for a link and complete instructions. You can also visit www.bluekc.com, and follow the directions, below:

Locating an In-Network provider for Preferred Care Blue, Blue Card and Dental Network of America.

1. Go to the Blue Cross and Blue Shield of Kansas City website at www.bluekc.com. Click on Find a Doctor in the upper right hand corner.
2. Select your current insurance plan from the drop-down box. For medical services this will be the Preferred Care Blue Network option, for dental it will the Dental-Preferred Care Network option.
3. Under Location, type in your City & State or Zip Code. Select drop down box for the radius you are willing to travel within the City & State or Zip Code you input.
4. Refer to chart below.
5. A list of providers matching your search criteria will appear on the next page.

TELEHEALTH--ACCESS TO PHYSICIANS 365 DAYS/YEAR

We have partnered with Blue Cross Blue Shield to provide TeleHealth Benefits. This is a way for You to speak with a Physician for common health issues and receive treatment, including prescriptions (if necessary), over the telephone, using your smart phone or computer. Physicians are available 24-hours per day, 365 days per year, including weekends and holidays. For more information, visit www.mokansheetmetal.org.

OTHER INFORMATION

The www.mokansheetmetal.org website also allows You to access Your Member portal, which provides personalized information such as Your Health & Welfare status and work reports received from Your employers. Address and other demographic changes can be submitted through the Member portal. Though the Fund Office does its best to keep this information up-to-

date on the Member portal, You should contact the Fund Office in person for Your official record, or if You notice the personal information for You or Your Dependents is not up-to-date.

SECTION 3. DEFINITIONS

The following capitalized terms have the meaning defined below when used in the Summary Plan Description and Certificate of Credible Coverage:

ACCIDENTAL INJURY means accidental bodily Injury by a Covered Person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause.

ADMISSION begins the first day a Covered Person becomes a registered Hospital bed patient or a Skill Nursing Facility patient and continues until he is discharged.

ADVERSE BENEFIT DETERMINATION means a determination by the Fund on a valid claim for benefits that an Admission, availability of care, continued stay or other Health Care Service has been reviewed and, based upon a review of all relevant factors including but not limited to the following: Experimental or Investigative procedures, determination of eligibility to participate with the Fund, availability of care, Utilization Review, the care does not meet Fund requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and application of Plan exclusions, that the payment for the requested benefit is therefore denied, reduced, or terminated.

ALLOWABLE CHARGES means the dollar amount upon which Benefits will be determined. Any amounts (other than Co-payments and Deductibles) a Covered Person is required to pay will be based on this Allowable Charge. Benefit limits, if any, will also be based on this Allowable Charge. The Allowable Charge may vary depending upon whether or not the provider is a Participating Provider or the terms of that Participating Provider's contract with the PPO.

AMBULANCE means a vehicle designed and used to provide medical services and that is appropriately licensed by state and local laws.

APPEAL means a written request for reconsideration of a previous Adverse Benefit Determination.

AUTHORIZATION OR AUTHORIZED means the decision of the Fund to approve a request for Benefits, services, supplies, equipment, or care that must occur in order for You to obtain Benefits under the Plan. This process allows Participating Physicians to be responsible to provide, arrange and coordinate Your care with assistance for the Fund.

BARGAINING EMPLOYEE means an Employee who is a member of a collective bargaining unit covered by a Collective Bargaining Agreement between his Employer and a Local Union participating in the Mo-Kan Sheet Metal Workers Welfare Fund, on the Employee's behalf.

A person who is a member of such bargaining unit is an "Owner Member" and is not a "Bargaining Employee" if he is an officer, director or partner, agent, contractor, jobber or the owner of an interest in the business entity that is his Employer, or is directly or indirectly

financially interested in or is otherwise involved in the management of a sheet metal shop, business or job.

A person will be deemed an officer, director, or the owner of an interest in the business entity that is his Employer to the extent such interest or position is owned, directly or indirectly, by, for or held by his Spouse (except for a Spouse from whom the person is Divorced or Legally Separated pursuant to a legal decree) Children (including Stepchildren and legally adopted children), grandchildren or parents.

BENEFIT or BENEFITS means the amount of Allowable Charges the Fund pays for Covered Services after the Co-payments, Deductible, and Coinsurance requirements have been met.

BENEFIT PERIOD means the 12 month period which begins on January 1 and ends December 31.

BOARD OF TRUSTEES means the individuals appointed by the Participating Employees and the Sheet Metal Local Unions participating in the Fund to act as the governing body of the Fund.

BODY MASS INDEX or BMI means an index for estimating weight status, obtained from the formula (weight in kilograms) divided by [(height in meters) squared] or kg/m^2.

BROTHER means the biological male sibling of the Member/Covered Person.

CALENDAR YEAR means the twelve (12) month period which begins January 1 and ends December 31.

CALENDAR YEAR MAXIMUM means the dollar amount, or a maximum number of days, visits or sessions as listed in the Benefit Summary for which Benefits for Covered Services are provided for a Covered Person in any one Calendar Year. Once a Calendar Year Maximum for a specific Covered Service is met, no more Benefits for such Covered Services will be provided during the same Calendar Year.

CASE MANAGEMENT means collaborating, assessing, planning, facilitating and the advocacy of options and services to meet a Covered Person's needs through communication and available resources to promote quality, cost-effective outcomes.

CERTIFICATE OF CREDITABLE COVERAGE means a certificate issued from a former health plan, insurance company, or Fund that documents the number of days of Creditable Coverage.

CERTIFICATION means a determination by the Fund that an Admission, availability of care, continued stay, or other Health Care Services have been reviewed and, based on the information provided, satisfied the Fund's requirement for Medically Necessary, appropriateness, health care setting, level of care and effectiveness.

CHEMICAL DEPENDENCY means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role function or both.

CHILD means a natural Child of the Member, a Stepchild of the Member, an adopted Child of Member or Member's Spouse, a child who has not reached the limiting age, and who has been placed for adoption or for whom a Petition for Adoption has been filed, or a child for whom the Member or Member's Spouse is the **permanent** Court appointed legal guardian, not including a foster child, and is the sibling, grandchild, niece, or nephew of the Member and the child's parents are deceased or unable to care for the child, provided proof of the guardianship is submitted with the enrollment card.

COBRA means the Consolidated Omnibus Budget Reconciliation Act.

COINSURANCE means the percentage of the Allowable Amount for Covered Services incurred that a Member is required to pay.

COLLECTIVE BARGAINING AGREEMENT means the Agreement by and between Participating Employers (or an Association representing such Employers) and a Participating Local governing participation in the Fund and in compliance with the National Labor Relations Act.

COMMON LAW SPOUSE means an individual who would be considered a Spouse under applicable State law without benefit of a legally recognized marriage ceremony.

COPAYMENT(S) means the dollar amount of a charge that a Covered Person must pay for certain Covered Services.

COURT ORDER means any written order by a governmental entity purporting to bind the Fund.

COVERED DENTAL CHARGES means fees or charges for dental care, treatment, services, or supplies which are provided or ordered by a Dentist, and are necessary for diagnosing or treating a dental disease, defect or Injury. The term "dental care" includes oral surgery, which means surgery performed on the gums, alveolar processes and teeth, removal of erupted teeth, and preparation of the gums for dentures.

COVERED PERSON means the Member or any of the Member's Dependents whose coverage is in effect under the Plan.

COVERED SERVICE(S) means Medically Necessary services, supplies; equipment and care specifically listed in the "Covered Services" Section, except those services, supplies, equipment and care excluded or subject to condition and limitations identified in the Certificate or Benefits Summary and which require payment of applicable Co-payments.

COVERED VISION CHARGES means **only** expenses incurred for complete examinations performed by and materials prescribed by a licensed optometrist or ophthalmologist, and that are not excluded under the Plan, as described in Section 6 of this SPD.

CUSTODIAL CARE means care in which the individual: 1) is disabled mentally or physically and such disability is expected to continue and be prolonged, (2) requires a protected, monitored, or controlled environment whether in an institution or in the home, (3) requires assistance to support the essentials of daily living, and (4) is not under active or specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

DATE OF PLACEMENT means the date you assume the legal obligation for total or partial support of the Child to be adopted in connection with formal adoption proceedings.

DEDUCTIBLE means the portion of Allowable Charges for Covered Services a Covered Person must pay each Calendar Year before the Fund will provide Benefits unless otherwise specified. The application of the Deductible during any Calendar Year will be based upon the date when Covered Services were actually received. Each Member and their Eligible Dependents must satisfy a Deductible each Calendar Year before Benefits will be paid.

DENTIST refers to a person authorized by law and duly licensed to practice dentistry. Dentist also includes a legally licensed Physician with respect to the performance of oral surgery.

DEPENDENT means those individuals in the Member's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section of this Summary Plan Description and are enrolled in the Fund.

DIVORCE means legal dissolution of marriage pursuant to the governing laws of the appropriate jurisdiction.

DURABLE MEDICAL EQUIPMENT means medical equipment which primarily and customarily serves a medical purpose, is intended for and able to withstand repeated use, generally is not used in the absence of Illness or Injury, is appropriate for use in a patient's home and is identified as Durable Medical Equipment as determined by the Fund.

EMPLOYEE ASSISTANCE PROGRAM OR **EAP** means benefits provided under a specific program established under the Plan that provides support for a Member's total well-being and not the provision of medical services, such as consultations and referrals for resources or services relating to the Member's emotional, legal, financial, health & wellness, family & care giving, or convenience needs.

EMPLOYEE means an eligible Employee of a Participating Employer as provided in the Plan.

EMPLOYER means the business organization or legal entity to which the Collective Bargaining Agreement or Participation Agreement is issued.

EMERGENCY MEDICAL CONDITION means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but not be limited to:

1. Placing the person's health in significant jeopardy;
2. Serious impairment to a bodily function;
3. Serious dysfunction of any bodily organ or part; or
4. Inadequately controlled pain.

ERISA means the Employee Retirement Income Security Act of 1974, and any regulations promulgated thereunder.

ESSENTIAL HEALTH BENEFITS shall have the meaning assigned to such term under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For purposes of identifying Essential Health Benefits, the Board of Trustees will look to the applicable Benchmark Plan for the State of Missouri.

EXPERIMENTAL/INVESTIGATIVE SERVICES means those services, which include drugs, devices, medical treatment or procedures, and related services and supplies, which the Fund determines to be Experimental or Investigative.

A drug, device, medical treatment or procedure is **Experimental** or **Investigative** if:

1. The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
2. Reliable evidence shows that the drug, device, medical treatment or procedure:
    a. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective; or
    b. Is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or
    c. Is Experimental/Investigative per the informed consent document utilized with the drug, device, medical treatment, or procedure.

FDA means the United States Food and Drug Administration.

FUND means Mo-Kan Sheet Metal Workers Welfare Fund. The Fund is legally responsible for providing the Benefits for Covered Services under the Summary Plan Description.

FUND ADMINISTRATOR means the person designated by the Board of Trustees to be responsible for the operations of the Fund Office and daily administration of the Fund.

FUND OFFICE means the office designated by the Board of Trustees to act as the primary operations location for Fund business.

HEALTH COVERAGE means Hospital, surgical, medical, dental, vision or prescription drug coverage provided under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, its implementing regulations, and any regulations promulgated thereunder, including but not limited to the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH").

HOME HEALTH AGENCY means an organization or entity that is licensed to provide health care services in the home.

HOSPICE CARE means a method of care for terminally ill patients provided by an agency or program that has the goals of patient comfort, palliative therapy only for pain control and development of effective coping mechanisms and which does not provide therapeutic care other than to address comfort, pain and bodily functions as they are affected by medication and the disease process.

HOSPITAL means a facility that:

1. Operates pursuant to law;
2. Provides 24-hour nursing services by Registered Nurses on duty or call; and
3. Provides health care services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of Physicians.

Hospitals do not include residential or nonresidential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; skilled Nursing Facilities; places that are primarily for the care of convalescents; clinics; Physicals offices; private homes; ambulatory surgical centers; or Hospices.

IN-NETWORK PROVIDER are healthcare facilities or providers who are members of your health plan's current PPO and therefore agree to certain discounts on services rendered and are reimbursed at the higher level of benefit payment.

INCURRED DATE refers to the first date services are rendered.

INJURY means an accident to the body requiring medical or surgical treatment.

LEGALLY SEPARATED means subject to Court Order from the appropriate jurisdiction creating a temporary or permanent status of separation of the spouses in an existing legal marriage.

LIFETIME MAXIMUM means that when Benefits total this amount, no more Benefits will be paid for a Covered Person under the Plan.

LOCAL UNION means a local of the Sheet Metal Workers International Association participating in the Fund.

MEDICALLY NECESSARY means services and supplies which are determined by the Fund Office or its advisors to be essential to the health of a Covered Person and are:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of a medical or surgical condition;
2. Consistent with acceptable medical practices according to established medical criteria (as amended from time to time);
3. Not primarily for the convenience of the Covered Person nor the covered Person's family, Doctor or another Provider;
4. Consistent with the attainment of reasonably achievable outcomes; and
5. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

MEMBER means an eligible individual covered by a Collective Bargaining Agreement or Participation Agreement calling for contributions to be made into the Fund.

NON-BARGAINING EMPLOYEE means any Employee who is not a Bargaining Employee.

OWNER-MEMBER means any Employee who is a Member of a Local Union, performs covered work and owns, directly or indirectly, stock or other ownership interest in his Employer. Immediate family members of owners will be deemed to be Owner-Members.

OUT-OF-POCKET MAXIMUM means the total amount of the Calendar Year Deductible plus the amount of any Coinsurance and/or Co-payments a Covered Person must pay each Calendar Year for Covered Services before Benefits will be paid at 100%. The Out-of-Pocket Maximum does not include:

1. Any amount that is above the Allowable Charge;
2. Any amount that exceeds a specific maximum for Benefits;
3. Prescription drug Co-payment and/or Coinsurance, if applicable;
4. Co-payments; and/or
5. Any amount for Covered Services incurred in a Non-Participating Provider Hospital or in a Non-Participating outpatient facility will go towards your Out-of-Network Out-of-Pocket Maximum.

   Amounts that You pay for non-Covered Services and for services that are denied by Us as not Medically Necessary cannot be used to meet the Out-of-Pocket Maximum.

OUT-OF-NETWORK PROVIDER is a provider who does not have a contract with the Plan's current PPO and therefore services rendered will be processed at the lower level of benefit payment.

PARENT means mother or father as defined under applicable State law.

PARTICIPANT means any individual currently eligible for coverage under the Fund pursuant to the terms and conditions of the Plan.

PARTICIPATING EMPLOYER means any Employer currently employing eligible Employees on whose behalf contributions are required to be made to the Fund.

PARTICIPATING PROVIDER is a provider who has entered into an agreement (contract) with BCBSKC to accept payment for services rendered. Benefits will be paid at the lower percentage or the out-of-network benefit when not contracted with the Member's specific network.

PARTICIPATION AGREEMENT means an agreement between the Fund and a Participating Employer providing for coverage of the Non-Bargaining Employees of the Participating Employer.

PLAN means the Benefits and rules governing coverage under the Fund.

PLAN ADMINISTRATOR means the Board of Trustees.

PRE-DETERMINATION/PRE-TREATMENT PLAN OR PREAUTHORIZATION. means the decision of the Fund to pre-approve a request for Benefits that must occur prior to You obtaining services, supplies, equipment or care in order for You to obtain Benefits under the Plan. This process allows Participating Physicians to be responsible to provide, arrange and coordinate Your care with assistance for the Fund.

PHYSICIAN means anyone qualified and licensed to practice medicine and surgery by the State in which services are rendered who has the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). Physician also means Doctors of Dentistry and Podiatry when they are acting within the scope of their license. The term Physicians includes other practitioners who are licensed by the State in which services are rendered and may include but are not limited to the following: optometrists, chiropractors, and psychologist.

PPO or PREFERRED PROVIDER ORGANIZATION is a network of select medical doctors, hospitals, and other health care providers who have covenanted with the Fund, either directly or through contract with an insurer, third party administrator, or network approved by the Fund, to provide health care at reduced rates to Plan Participants.

QMCSO means a Qualified Medical Child Support Order.

REASONABLE AND CUSTOMARY means a general level of fees charged by other Physicians or Hospitals, in the same geographical area for services which are similar.

RESCISSION, RESCIND, or RESCINDED means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if; (1) the cancellation or discontinuance of coverage has only a prospective effect; or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

RETIRED EMPLOYEE means an Employee who meets the definition of Retiree and is no longer employed full-time (but could be employed part-time) by a Participating Employer.

RETIREE means a person who meets the Retiree eligibility requirements of the Plan and makes any required self-payment to the Fund on a timely basis.

SERVICE IN THE UNIFORMED SERVICES means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty; active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

SISTER means the biological female sibling of the Member / Covered Person.

SKILLED NURSING FACILITY means a facility that:

1. Operates pursuant to law; and
2. Provides 24-hour nursing services by Registered Nurses on duty or on call.

The Skilled Nursing Facility may be operated either independently or as part of an accredited general Hospital.

SPOUSE means the legally recognized marital partner of a Member under applicable law, except common law marriage.

STABILIZE means that with respect to an Emergency Medical Condition, no material deterioration of the condition is likely to result or occur if an individual is moved. This must occur before an individual may be transferred to another facility.

STEP-CHILD means a legally recognized child of a Spouse or Member not adopted by or a descendant of the Member.

TAFT-HARTLEY PLAN means a private welfare and/or pension plan that must adhere to the Taft-Hartley Act and ERISA. These plans are set up and administered jointly by unions and participating employers.

TRUSTEE means a current member of the Board of Trustees.

UNIFORMED SERVICES means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or emergency.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

USUAL, CUSTOMARY AND REASONABLE CHARGE means the lesser of: (a) the charge usually made by the provider for the services or supplies furnished; or (b) the charge most other providers in the same locality would make for those or comparable services or supplies, as determined by the Fund.

WELLNESS BENEFIT ACCOUNT or WBA means an internal accounting by the Fund to track a Member's accumulated financial incentive benefit under the Wellness Plan. This term has the meaning set forth in Section 14 of this SPD.

WE, US, or OUR means Mo-Kan Sheet Metal Workers Welfare Fund.

WEEKLY BENEFITS means the weekly Loss of Time benefits described herein.

YEAR END TERMINATION RULE means the rule governing ongoing eligibility of a Member based on contribution hours worked during the Calendar Year.

YOU, YOUR OR YOURSELF means the Member or Dependent who is obtaining or seeking to obtain Covered Services, exercising a right created by the Plan or performing any other function or responsibility specified in the Plan, or someone legally entitled to act on the Member's or Dependent's behalf if the Member or Dependent is a minor or for some reason cannot act on his or her own behalf.

SECTION 4. ELIGIBILITY RULES

4-1. ACTIVE EMPLOYEES

Who is Eligible

1. A **Bargaining Employee** is eligible for coverage under the Plan if he performs work covered by the terms of a Collective Bargaining Agreement between his Employer and Local Union participating in the Mo-Kan Sheet Metal Workers Welfare Fund.
2. A **Non-Bargaining Employee** is eligible for coverage under the Plan if he consistently performs work for at least 25 hours per week for an Employer which is bound by the terms of a Participation Agreement with the Mo-Kan Sheet Metal Workers Welfare Fund to make contributions to the Fund on behalf of all the Non-Bargaining Employees of the Employer, or if he performs work for the Mo-Kan Sheet Metal Workers Welfare Fund based on a minimum of at least 144 hours per month, or such amount as established from time to time by the Board of Trustees, at the rate established from time to time by the Board of Trustees.
3. An **Owner-Member** is eligible for coverage under the Plan if he performs work covered by the terms of a Collective Bargaining Agreement between his Employer and a Local Union participating in the Mo-Kan Sheet Metal Workers Welfare Fund and the Employer is bound by the terms of a Participation Agreement with the Fund to make contributions on behalf of the Owner-Member based on a minimum of at least 144 hours per month, or such amount as established from time to time by the Board of Trustees, at the rate established from time to time by the Board of Trustees.

Initial Eligibility---Bargaining Employees

If Your employment is subject to a Collective Bargaining Agreement, You will become eligible for coverage under this Plan on the first day of the month which:

1. Follows a period of 4, 5, or 6 consecutive months with at least 480 hours reported on your behalf by a contributing Employer, beginning with Your initial date of employment; and
2. You are in good standing with the Union.

Initial Eligibility --- Non- Bargaining Employees

If Your employment is not subject to a Collective Bargaining Agreement, You will become eligible for coverage on the first day of the month in which a signed Participation Agreement and the corresponding Employer contributions at the rate established from time to time by the Board of Trustees for all such Employees are received by the Fund Office.

Effective Date

You will be covered on the date You become eligible. However, if You are Disabled on such date, You will be covered for all Plan benefits **except** Loss of Time Benefits. Your coverage for Loss of Time Benefits will become effective on the date You return to active employment.

Special Enrollment

If Your Dependent(s) are eligible to participate under this Fund, but have not enrolled in the Fund, You or Your Dependent(s) shall be allowed to enroll in the Fund if You request enrollment after:

1. You or Your Dependent(s) lose eligibility for coverage under another plan for reasons other than Your termination of coverage for cause or Your failure to pay premiums;
2. Your or Your Dependents' Employer stops contributing toward Your or Your Dependents' coverage under another plan;
3. You acquire a new Dependent(s) through marriage, birth, adoption, or placement for adoption;
4. You or Your Dependent lose coverage under Medicaid or a state children's health insurance program; or
5. You or Your Dependent becomes eligible for state assistance with respect to paying Your or Your Dependent's contributions to this Plan.

Special rules may apply. For more information regarding Special Enrollment, contact the Fund Office.

Termination of Eligibility

Your eligibility will continue until one of the Termination of Eligibility rules applies to You. Your coverage will terminate on the earliest of the following:

1. The date established for termination in accordance with the Year-End Termination Rule;
2. The day You complete a period of 6 consecutive calendar months with less than 160 hours contributions made on Your behalf by contributing Employers, except that Your Weekly Benefits for Loss of Time will terminate on the day You complete a period of 3 consecutive calendar months without such contributions unless You are Disabled for more than 3 months or earlier, if you fail to meet the Plan's requirements for payment of Benefits as described in Section 12;
3. The date You elect not to accept work with a contributing Employer for which You are qualified and able to perform, except that a Member may be considered actively at work during a disability leave or absence for a period not to exceed ninety (90) days from the date the Member is no longer actively at work or, for a qualified employee (as qualified under the FMLA), during any leave taken pursuant to the FMLA;
4. Immediately if You continue to work for a contributing Employer whose contractual obligation to contribute to the Fund is no longer in effect;

5. For Non-Bargaining Employees, the first day of any month in which the required contribution is not made;
6. The date You are deceased;
7. The date this Plan terminates;
8. The date You are no longer a Member of an eligible group;
9. The date a change is made in this Plan to terminate coverage for Your group;
10. For COBRA, the date self-pay contribution payments on Your behalf cease or the number of months you are eligible for COBRA is exhausted; or
11. The first day of the month which follows the date You are inducted into the Armed Forces of the United States, except as covered under SPECIAL CONTINUATION RULES, Section 4-4, under USERRA.

Year End Termination Rule

At the end of each Calendar Year, a review will be made of Your employment record. If You did not work at least 800 hours with contributing Employers during that year, Your coverage under this Plan will be terminated. This rule will not apply, however, if You gained eligibility in the last quarter of the year being reviewed.

Reinstatement of Eligibility

If You lose Your eligibility for coverage, You may be reinstated as a fully covered Employee:

1. Upon completion of 2 consecutive calendar months of work with contributing Employers;
2. If You worked a minimum of 160 hours during such period, with some employment in each of the 2 months;
3. You remained available for, or continued working for a contributing Employer; and
4. You are in good standing with your Local Union—as determined by the Union in its sole discretion and certified to the Fund.

If at any time you are determined ineligible to be reinstated, you may be required to satisfy the Initial Eligibility Requirements before you are covered by the Fund.

4-2. DEPENDENT ELIGIBILITY AND TERMINATION

Eligible Dependents

Only Your lawful Spouse (excluding Common-Law and Legally Separated Spouses), and each Child are eligible for Dependent coverage. The Fund has certain procedures that must be followed before it can recognize a Court Order or a Qualified Medical Child Support Order (QMCSO).

Child includes:

1. Your natural Child;
2. Your Step-child;
3. Your adopted Child. An adopted Child who has not reached the limiting age shall be considered to be an Eligible Dependent from the Date of Placement. Coverage for an adopted Child will be on the same basis as other Dependents.
4. A Child for whom You have been established by a Court Order as **permanent** legal guardian provided the Child is also Your grandchild, niece, or nephew, the Child's parents are deceased or unable to care for the Child.

The Plan's obligation to pay benefits will be subject to the Plan's Coordination of Benefits provisions, as set forth herein.

Upon request, You must provide the Fund Office with sufficient proof that a claimed Dependent meets the definition of a Child. To prove a Dependents' eligibility, you must supply the Fund with the following:

1. You and Your Spouses Certificate of Marriage;
2. Birth Certificates for Your Children and/or Dependent(s);
3. A Court Order stating Your responsibility with respect to Dependent(s);
4. Your Internal Revenue Service Income Tax Returns showing Your claim of Dependent(s); and/or
5. An Order from a governmental authority having jurisdiction over such matters in the state of residence requiring You to provide health insurance to Dependent(s).

The Fund may require additional proof of Dependents' eligibility from time to time.

Dependents Not Eligible

The following are not eligible for Dependents' coverage:

1. Your Divorced and/or Legally Separated Spouse and former Stepchildren;
2. Common Law Spouses;
3. Foster children;
4. Anyone eligible for coverage as an Employee, except for a Child who has not yet reached the limiting age, who is subject to the Coordination of Benefits language below;
5. A Child who has attained the limiting age;
6. A Dependent Child's child; or
7. A Dependent Child's spouse.

If a Member wishes to remove Dependents from coverage under the Plan, he may do so at any time by providing written notice to the Fund Office. If the Member later wishes to reinstate

coverage for the removed Dependents, they can be added as new Dependents at open enrollment or following a Special Enrollment event, subject to Fund rules. Reinstated coverage is not retroactive; it is prospective only. If a removed Dependent no longer meets the definition of Eligible Dependent at the time of application for reinstatement, coverage will not be reinstated under the Plan.

The limiting age is:

1. The Child's 26th birthday;
2. An unmarried Child who is a Dependent and has reached the limiting age will remain eligible for coverage under this Plan to the extent he is incapable of self-sustaining employment and is 100% dependent upon You for support and maintenance due to a mental or physical illness or handicap. The Child must have become handicapped prior to attaining the limiting age. Proof of incapacitation must be provided within 31 days after the Child attains age 26, and thereafter will be required each year and must be considered satisfactory by the Board of Trustees in its sole discretion. Coverage will terminate if the Board of Trustees determine, based upon medical evidence, that the Child is no longer handicapped, or if the Child does not undergo an examination as required by the Plan. The Dependent must have been covered under this Plan before attaining the otherwise applicable limiting age in order to be eligible for this continued coverage; or
3. Effective January 1, 2010, and notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law as set forth in this section. Any requirement that a Dependent child have full-time student status in order to extend coverage past a stated age will generally not apply if the child's failure to maintain full-time status is due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student. Except for a student who is on a Medically Necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Effective Date of Dependents' Coverage

Normally, coverage for Your Dependent(s) starts on the date Your coverage starts or on the date Your Dependent(s) acquire the status of an Eligible Dependent. However, for a newborn

Dependent Child, You have up to 12 months to add the Child as a Dependent. If such Child is not added within this 12-month period, upon adding the Child, coverage for the Child will be retroactive to 12 months prior to Your request to add the Child (not retroactive to the date of the Child's birth).

It is Your responsibility to request and update any enrollment information any time a change in this information occurs.

Exception --- Newborn Child of The Employee or Employee's Spouse

If both parents are Covered under the Plan and are legally married, but not common law married, a newborn Dependent Child is covered from the moment of birth. Coverage shall consist of coverage of Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Proof of relationship satisfactory to the Fund Office may be required to determine Dependent status.

Termination of Your Dependents' Coverage

Your Dependents' coverage will terminate on the earliest of the following:

1. The date Your eligibility terminates;
2. The date a change in the Plan terminates Dependents' coverage;
3. The date Dependent(s) is no longer an Eligible Dependent, as defined, and, for those Dependent Children whose coverage shall terminate due to the attainment of the limiting age, the last day the Dependent Child shall be covered is the day before the Child's 26th birthday;
4. The first day of the month which follows the date You are inducted onto the Armed Forces of the United States (see SPECIAL CONTINUATION RULES, Section 4-4, for further information); or
5. With respect to a Dependent Spouse and former Step-children, the date You become Legally Separated or Divorced, which shall be the date of entry of a court order or decree dissolving the marriage between You and the Dependent Spouse or legally separating You and the Dependent Spouse, regardless of whether such order or decree is subject to appeal or modification, requires You to provide health insurance coverage, or includes a delay in the finality or operation of the order or decree. Note that such court order or decree cannot alter or modify the terms of the Plan or require the Fund to provide any benefit type, form, eligibility option, or other option not otherwise provided under the Plan.

Exception --- Special Continuation for Dependents of Bargaining Employees After Your Death

1. If Your Dependents' coverage would otherwise terminate due to Your death while eligible as an Active Employee, coverage for Your eligible Dependent(s) who were covered under this Plan on the date of Your death can continue on a self-pay basis for six (6) full calendar months following the date of Your death. If You have coverage in the

Fund for at least 10 full calendar years during the 15 calendar years immediately prior to Your death, Your Eligible Dependent(s) may be able to make self-payments for retired Employee Benefits provided that they remain eligible for Retired Employee's Dependent coverage. Otherwise, Your Dependents' coverage will terminate on the earliest of the following dates:

a. The first day of the month following 6 full calendar months after the date of Your death; or

b. The date a Dependent ceases to be an eligible Dependent.

The 6-month period does not apply if You obtained coverage **immediately** from the Fund. Self-payments must begin **immediately**.

2. If the Dependent has had coverage continued for 6 months as described in 1. above, this Dependent may arrange to continue coverage for an additional period. This is described in the Section of the booklet titled Continuation of Coverage (self-pay) as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA). The COBRA period will be reduced, however, by the continuation described in 1. above.

4-3. RETIREE ELIGIBILITY

Eligibility For Retired Employee Benefits

If You do not apply for COBRA coverage when You retire from work in the Sheet Metal Industry, and Your coverage for Welfare Fund Active Employee Benefits would otherwise terminate, You may apply for coverage for Yourself and Your eligible Dependent(s), if, before terminating employment within the jurisdiction of the Collective Bargaining Agreement of one of the participating Local Unions or under a Participation Agreement calling for contributions to the Fund.

1. You are at least age 55 and not eligible for Medicare coverage; and
2. You had either:
   a. Five (5) full consecutive calendar years of eligibility immediately prior to retirement, with at least 3,000 hours of work for which contributions were required to the Fund, including hours credited as a result of disability, and some covered employment on the last 3 years; or
   b. At least 10 full calendar years of eligibility during the 15 calendar years immediately prior to retirement.

For purposes of calculating eligibility under paragraphs 2(a) and 2(b) above, periods of Your employment with the Sheet Metal Workers International Association, the International Training Institute or the Sheet Metal and Air Conditioning Contractors' National Association will be disregarded (*i.e.*, treated as if the period during which You were so employed did not exist).

You must apply for coverage within 60 days of the date You lose eligibility for the Fund Benefits as an Active Employee, or if You become employed by the Sheet Metal Workers

International Association, the International Training Institute or the Sheet Metal and Air Conditioning Contractors' National Association and are otherwise eligible as a Retiree, then within 60 days of the date You cease to be employed by such organization. Payment is due by the 20th day of the month preceding the month coverage is to begin, and in each following month. If payment is not received on a timely basis for any month, coverage will terminate and cannot be reinstated without a return to Active Employee eligibility.

You and Your eligible Dependent(s) will be covered under the same Plan that You were covered under as an Active Employee immediately prior to Your retirement.

Benefits for Retired Employees under each of these Plans are different in some ways from those of Active Employees, as described in the Benefit Summary.

Certified Disability of Retirees

If You are unable to work because of a Certified Disability, You will be considered eligible for Retired Employee Benefits if You meet the requirements concerning employment stated in Item 2. in the previous Section, and You were eligible for this Plan's benefits on the date of termination of Your employment. There is no minimum age requirement.

A Certified Disability is one for which You are drawing:

1. A Social Security Disability Pension; and/or
2. A Disability Pension from a Sheet Metal Industry Pension Plan.

If You qualify as a disabled Retiree You may obtain coverage for Retired Employee Benefits by sending Your proof of disability and the required contribution to the Fund Office in the manner and amount specified by the Board of Trustees.

Long Term Service Retirees (Effective January 1, 1987)

You will be eligible for a Special Life Insurance Benefit if, at retirement:

1. You are age 60 or over;
2. You had 25 years of employment covered by the Collective Bargaining Agreement of a Local Union affiliated with the Sheet Metal Workers International Association or a Participation Agreement with the Fund;
3. You had 5 full consecutive calendar years of eligibility immediately prior to retirement, with at least 3,000 hours of work for which contributions were required to the Fund, including hours credited as a result of disability, and some covered employment in the last 3 years;
4. You had at least 10 full Calendar Years of eligibility during the 15 Calendar Years immediately prior to retirement; and
5. You were eligible for this Plan's Benefits on the date of termination of Your employment.

Effective Date of Coverage for Retiree Benefits

If You meet the qualifications for one of the types of Retired Employee Benefits described, You will become eligible for such Benefits on the first day of the month following the month Your application and self-payment are received by the Fund Office.

Termination of Retired Employee Benefits

Eligibility for Retired Employee Benefits will terminate on the earliest of the following dates:

1. The date You attain 65 years of age:
2. The date You become eligible for Medicare; or
3. The last day of the month preceding any month for which You have not made the required self-payment to the Fund Office.

The Retired Employee shall notify the Fund Office within 10 days of notification of eligibility for Medicare.

Eligible Dependent of Retired Employees

Your Dependents who were eligible for coverage under this Plan while You were an Active Employee may also be covered under this Plan for Retired Employee Benefits. When You apply for Retired Employee Benefits, You will have the opportunity to apply for Dependent coverage. You will have one 60-day period in which to consider the decision for Retiree and Dependent coverage. **The choice not to cover a Dependent in this manner may not be changed at a later date.**

If You retire from work in the Sheet Metal Industry after You attain age 65 and are otherwise eligible as a retiree, your Dependent Spouse who was covered under this Plan immediately prior to your retirement, and who is less than age 65, will automatically be eligible to remain covered under this Plan, as long as the required self-payments described below are made to the Fund Office, and as long as the Dependent Spouse is otherwise eligible for coverage under the Plan.

Termination of Retired Employees' Dependent Coverage

Dependent coverage will terminate on the earliest of the following:

1. The date a Dependent Spouse attains 65 years of age;*
2. The date a Dependent Spouse becomes eligible for Medicare;
3. The date a Dependent Child no longer satisfies the definition of an eligible Dependent;
4. The last day of the month preceding any month the required contribution payment to the Fund Office is not made; or

5. For a Dependent Child, the date a Retiree or the Retiree's Spouse cancels coverage or such coverage is terminated; or
6. With respect to a Dependent Spouse and former Step-children, the date You become Legally Separated or Divorced, which shall be the date of entry of a court order or decree dissolving the marriage between You and the Dependent Spouse or legally separating You and the Dependent Spouse, regardless of whether such order or decree is subject to appeal or modification, requires You to provide health insurance coverage, or includes a delay in the finality or operation of the order or decree. Note that such court order or decree cannot alter or modify the terms of the Plan or require the Fund to provide any benefit type, form, eligibility option, or other option not otherwise provided under the Plan.

*If when You attain age 65; or are eligible for Medicare; or retire from work in the Sheet Metal Industry after you attain age 65, Your Spouse is less than age 65, benefits for Your Spouse will continue until Your Spouse attains age 65 or is eligible for Medicare, provided the required self-payments are made to the Fund Office so long as he/she also remains Your Spouse, as defined herein, and otherwise eligible for coverage under the Plan.

Dependent Spouse Self-Payments

Your Dependent Spouse may continue coverage by making payments to the Fund after Your death until the earliest of:

1. The date Your Spouse remarries;
2. The date Your Spouse becomes eligible under another group health plan;
3. The date Your Spouse reaches age 65;
4. The date Your Spouse becomes eligible for Medicare ; or
5. The last day of the month preceding any month for which Your Spouse has not made the required self-payment to the Fund Office.

Retiree Refund

Retirees who are covered by the Plan and who work up to 39 hours a month for an Employer who is bound by a Collective Bargaining Agreement between that Employer and a Local Union participating in the Fund will be eligible to receive a refund of up to 39 hours of the hourly contributions paid on their behalf for each month in which work was performed. This refund will be available each January for hours contributed the previous year. The refund must be requested in writing and submitted to the Fund Office by the Retiree. The Retiree must continue to make monthly self-payments in order to maintain eligibility with the Fund.

4-4. SPECIAL CONTINUATION RULES

Continuation During Disability Periods

If, after You become covered under this Plan, You are unable to work because of a Total Temporary Disability, You will be credited, for the purpose of maintaining eligibility, with 25 Disability Hours for each full week of such disability. However, in no event will more than 650 hours of such Disability Hours credit be granted during any continuous 12-month period.

A Total Temporary Disability is one for which You are:

1. Receiving weekly Loss of Time Benefits through the Fund; or
2. Receiving Workers' Compensation Benefits as the result of a total disability incurred within the jurisdiction of a participating Local Union and You submit evidence to the Fund Office that You are receiving such benefits.

The period of coverage for disabled Employees starts the first day the Employee became Totally Temporarily Disabled and last worked. At the end of such period, if You are still Totally and Permanently Disabled and/or drawing Workers' Compensation benefits, You may self-pay for continued medical coverage under the Continuation of Coverage (self-pay) as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) rules described in Section 4-5.

Reciprocal Agreements

Your eligibility may be extended after it would otherwise have terminated when You work outside the jurisdiction of this Fund and the Fund participates in the Sheet Metal Workers International Health and Welfare Reciprocal Agreement ("Reciprocal Agreement"), and may have other such agreements in effect from time to time.

When You work in the jurisdiction of another Fund which is signatory to the Reciprocal Agreement and contributions made on Your behalf, You will be credited with Your hours worked under this Fund, and they may be sufficient to meet requirements for continuing eligibility. If You have questions about whether working in another jurisdiction will affect Your eligibility, You may call the Fund Office to find out whether a Reciprocal Agreement is in effect.

4-5. USERRA

In any case in which a Member or any of such Member's Dependent has coverage under the Plan, and such Member is not actively at work by reason of active duty Service in the Uniformed Services, Your coverage and Your Dependents' coverage will terminate on the first day of the month which follows the date of Your induction unless You choose to self-pay for this coverage described in this Section.

Upon Your discharge from the Armed Forces, You may be reinstated as a fully covered Employee on the date You return to active employment for a contributing Employer, if You return to such work within 90 days from the date of Your discharge from active duty or from hospitalization continuing after discharge for a period of not more than one year. If You do not return to covered employment within such time, You will have to satisfy the requirements for eligibility as a new Employee.

Uniformed Services Employment and Reemployment Rights are Federally Mandated

Continuation of Group Health Coverage

1. For You and Your eligible Dependent(s), if Health Coverage ends because of Your Service in the Uniformed Services, You may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
    a. The end of the period during which You are eligible to apply for reemployment in accordance with USERRA; or
    b. Up to 24 consecutive months after coverage ended.
2. To continue coverage, You or Your Dependent(s) must pay the required premium, except that, in the case of a Member who performs Service in the Uniformed Services for less than thirty-one (31) days, such Member will pay the normal contribution for the thirty-one (31) days. The Fund Office will inform You or Your Dependent(s) of procedures to pay premiums.
3. An eligible Participant's and Dependent's continued Health Coverage will end at midnight on the earliest of:
    a. The day Your former Employer ceases to provide any group health plan to any Employee;
    b. The day the required premium is due and unpaid;
    c. The day an Eligible Participant or Dependent again becomes covered under the Plan; or
    d. The day continued coverage under the Plan ends.

The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

Reemployment (following Service in the Uniformed Service)

Following discharge from active duty services, You may be eligible to apply for reemployment with Your former Employer in accordance with USERRA. A Member who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Upon Your discharge from active duty services, You may be reinstated as a full Participant Member on the date You return to active employment with a contributing Employer, if You return to such work within 90 days from the date of Your discharge from active duty or from hospitalization continuing after discharge for a period of not more than one year. If You do not return to covered employment within such time, You will have to satisfy the requirements for eligibility as a new Member. Except as otherwise provided in the last paragraph of this section, upon re-employment and reinstatement of coverage no new exclusion or waiting period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This applies to the Member who is re-employed and to a Dependent who is eligible for coverage under the Plan by reason of the reinstatement of the coverage of such Member.

4-6. COBRA

Continuation of Coverage (Self-Pay) as Required by COBRA

Who may elect COBRA, and when?

The Fund agrees to offer continuation of coverage pursuant to the provisions of COBRA, if required, to eligible Participants who experience a Qualifying Event while the Plan is in force. You and Your Eligible Dependent(s) have the right to continue Your Health Coverage (and dental or vision coverage, if applicable) under this Plan on a self-pay basis, as described under this Section, if coverage would otherwise terminate due to a Qualifying Event. COBRA continuation coverage may become available to Members or Members' Dependents when such individuals would otherwise lose group health coverage. COBRA coverage is a temporary extension of coverage under the Plan. COBRA requires the Fund to allow eligible individuals to continue their Health Coverage for eighteen (18), twenty-nine (29), or thirty-six (36) months, depending on the Qualifying Event, as further described herein.

This provision does not apply to Accidental Death and Dismemberment, Loss of Time, or Life Insurance.

A **"Qualified Beneficiary"** includes a Member or a Member's Dependent who, on the day before the Qualifying Event, is covered by the Plan. A qualified beneficiary also includes a Participant Member's newborn Child or children Legally Placed for Adoption with the Participant Member during the continuation period. A Child born to, adopted by, or Legally Placed for Adoption with a Participant Member during a period of COBRA continuation coverage is considered a Qualified Beneficiary provided that, if the Participant Member is a Qualified Beneficiary, the Participant has elected COBRA continuation coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan, whether through Special Enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other Family members of the Member. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A Child of the Participant Member who is receiving Benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Fund Office during the Participant Member's period of employment with a contributing Employer is entitled to the same rights to elect COBRA continuation coverage as an eligible Dependent Child of the Participant Member.

"Qualifying Event" means one of the following occurrences which would otherwise terminate Your or Your Dependents' coverage in the absence of this provision:

1. Termination of Your employment, other than for gross misconduct;
2. Your work hours are reduced so as to render You ineligible for coverage;
3. Your retirement;
4. Your death;
5. Your entitlement to Medicare;

6. Your Divorce or Legal Separation, (also, if Your Spouse (the Employee) reduces or eliminates Your group Health Coverage in anticipation of a Divorce or Legal Separation, and a Divorce or Legal Separation later occurs, then the Divorce or Legal Separation may be considered a Qualifying Event for You even though Your coverage was reduced or eliminated before the Divorce or Legal Separation);
7. With respect to Your Dependent Child, his ceasing to satisfy the Plan's definition of an eligible Dependent; or
8. With regard to Retirees under the Plan, a proceeding in bankruptcy under Title XI of the United States Code with respect to an Employer, if such bankruptcy results in the loss of coverage of any Retiree under the Plan (including the Retiree's Dependents if such Dependents also become Qualified Beneficiaries if such bankruptcy results in their loss of coverage under the Plan).

Notifying the Fund Office of Qualifying Events

Your employer must notify the Fund Office within 30 days of the Qualifying Event if the Qualifying Event is the end of Your employment, reduction in Your hours of employment, eligibility for Medicare, your employer's bankruptcy proceedings, or Your death. **However, for Your protection, You or Your Qualified Beneficiaries should also notify the Fund Office of these events within 30 days.**

For the other qualifying events, such as Your Divorce or Legal Separation, or Your Dependent Child losing eligibility for coverage as a Dependent Child under the Plan rules, a COBRA election will be available to You ONLY if You notify the Fund Office, IN WRITING, within 60 days of the later of:

1. **The date of the Qualifying Event; or**
2. **The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.**

IN PROVIDING ANY NOTICE TO THE FUND OFFICE, You MUST use the Plan's form and You must follow the procedures outlined below. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED TO THE PLAN ADMINISTRATOR IN WRITING during the 60 day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA. You may obtain a free copy of the Plan's notice form from the Fund Office.

Electing COBRA coverage

To elect COBRA continuation coverage, You must complete the election form that is part of the Plan's COBRA election notice and mail or hand-deliver it to the Fund Office. An election notice will be provided to You at the time of a Qualifying Event. You may also obtain a copy of the election form from the Fund Office.

Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for only one, several, or for all Dependent

Children who are Qualified Beneficiaries. Parents may elect to continue coverage on behalf of any Dependent Children. The Member may elect COBRA continuation coverage on behalf of their Spouse.

Election Period

You and/or Your Dependent(s) must elect to continue coverage within 60 days of the later of:

1. The date You and/or Your Dependent(s) would otherwise lose coverage due to the Qualifying Event;
2. The date You and/or Your Dependent(s) are notified of Your right to elect the continuation coverage; or
3. The date the Participant becomes an "eligible individual" (as that term is used in the Trade Act of 2002) provided that such election is made not later than six (6) months after the Qualifying Event that gives rise to eligibility under the Trade Act of 2002.

Such election must be in writing, on a form provided by the Fund Office. Elected Benefits will be continued provided:

1. The election form is duly completed and returned to the Fund Office within the 60-day period noted above; and
2. The required self-pay contribution is paid to the Fund Office within 45 days of Your and/or Your Dependents' election.

If mailed, Your election must be postmarked, and if hand delivered, Your election must be received by the individual at the address specified on the election form, no later than the due date. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA**.

Each qualified beneficiary will have an independent right to elect COBRA. Continuation coverage may be elected for only one, several, or for all Dependent Children who are qualified beneficiaries. A Parent may elect to continue coverage on behalf of any Dependent Children. The Employee or the Employee's Spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

Notice of Unavailability of COBRA Coverage

If the Fund Office reviews Your application for COBRA continuation coverage and determines that You are not entitled to COBRA coverage, You will receive a notice of unavailability of COBRA Health Care Continuation Coverage. The notice will state Your reason for requesting coverage and the Fund Office's reason for denying COBRA coverage, including any information relied upon in making the determination. The notice will state the date upon which Your coverage terminated or will terminate, accordingly. If You disagree with the Fund Office's determination, You can request its reconsideration by appealing the decision as follows:

1. Send a written letter to the Fund Office within 30 days of Your receipt of this notice.

2. Explain why You believe that You are entitled to COBRA or extended COBRA coverage, including a copy of all information or documentation You wish to be reviewed.
3. Be sure to include Your name, current address, and the names of any covered Dependents You wish to include in Your appeal.

The Fund Office will respond to Your appeal within 14 days of its receipt.

Trade Act of 2002

The Trade Act of 2002 (TAA) created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain Retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of sixty-five percent (65%) of premiums paid for qualified health insurance, including continuation coverage. American Recovery and Reinvestment Act of 2009 (ARRA) made several amendments to these provisions, including an increase in the amount of the credit to eighty percent (80%) of premiums for coverage before January 1, 2011, and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (Participant Members who have a non-forfeitable right to a Benefit, any portion of which, is to be paid by the PBGC) and TAA-eligible individuals.

If You have questions about these provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Special considerations in deciding whether to elect COBRA

In order to protect Your family's rights, You should keep the Fund Office informed of any changes in the addresses and contact information of family members. You should also keep a copy, for Your records, of any notices You send to the Fund Office.

In considering whether to elect continuation coverage, You should take into account that a failure to continue Your group Health Coverage will affect Your future rights under Federal Law. First, You can lose the right to avoid having pre-existing condition exclusions applied to You by other group health plans if You have more than a 63 day gap in health coverage, and election of continuation coverage may help You not have such a gap. Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if You do not get continuation coverage for the maximum time available to You. Finally, You should take into account that You have special enrollment rights under Federal Law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your Spouse's employer) within 30 days after Your group Health Coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of continuation coverage if You get continuation coverage for the maximum time available to You.

Under special rules that apply if an Employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the Fund Office for more information about these special rules.

Certain Employees and former Employees who are eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within 6 months after plan coverage is lost). ***If You are an Employee or former Employee and You qualify for TAA or ATAA, contact the Fund Office promptly after qualifying for TAA or ATAA or You will lose any right that You may have to elect COBRA during a special second election*** *period.*

How long will my COBRA Continuation Period last?

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of these maximum coverage periods for several reasons, which are described in more detail below.

Initial coverage

Coverage for You and/or Your Dependent(s) may be continued for up to 18 months, if coverage terminated due to the person's:

1. Termination of employment, other than for gross misconduct;
2. Reduced work hours; or
3. Retirement.

The 18-month period of continuation may be extended pursuant to a disability or second Qualifying Event extension, as detailed below.

Coverage for Your Dependent may be continued for up to a total of 36 months, if coverage terminated due to:

1. Your death;
2. Your entitlement to Medicare;
3. Divorce or Legal Separation; or
4. With respect to Your Dependent Child, his ceasing to satisfy the Plan's definition of an Eligible Dependent.

When the Qualifying Event is end of employment or reduction of the Employee's hours of employment, and the Member became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Member lasts under 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment

terminates, COBRA coverage under the Plan for his Spouse and Children who lost coverage as a result of his termination can last up to 36 months after the date of the Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Extension of coverage due to a disability

A Member or Dependent who is determined to be disabled under Title II or XVI of the Social Security Act before the COBRA event or within the first sixty (60) days of COBRA continuation coverage is entitled to an additional 11 months of coverage, for a total maximum of twenty-nine (29) months of continuation coverage, but only if such Member or Dependent has provided written notice of the determination of disability to the Fund Office within sixty (60) days after determination is issued and before the end of eighteen (18) months of coverage, i.e., the disability must last until the end of the 18-month period of continuation coverage. Such disabled Member or Dependent must also notify the Fund Office within thirty (30) days of any determination that the Member or Dependent is no longer disabled. The extended period of COBRA continuation coverage applies to both the Member and Dependents.

Extension of coverage due to second Qualifying Event

If a second Qualifying Event occurs within the initial 18-month period of continuation coverage, the coverage for any affected Dependent who was a Participant under this Plan both at the time of the first and the second Qualifying Events may be extended up to thirty-six (36) months from the first Qualifying Event. You must notify the Fund Office of the second Qualifying Event in writing in order to extend the initial period of COBRA coverage. This extension may be available to any Dependent receiving continuation coverage if the Member or the former Member dies, becomes entitled to Medicare benefits, gets Divorced or is Legally Separated, or if the Dependent Child stops being eligible under the Plan as a Dependent, but only if the Qualifying Event would have caused the Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice Procedures

Any notice that You provide to the Fund Office MUST be in writing. Oral notice, including in person or on the telephone, is NOT acceptable. You MUST mail (to the P.O. Box) or hand-deliver (to the physical address) Your notice to the Fund Office at this address:

Fund Office
Mo-Kan Sheet Metal Workers Welfare Fund
2902 Blue Ridge Blvd., Ste. 100
P. O. Box 300019
Kansas City, Missouri 64130

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the name of the Plan, **MO-KAN Sheet Metal**

Workers' Welfare Fund, the name, address, and social security number of the Employee covered under the Plan, the names, addresses, and social security numbers of the qualified beneficiaries, the Qualifying Event, and the date that it happened.

Your notice of a second Qualifying Event must also list the name, address, and social security numbers of the person(s) receiving continuation coverage, the Qualifying Event, and the date that it happened. If the Qualifying Event is the death of the Employee, Your notice must also include a copy of the Death Certificate. If the Qualifying Event is a Divorce or Legal Separation, Your notice must also include a copy of the Divorce Decree or the Decree of Legal Separation. If the Qualifying Event is disability of the Employee or beneficiary, Your notice must also include the name of the disabled person, and a copy of the Social Security Administration's determination letter.

The Fund Office has a form for Your use in notifying the Plan of a Qualifying or second Qualifying Event, a disability determination, or a determination that a person is no longer disabled.

Termination of COBRA Coverage before the end of the maximum coverage period

The continued coverage will end on the first of the following dates:

1. The date this Plan terminates;
2. The date a required contribution is due and unpaid after any applicable grace period;
3. The date You and/or Your Dependent(s) become covered under another group health plan. This may not apply if You or Your Dependent has a pre-existing condition which is not covered under the new plan. Contact the Fund Office for additional information when You and/or Your Dependent(s) become covered under another group plan;
4. The date You and/or Your Dependent(s) become eligible for Medicare;
5. The date the applicable period of continuation is exhausted; or
6. The first day of the month which begins 30 days after You or Your Dependent receives a final determination from Social Security that the individual is no longer disabled, in situations where the Qualifying Event was termination of employment or reduction in hours and where COBRA coverage was being continued for an additional 11 months for a disabled individual.

COBRA continuation coverage may end prior to the end of the maximum period for COBRA coverage. If the Fund Office determines that Your COBRA coverage will terminate before the end of the maximum period of coverage, You will receive a notice of termination of continuation coverage. This notice will state the beneficiaries whose coverage is being terminated, the reason for the termination, the date Your coverage will terminate or was terminated, and any other information deemed necessary by the Fund Office.

If You disagree with this determination (that is, if You believe that Your COBRA coverage should not have been terminated), You can request that we reconsider our decision by filing an appeal as follows:

1. Send a written appeal to the Fund Office, at the address listed above, within 30 days of Your receipt of the Notice.
2. Explain why You believe that Your COBRA continuation coverage was improperly terminated, including copies of all information or documentation You wish to include in Your appeal.
3. Be sure to include Your name, current address, and the names of any covered Dependent(s) You wish to include in Your appeal.

The Fund Office will respond to Your appeal within 14 days of its receipt.

When Your COBRA Continuation ends, You will be provided with certification of Your length of coverage under the Plan, as required by the Health Insurance Portability and Accountability Act (HIPAA). This may help to eliminate or reduce any pre-existing limitation under a new group medical plan.

Cost of COBRA coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the Plan (including both employer and Employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. If Plan Benefits or costs for coverage change for active Employees under the Plan, such changes in Benefits and costs will be applicable to You, as well (changes in cost will be reflected in future premium rate adjustments). You will be notified of COBRA premium changes.

Payment for COBRA coverage

You should pay for COBRA coverage by check. **Please make checks payable to: Mo-Kan Sheet Metal Workers Welfare Fund**. Your first payment and all periodic payments for continuation coverage should be sent to:

Mo-Kan Sheet Metal Workers Welfare Fund
2902 Blue Ridge Blvd., Ste. 100
P. O. Box 300019
Kansas City, Missouri 64130-0019

First payment for continuation coverage

If You elect continuation coverage, You do not have to send any payment with the Election Form. However, You must make Your first payment for continuation coverage not later than 45 days after the date of Your election. (This is the date the Election Notice is post-marked, if mailed.) **If You do not make Your first payment for continuation coverage in full not later than 45 days after the date of Your election, You will lose all continuation coverage rights under the Plan.**

For example, Sue's employment terminates on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of Your first payment is correct. You may contact the Fund Administrator at the address and telephone number listed below to confirm the correct amount of Your first payment.

Periodic payments for continuation coverage

After You make Your first payment for continuation coverage, You will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period will be provided to You in the election notice, which the Fund Office provides when it is notified of a qualifying event. The periodic payments are made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. If You make a periodic payment on or before the first day of the coverage period to which it applies, Your coverage under the Plan will continue for that coverage period without any break. **The Plan WILL NOT send periodic notices of payments due (bills) for these coverage periods. You must provide payments within the appropriate time frame, or You will lose coverage under the Plan.** If You have any questions about how much You owe, You may contact the Fund Office for clarification.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, You will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment**. If You fail to make a periodic payment before the end of the grace period for that coverage period, You will lose all rights to continuation coverage under the Plan.**

4-7. TERMINATION OF CONTINUATION COVERAGE

The continued coverage will end on the first of the following dates:

1. The date this Plan terminates;
2. The date a required contribution is due and unpaid after any applicable grace period;
3. The date You and/or Your Dependent(s) become covered under another group health plan. This may not apply if You or Your Dependents has a pre-existing condition which is not covered under the new plan. Contact the Fund Office for additional information when You and/or Your Dependent(s) become covered under another group plan;
4. The date You and/or Your Dependent(s) become eligible for Medicare;
5. The date the applicable period of continuation is exhausted; or
6. The first day of the month which begins 30 days after You or Your Dependent receives a final determination from the Social Security that the individual is no longer disabled, in

situations where the Qualifying Event was termination of employment or reduction in hours and where COBRA coverage was being continued for an additional 11 months for a disabled individual.

Contact the Fund Office as soon as possible when a Qualifying Event has occurred for additional information about You and Your Dependent's right to Continuation of Coverage.

When Your COBRA Continuation ends, You will be provided with certification of Your length of coverage under the Plan. This may help to eliminate or reduce any pre-existing limitation under a new group medical plan.

4-8. FAMILY AND MEDICAL LEAVE ACT

If both You and your Employer are eligible, the Family and Medical Leave Act of 1993 (FMLA) creates a federal right for You to take up to 12 weeks of unpaid leave for Your serious illness, after the birth or adoption of a Child, or to care for Your seriously ill Spouse, Parent, or Child. FMLA requires eligible Employers to maintain health care coverage under any health plan for the length of the leave as if You were still employed. In addition, FMLA states that if You take FMLA leave, You may not lose any benefits that You had accrued before the leave. The Fund will grant eligibility for a family medical leave and maintain Your prior eligibility status until the end of the leave, provided the Employer properly grants the leave under FMLA and the required payments are made to the Fund.

4-9. QUALIFIED MEDICAL CHILD SUPPORT ORDER

Notwithstanding any other provision of this Plan to the contrary, the Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA Section 609(a).

Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient's custodial parent or legal guardian.

Upon receipt of a QMCSO, the Fund Office shall promptly notify the Employee and each alternate recipient, as that term is defined in ERISA Section 609(a), of the receipt of such Order and the Plan's procedure for determining whether the Order is a QMCSO. The Fund Office will then determine whether the Order is a QMCSO pursuant to the Plan's procedures and notify the Employee and each alternate recipient of the determination.

4-10. CREDITABLE COVERAGE ISSUED BY THIS FUND

You and any of Your eligible Dependents will be automatically provided with a Certificate of Creditable Coverage when:

1. Your coverage under the Fund terminates;
2. Any continuation coverage under the Fund ceases; and

3. At any time You or Your eligible Dependents make a written request, in writing, while You or Your Dependent is covered by the Fund and for 24 months after coverage under the Fund ceases.

4-11. NOTICE TO THE FUND OFFICE

Please notify the Fund Office if any of the following occur:

1. You and/or Your Dependents have a change of address;
2. You acquire new Dependents, as supported by proper documentation;
3. You get married or divorced, as supported by the date of the event, Your Spouse's name, Your Spouse's date of birth, and a copy of Marriage Certificate or Divorce decree;
4. You would like to change Your beneficiary, supported by a change of beneficiary card;
5. You are involved in an accident which results in Workers' Compensation Benefits or for which you recover (or could potentially recover) payments or benefits from a third-party as a result of the accident, supported by the date of the accident, the claim number, the duration of disability, and any other relevant information;
6. You incur an Injury resulting in a Total and Permanent Disability; or
7. You and/or Your Dependents are entitled to other health insurance coverage.

SECTION 5. COVERED SERVICES

This Section describes the Benefits for Covered Services available under the Plan. The payment of Benefits for Covered Services is subject to all terms and conditions of the Plan and the Schedule of Health Benefits. In the event of a conflict between the Plan document or SPD and the Schedule of Health Benefits, the Schedule of Health Benefits controls. The percentage of Allowable Charges for Covered Expenses will be paid as indicated on the Schedule of Health Benefits.

All Covered Services are subject to the condition, limitations and exclusions of the Plan. All Covered Services are subject to Deductible, Co-payment, and Coinsurance requirements and the limitation and exclusion requirements of the Plan, unless otherwise specified.

The specified services and supplies will be Covered Services only if they are:

1. Incurred for a Covered Person while coverage is effective;
2. Performed, prescribed, or ordered by a Physician or other properly licensed provider;
3. Medically Necessary for the treatment of Your injury or illness, except for specifically listed routine preventive or diagnostic services;
4. Not excluded under the Plan;
5. Received in accordance with the requirements of the Plan, including any requirements regarding Usual, Customary, and Reasonable Charges and Allowable Charges;
6. For which the appropriate Pre-Admission Review, Emergency Admission Review, Pre-Authorization, and/or Continued Stay Review has been requested and Pre-Authorization was received, as required by the Plan; and
7. After the payment of all required Deductibles, Coinsurance, and Copayments.

To verify that a service is covered under the Plan before the service is received and/or a charge is incurred, please call 1-866-531-5488.

5-1. BENEFITS

We provide Benefits for Covered Services in excess of the Deductible, Co-payments, and Coinsurance. Certain Covered Services are subject to Calendar Year, Lifetime, and other maximums and other limits and conditions specified in the Plan.

Benefits are different depending on whether Covered Services are received from an In-Network Provider or an Out-of-Network Provider. Benefits for Covered Services will be greater if Covered Services are received from In-Network Providers. It is Your responsibility to ensure that You use In-Network Providers to receive the maximum Benefits. Failure to do so will increase Your financial responsibility. Call the PPO or use their website for a listing of In-Network Providers.

5-2. DEDUCTIBLE

The Deductible is applied each Calendar Year. Except as specifically provided, the Calendar Year Deductible must be satisfied before We will provide benefits for Covered Services. After a combination of covered family members have satisfied the family Deductible for a Calendar Year, the Deductible will be considered satisfied for all covered family members. No Covered Person is allowed to contribute more than its own individual Deductible to the family Deductible per Calendar Year.

The Deductible applies only once in a Calendar Year. Any Expenses incurred in the last three (3) months of a Calendar Year which are used to satisfy the Deductible, in part or in full, will also be applied to reduce the deductible for the following Calendar Year.

5-3. CO-PAYMENTS

Co-payments are a specified charge that You must pay each time You receive a service of a particular type or in a designated setting.

5-4. OUT-OF POCKET MAXIMUM

After a combination of covered family members have satisfied the family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be considered satisfied for all covered family members.

There are separate Out-of-Pocket Maximums for In-Network Providers and Out-of-Network Providers. The amount You pay for Covered Services received from In-Network Providers or Out-of-Network Providers will apply to the Out-of-Pocket Maximum for each other.

Please see the definition of Out-of-Pocket Maximum for a listing of expenses that do not apply to the Out-of-Pocket Maximum.

5-5. APPROVED IN ADVANCE

Services that must be Approved in Advance by Us will state so in the applicable Covered Service provision. The following explanation outlines Your responsibilities for obtaining such approval and the consequences of obtaining such services when they have not been Approved in Advance.

Services Received from In-Network Providers

If these services are not Approved in Advance, the admitting Physician, provider, and/or Hospital will be responsible for the cost associated with such services, regardless of Medical Necessity.

Services Received from Out-of-Network Providers

If these services are not Approved in Advance, You will be responsible for the cost associated with such services, regardless of Medical Necessity.

5-6. COVERED SERVICES DESCRIPTIONS

5-6(1) DENTAL SERVICES/SURGERY

Accidental Injury

We provide Benefits for dental services under the medical benefit only when such services are for treatment of an Accidental Injury. Covered Services under the medical Plan are limited to treatment of natural teeth. Treatment must be completed within 90 days of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the Covered Person prevents treatment from being rendered within 90 days of the date of the Accidental Injury. Covered Services also include treatment of jaw fractures or complete dislocations and diagnostic x-rays in connection with these fractures and dislocations.

The purchase, repair, or replacement of dental prostheses needed as a direct result of an Accidental Injury (except injury from biting or chewing) will be covered under dental.

Tooth Extractions

We provide benefits for extraction of the tooth (teeth) and services related to such extraction(s) when performed in conjunction with the treatment of head and/or neck tumor(s).

Dental Implants

We provide benefits for dental implants and bone grafts for the following conditions:

1. The repair of defects in the jaw due to tumor/cyst removal;
2. Severe atrophy in a toothless arch;
3. Exposure of nerves;
4. Non-union of a jaw fracture;
5. Loss of tooth (teeth) due to an Accidental Injury; and
6. Correction of a defect diagnosed within 31 days of birth.

Orthognathic Surgery

We provide benefits for orthognathic surgery for the following conditions:

1. Correction of a defect diagnosed within 31 days of birth; or
2. Correction of a defect due to an Accidental Injury. Treatment for correction of a defect due to an Accidental Injury must be completed within 12 months of the date of the Accidental Injury to be considered a Covered Service, unless the medical condition of the

Covered Person prevents treatment from being rendered within 12 months of the date of the Accidental Injury.

Complications of Dental Treatment

We provide Benefits for inpatient Hospital services required as a result of complications of dental treatment. Covered Serves are limited to services that cannot be adequately provided in an outpatient setting.

5-6(2). ALLERGY

We provide Benefits for allergy services provided in a Physician's office. Covered Services are limited to office visits and Medically Necessary testing, injections, and allergy antigens.

5-6(3). AMBULANCE SERVICES

We provide Benefits for transportation by a licensed Ambulance service when it is Medically Necessary to transport You from the place where an Accidental Injury or other Emergency Medical Condition occurred to the nearest facility where appropriate treatment can be obtained.

Covered Services include transportation by an air Ambulance only when it is Medically Necessary to utilize an air Ambulance and will be limited to transportation to the nearest facility where appropriate treatment can be obtained.

5-6(4). ANESTHESIA

Medical

We provide Benefits for anesthesia materials and their administration if the surgical, orthopedic, diagnostic, or obstetrical service requiring the anesthesia is covered. Covered Services must be provided by a Physician (other than the operating Physician) or Certified Registered Nurse Anesthetist (CRNA).

Dental

We provide Benefits for general anesthesia materials and their administration for dental care if provided to the following Covered Persons:

1. Children age 26 and under;
2. Persons who are severely disabled; or
3. Persons who have medical or behavioral conditions requiring hospitalization or general anesthesia when dental care is provided.

Whether such services are provided in a Hospital, surgical center, or office, Covered Services must be provided by a Physician, Certified Registered Nurse Anesthetist (CRNA), or Dentist.

5-6(5). CHIROPRACTIC SERVICES

We provide Benefits for Chiropractic Services. Coverage includes initial diagnosis and clinically appropriate and Medically Necessary services to treat the diagnosed disorder. X-rays are the only diagnostic service covered under the Chiropractic Benefit and the x-rays must be performed and read in the Chiropractic office. Covered Services may be limited as indicated in the Benefit Summary.

5-6(6). CLINICAL TRIALS

We provide Benefits for Routine Patient Care Costs as the result of a Phase III or IV clinical trial for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease, if approved by one or more of the following entities and the treating facility and personnel has the expertise and training to provide the treatment and treat a sufficient number of patients:

1. One of the National Institutes of Health ("NIH");
2. An NIH cooperative group or center;
3. The FDA in the form of an investigational new drug application;
4. The Federal Departments of Veterans Affairs or Defense;
5. An institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with an implementation of regulations for the protection of human subjects; and/or
6. A qualified research entity which meets the criteria for NIH center support grant eligibility.

Covered Services are limited to Clinical Trials where the available clinical or pre-clinical data provide a reasonable expectation that the treatment will be superior to non-investigational treatment alternatives.

"Routine patient care cost" is defined as follows:

1. Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA, for use in treating the patient's particular condition;
2. Reasonable and Medically Necessary services needed to administer a drug or device under evaluation in a clinical trial; and
3. All other items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial, except:
    a. The investigational item or service itself;
    b. Items and services provided solely to satisfy data collection and analysis needs which are not used in the direct clinical management of the patient; and

c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Clinical trial services must be Approved in Advance by Us.

5-6(7). COCHLEAR IMPLANTS

We provide Benefits for a cochlear implant, but the procedure must be Approved in Advance by Us. Covered Services are limited to the initial cochlear implant and related implant services. Covered Services do not include repairs, replacements, or duplicates.

5-6(8). DIABETES

We provide Benefits for the treatment of diabetes. Covered Services are limited to self-management training (including diet counseling from a registered dietician or certified diabetes educator) and Physician-prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes. Benefits are available only for Covered Persons with gestational, type I, or type II diabetes. Insulin, oral anti-diabetic agents, syringes, test strips, lancets, needles, and glucometers are Covered Services under the Prescription Drug Benefit.

5-6(9). DURABLE Medical EQUIPMENT

We provide Benefits for the rental or purchase of Durable Medical Equipment ("DME") for use outside a Hospital subject to the following conditions:

1. Use of DME will be authorized for a limited period of time;
2. We retain the right to possess the equipment and You agree to cooperate with Us in arrangements to return the equipment following Your authorized use; and
3. We have the right to stop covering the rental when the item is no longer Medically Necessary.

Covered Services are limited to the basic DME which meets the minimum specifications which are Medically Necessary. Covered Services include:

1. Hand-operated wheelchairs;
2. Hand-operated hospital-type bed;
3. Oxygen and the equipment for its administration;
4. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators);
5. Two wigs per Calendar Year (as Medically Necessary);
6. Three mastectomy bras per Calendar Year;
7. Three pairs of Compression Stockings or Edema Sleeves per Calendar Year;
8. Breast Pumps: One pump per pregnancy (manual or electric, single or double pump), covered at 100% with an In-Network provider. This benefit excludes items coded E0604

or items such as nursing pads, replacement parts, and/or accessories (such as tubing, adapters, shield protectors, bottles, bottle caps, milk bags, locking rings, etc.) Breast Pumps may be ordered within thirty (30) days of the patient's estimated delivery date with a prescription from the patient's doctor.

When Medically Necessary, an electrically operated bed or wheelchair may be covered at the discretion of the Plan Administrator after review of available alternatives.

The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing. Covered DME includes those items covered by Medicare, unless otherwise specified.

Covered Services include some warning or monitoring devices, including but not limited to glucose monitors, home apnea monitors for infants, 24-hour ECG monitors ("Holter"), home uterine monitors, and home oximetry monitors.

Covered Services do not include repair or replacement required as a result of abuse or misuse of DME. If repair or replacement of DME is authorized, We retain the option to determine whether to repair or replace the equipment. Covered Services do not include muscle stimulators, portable paraffin bath units, sitz bath units, stethoscopes, blood pressure devices, or items for comfort or convenience, such as (but not limited to) spas, whirlpools, Jacuzzis, hot tubs, humidifiers, dehumidifiers, and air conditioners. Covered Services do not include DME that would normally be provided by a Skilled Nursing Facility. See the Exclusions and Limitations Section of the Plan for additional exclusions which may apply.

The Benefit limit for renting DME will not exceed the reasonable purchase cost.

5-6(10). ELECTIVE STERILIZATION

We provide Benefits for elective sterilization.

5-6(11). EMERGENCY SERVICES AND SUPPLIES

We provide Benefits for the treatment of Emergency Medical Conditions. You must pay the Emergency Services and Supplies Co-payment if indicated in the Benefit Summary for each visit to an emergency room. This Co-payment will not apply if You are admitted to a In-Network Provider Hospital for the same condition within 24 hours.

Emergency Services are subject to the Deductible and Coinsurance requirements of the Plan in addition to Your emergency room Co-payment.

Co-payments for emergency room services will not apply to and will not be limited by Your Out-of Pocket Maximum.

5-6(12). FORMULA AND FOOD PRODUCTS FOR PHENYLKETONURIA (PKU)

We provide Benefits for formula and low protein modified food products recommended by a Physician for the treatment of Phenylketonuria ("PKU") or any inherited disease of amino and organic acids. Covered Services for formula and low protein modified food products are limited to Covered Persons under the age of 26. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Summary.

Low protein modified food products are limited to those products specifically formulated to have less than one (1) gram of protein per serving and are intended to be used under the direction of a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Formula and Food Product Benefits must be the patient's only source of nutrition to be covered, and are subject to the same Coinsurance provisions as other Covered Services.

5-6(13). GENETIC TESTING

This Plan provides genetic counseling and evaluation for routine BRCA testing, including BRCA screening, genetic counseling, and the BRCA test itself, if appropriate. Women may receive these Benefits if they are asymptomatic and have not previously received a BRCA-related cancer diagnosis, but have previously had breast, ovarian, or other cancer, or if they have had family history associated with an increased risk of BRCA-related cancer. Benefits apply regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

5-6(14). HEARING AID

Hearing aids are covered according to the Benefit listed in the Benefit Summary.

5-6(15). HOME HEALTH SERVICES

We provide Benefits for home health services provided in the home or other outpatient setting.

1. Covered Services are limited to part-time skilled nursing care, physical therapy, occupational therapy, or speech therapy;
2. The services must be received as an alternative to inpatient confinement in a Hospital or Skilled Nursing Facility; and
3. Your Physician must determine that You need home health care and design a home health care plan for You.

Covered Services do not include meals delivered to Your home, custodial care, companionship, or homemaker services.

5-6(16). HOSPICE SERVICES

Hospice Care services are covered when provided by a Participating Provider and You have less than six (6) months to live in the judgment of the Physician treating You. Hospice Care services shall include outpatient services, professional services of a Physician, and services of a psychologist, social worker, or family counselor for individual and family counseling.

Hospice Care services do not include the following:

1. Services of a person who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house;
2. Services or supplies not listed in the Hospice Care program;
3. Services for curative or life prolonging procedures;
4. Services for which any other Benefits are payable under the Agreement;
5. Services or supplies that are primarily to aid You or Your Dependent in daily living;
6. Services for respite care; or
7. Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins, or minerals.

5-6(17). IMMUNIZATIONS FOR CHILDREN AND ADULTS

We provide Benefits for routine and necessary childhood immunizations for covered Dependent Children, as required by the United States Center for Disease Control ("CDC"). Additionally, We provide Benefits for covered adults for immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the CDC with respect to the individual involved.

Covered Services for routine and necessary immunizations will be provided at 100% of the Allowable Charge and will not be subject to the deductible.

5-6(18). INFUSION THERAPY AND SELF-INJECTABLES

Infusion Therapy

We provide Benefits for infusion therapy services and supplies.

Infusion therapy is the administration of drugs or nutrients using specialized delivery systems which otherwise would have required You to be hospitalized. Infusion therapy in Your home or a Physician's office will be a Covered Service only if all of the following criteria are met:

1. If You did not receive infusion therapy at home or in Your Physician's office, You would have to receive such services in a Hospital or Skilled Nursing Facility;
2. The services are ordered by a Physician and provided by an infusion therapy provider or Physician licensed to provide such services; and

3. Services are Approved in Advance by Us.

Self-Injectables

We provide Benefits for self-injectables administered in the Physician's office or in the home setting. These services must be Approved in Advance by Us. Covered Services for growth hormones are limited to treatment for pediatric growth deficiency for Covered Persons under age 26. Most self-injectables are processed under Your Outpatient Drug Benefit; however, selected self-injectables may be processed under Your medical benefit.

5-6(19). INPATIENT HOSPITAL SERVICES

We provide Benefits for inpatient services at a Hospital for evaluation or treatment of conditions that cannot be adequately treated in an outpatient setting. Covered Services include room and board, general nursing care, intensive care services, operating and treatment rooms and their equipment, emergency rooms and their equipment and supplies, dressings, splints, and casts, electroshock or drug-induced shock therapy, and blood and the administration of blood and blood products. Personal care or convenience items are not covered.

All Admissions, except maternity and emergency Admissions, must be Approved in Advance by Us. We require notification of emergency and maternity Admissions within 48 hours of the Admission or as soon as reasonably possible.

5-6(20). LABORATORY AND X-RAY

This benefit will be payable if You or Your Eligible Dependents have laboratory tests or x-rays made or recommended by a Physician. Benefits will be payable only for charges in connection with the diagnosis of an Illness or Injury that is not employment-related.

5-6(21). MATERNITY SERVICES AND RELATED NEWBORN CARE

We provide Benefits for maternity services. Covered Services are limited to pre-natal, obstetrical, and postpartum services. The Co-payment will be assessed at the time of delivery and will be in addition to any applicable Deductible and Coinsurance. If the Mother is covered by the Plan and pays a Co-Payment at the time of delivery, then the newborn inpatient co-pay will be waived.

Dependent Children are not covered for maternity services.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Under the terms of the Newborn and Mother's Health Act of 1996, the Plan generally may not restrict Covered Services for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or

newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Plan may not require that a Provider obtain Authorization from the Plan for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours, as applicable. However, Pre-Authorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

Complications of Pregnancy

Covered Services do not include elective pregnancy termination, except when the life of the mother would be endangered if the fetus was carried to term.

5-6(22). MENTAL ILLNESS AND CHEMICAL DEPENDENCY

We provide Benefits for the treatment of Mental Illness and Chemical Dependency. Covered Services will be provided to the same extent as any other illness or condition. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008.

Covered Provider: In addition to Physicians and Hospitals, Covered Services provided by the following providers will be eligible for coverage, if such services are within the lawful scope of the provider and the provider is licensed by the state in which the services are rendered (if applicable), and the services are determined to be medically necessary: (1) psychologists; (2) licensed clinical social workers; (3) psychiatric residential and nonresidential treatment of facilities; (4) alcoholism treatment facilities; (5) drug abuse treatment facilities; (6) community mental health centers or clinics; and (7) licensed professional counselors.

Chemical Dependency Services

"**Chemical Dependency**" means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

"**Day Program Services**" means a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.

"**Episode**" means a distinct course of Chemical Dependency treatment separated by at least 30 days without treatment.

"**Medical Detoxification**" means Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with Chemical Dependency.

"**Nonresidential Treatment Program**" means a program certified by the Department of Mental Health involving non-residential care and structured, intensive treatment. This program provides treatment while allowing individuals to work, go to school, and carry on their regular daily

activities while receiving treatment such as services and supports."**Residential Treatment Program**" means a program certified by the Department of Mental Health involving residential care and structured, intensive treatment. This program is highly focused and primarily does not allow individuals to work, go to school, or carry on their regular daily activities while receiving services.

5-6(23). ORGAN TRANSPLANTS

We provide Benefits for Organ Transplants. These services must be Approved in Advanced by **Us or the Pre-certification Company.** If it appears You may need an Organ Transplant, We encourage You to review these Covered Services with Your Physician.

Covered Services are limited to services and supplies for Organ transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, and ancillary services. Coverage is provided for Cornea; Kidney, Kidney/Pancreas; autologous Islet Cell; Small Bowel; Small Bowel/Liver; Liver/ Kidney; Heart; Heart/Lung(s); Lung(s); and (allogenic and autologous) Bone Marrow and stem cell transplants for breast cancer and certain other conditions, when such transplants are Medically Necessary in accordance with Our policies for transplantation services. Contact the Pre-Authorization company for information on Designated Transplant Providers and Our policies for transplantation.

Designated Transplant Provider

A "**Designated Transplant Provider"** is a provider who has entered into an agreement with Us or through a national organ transplant network with which We contract to render Organ Transplant Services.

If Organ Transplant services are provided at a provider that is not a Designated Transplant Provider, Covered Services will be subject to the following limitations:

1. Benefits will be provided at the Out-of Network Provider level; and
2. The Coinsurance level for Organ Transplant Services received for Out-of-Network Providers will always be paid at the Out-of-Network Provider Benefit level.

Any amount for Covered Services incurred at a non-designated Transplant Provider will not apply to and will not be limited by Your Out-of-Pocket Maximum.

Donor Covered Services

The following apply when a human Organ Transplant is provided from living donor to a transplant recipient:

1. When both the recipient and the donor are covered under the Plan, Covered Services received by the donor and recipient will be provided;
2. When only the recipient is covered under the Plan, both the donor and the recipient are entitled to the Covered Services of the Plan. The donor's Covered Services are limited to

only those Benefits which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. Covered Services provided to a donor will be applied towards the recipient's Benefit limits under the Plan to the extent Covered Services are provided to the donor;

3. When only the donor is covered under the Plan, Covered Services are limited to only those services which are not provided by or available to the donor from any other source. This includes, but is not limited to, other health care plan coverage or any government program. No Covered Services will be provided to a transplant recipient who is not covered under the Plan; or
4. If any organ or tissue is sold rather than donated to a recipient covered under the Plan, no Covered Services will be provided for the purchase price of such organ or tissue. However, other costs related to evaluation and organ "Procurement Services" are covered.

As used herein, "**Procurement Services**" are the services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor, and transplant the organ to the location of the recipient within 24 hours after the match is made.

Immunosuppressant Drugs

We provide Benefits for immunosuppressant drugs required as a result of a covered Organ Transplant under the Outpatient Prescription Drug Benefit.

Limitations

A Covered Person is eligible for retransplantation as deemed Medically Necessary and appropriate by Us. All retransplantation must be Approved in Advance by the Pre-Certification company that We are in contract with.

Exclusions

You have no Benefit for a nonhuman or mechanical Organ Transplant.

You have no Benefit for transplant services which are Experimental or Investigative.

You have no Benefit for testing, typing, or screening when the person does not become a transplant or tissue donor.

5-6(24). OSTEOPOROSIS

We provide Benefits for the diagnosis and treatment of osteoporosis including bone density studies if Medically Necessary.

5-6(25). PRESCRIPTIONS DRUGS

We provide Benefits for drugs and medicines for use outside a Hospital which require a Physician's prescription. Due to concerns with appropriate use, certain medications or classes of medication may require Prior Authorization. To receive Prior Authorization, Your Physician will need to submit to Us a statement of Medical necessity.

You must always pay the lower of either: (1) Your applicable Prescription Drug Co-payment, specified in the Benefit Summary; or (2) the participating pharmacy's Usual and Customary Charge if the Usual and Customary Charges is less than Your Co-payment or Coinsurance.

Covered Drugs

Covered Services are limited to:

1. Legend drugs that, by Federal or State Law, can only be dispensed upon written prescription from an authorized prescriber;
2. Compound medications that contain at least one legend drug in a therapeutic amount; and
3. Off-label use of prescription drugs when treatment of the indication is recognized in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Your Physician must submit documentation supporting the proposed off-label use if requested by Us.

   For this specific Benefit, the following terms are defined as follows:

   a. "**Peer-reviewed medical literature**" means a published scientific study in a journal or other publication only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts, and that has been determined by the international committee of medical journal editors to have met the uniform requirements for manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

   b. "**Off-label use of prescription drugs**" means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA; and

   c. "**Standard reference compendia**" means that United States pharmacopoeia drug information, the American Hospital formulary service drug information, or the American Medical Association drug evaluation.
4. Insulin, syringes, needles, lancets, test strips, oral anti-diabetic agents, and glucometers;
5. Oral and injectable contraceptive drugs; and
6. Contraceptive devices and implants which require a Physician's prescription;

Covered Services are limited to drugs and medicines that have been approved for use in the United States by the FDA regardless of where the drugs are obtained. Drugs or medicines approved by the FDA for Experimental or Investigative Services are not covered. We may

impose administrative limits on the quantity or frequency by which a drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by community Physicians and pharmacists.

Exclusions

Benefits for prescription drugs are subject to the exclusion stated in the Exclusions and Limitations Section of the Plan. In addition, Covered Services do not include any of the following:

1. Appetite suppressants, anorexiants, and anti-obesity drugs;
2. Compounded medications with ingredients that do not require a prescription;
3. Experimental, Investigative, or unproven services and medication; medications used for Experimental indications and/or dosage regiments determined by Us to be Experimental including, but not limited to, those labeled "caution-limited" by federal law to investigational use; and drugs found by the FDA to be ineffective;
4. Medications for cosmetic purposes;
5. Medications and other items available over-the-counter that do not require a prescription order or refill by Federal or State Law (whether provided with or without a prescription) unless specified in the Benefit Summary;
6. Any medication that is equivalent to an over-the-counter medication;
7. Medications with no approved FDA indications;
8. Immunization agents related to voluntary travel;
9. Drugs related to treatment that is not a Covered Service under the Plan;
10. Prescription drugs that are not Medically Necessary unless otherwise specified;
11. Anabolic steroids, anti-wrinkle agents, dietary supplements, fluoride supplements, and growth hormones prescribed for anyone over age 26;
12. Blood or blood storage;
13. Lifestyle enhancing drugs, unless otherwise specified;
14. Fertility drugs; and
15. Drugs and devices that are intended to induce an abortion.

5-6(26). OUTPATIENT SURGERY AND SERVICES

We provide Benefits for outpatient surgery provided under the direction of a Physician at a Hospital or an outpatient facility.

Outpatient Therapy

We provide Benefits for Speech Therapy, Hearing Therapy, Physical Therapy, and Occupational Therapy provided on an outpatient basis.

Speech Therapy and Hearing Therapy

This is treatment for the loss or impairment of speech or hearing disorders provided by a speech pathologist, speech/language pathologist, or audiologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which falls within the scope of such license or certification. Covered Services include examination, evaluation, counseling, and any testing required to diagnosis any loss or impairment of speech or hearing.

Benefits for Speech Therapy are covered only when the Speech Therapy is being requested as the result of illness; injury; permanent, moderate to severe, bilateral sensorineural hearing loss; and/or birth defects, such as cleft lip and cleft palate.

Covered Services do not include screening examinations or services arranged by or received under any health plan offered by any governmental body or entity, including school districts for their students. See the Exclusions and Limitations section of the Plan for other exclusions which may apply.

Speech and hearing therapy must be Approved in Advance by us.

Physical Therapy

Physical Therapy Services provided by a Physician, registered Physical Therapist (R.P.T.), or Licensed Physical Therapist (L.P.T.) are covered when these services are expected to result in significant improvement in a Covered Person's condition. Services are limited to treatment of acute illnesses or injuries and must be ordered by a M.D. or and O.D. If physical therapy is performed by a Chiropractor, it will go towards the chiropractic benefit.

Occupational Therapy

Occupational Therapy Services provided by a Physician or Registered Occupation Therapist (O.T.R.) are covered when these services are expected to result in significant improvement in a Covered Person's condition. Covered Services are limited to treatment of acute illnesses and injuries. Occupational therapy is provided only for purposes of training Covered Person to perform the activities of daily living. Covered Services do not include occupational therapy provided on a routine basis as part of a standard program for all patients.

5-6(27). PHYSICIAN SERVICES

We provide Benefits for Physician services unless otherwise noted.

Out-of-Network Provider

All services received from Out-of-Network Providers are subject to the Deductible and Co-insurance indicated in the Benefit Summary.

5-6(28). PODIATRY

We provide Benefits for routine foot care only if the Covered Person has a medical diagnosis. "Routine foot care" means the paring and removal of corns and calluses or trimming of nails.

5-6(29). PROSTHETIC AND ORTHOTIC APPLIANCES

We provide Benefits for prosthetics and orthotics other than foot orthotics (including shoes).

Covered Services are limited to the initial purchase and fitting of prosthetic and orthotic devices that are necessary as a result of congenital defects, injury, or sickness. Repairs or replacement or prosthetics are Covered Services only when necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device; or
3. The condition of the device requires repairs and the cost of such repairs would be more than 60% of the replacement cost.

Initial purchase and fitting means the entire process necessary to provide a Covered Person's prosthesis (whether paid by the Fund or someone else) and may include one or more temporary prosthesis when Medically Necessary.

Repairs and replacements are not Covered Services if the need for repair or replacement is due to misuse or abuse of the device, or to the extent the device is covered under any warranty. Covered Services do not include replacement of prosthetic and orthotic devices due to changes in technology. Prosthetics that may enhance function after initial purchase are not Covered Services.

Benefits are limited to the amount normally available for a basic (standard) item which meets the minimum specifications to allow for necessary activities for daily living. Activities of daily living include bathing, dressing, continence, toileting, transferring, and ambulating. Charges for deluxe or electrically operated prosthetic orthotic devices are not covered, beyond the extent allowed for basic (standard) items.

5-6(30). RADIATION THERAPY

We provide Benefits for treatment of a medical condition with x-ray, radium, or radioactive isotopes.

5-6(31). RECONSTRUCTIVE SURGERY/PROSTHETIC DEVICES FOLLOWING MASTECTOMY

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals

receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy. If you would like more information on WHCRA benefits, please access our website at www.mokansheetmetal.org or contact the Fund Office at (816) 531-0334 or toll free outside the Kansas City Metropolitan area at (866) 531-5488.

5-6(32). ROUTINE PREVENTIVE CARE

We provide Benefits for routine preventive care as required by Federal Law. Covered Services are limited and may be received from In-Network or Out-of-Network Providers. If the services are performed by an Out-of-Network Provider, these services will be reduced to the Out-of-Network Co-insurance. Please check Your Benefit Summary for details on coverage. The preventive services covered by the Plan are listed in the Benefit Summary Section of this SPD.

We also provide Benefits for routine preventive care received from In-Network or Out-of-Network Providers to evaluate and manage a well person's health status according to the Covered Person's age.

5-6(33). SKILLED NURSING FACILITY

We provide Benefits for services and supplies furnished by a Skilled Nursing Facility for the treatment of a medical or surgical condition when authorized by Your Physician, except patient convenience items. These services are limited to those who are eligible to receive as a Hospital bed patient which would otherwise require confinement in a Hospital.

These benefits are not available unless Approved in Advance by us. No Benefits are available under this provision for custodial care or for the care of a nervous or mental condition, drug addiction, alcoholism, or chemical dependency.

5-6(34). SMOKING CESSATION

We provide benefits for smoking cessation. Benefits are payable up to the maximum payment, per calendar year and lifetime, shown in the Benefit Summary.

5-6(35). SUPPLEMENTAL ACCIDENT EXPENSE BENEFIT

This Benefit will be payable if You or Your Dependents, while eligible, sustain an Injury due to an accident that is not employment-related. Charges must be incurred within 90 days of the accident in order to be covered.

Your Benefits

The Benefits payable are the Reasonable and Customary charges which are in excess of Benefits payable under the basic Plan with respect to such Injuries.

Benefits are payable up to the maximum payment, per Calendar Year, shown in the Benefit Summary.

Expenses That Are Covered

Covered Charges include the Reasonable and Customary charges:

1. Made by a Hospital for room and board and other services;
2. Made by a Physician for diagnosis, treatment, or surgery;
3. Made by a private duty nurse for private duty nursing; or
4. X-ray and laboratory tests when ordered by the Physician.

Benefits are payable only for an Injury that is otherwise covered under the Plan.

Expenses That Are Not Covered

See the Exclusions and Limitations Section for limitations under this Plan.

5-6(36). VISION CARE

We provide Benefits for routine vision care. Routine vision care must be provided by an optometrist or Physician. Your visit and prescription lenses will be subject to benefits indicated in the Benefit Summary.

5-6(37). MEDICAL WEIGHT LOSS PROGRAM/BARIATRIC SURGERY POLICY

The Plan provides a Medical Weight Loss Program at recommended and approved facilities, as listed. This program requires:

1. A demonstration of social support system;
2. Psychological evaluation and approval; and
3. BMI between 35 and 40 with Co-Morbidities and above 40 without Co-Morbidities. “Co-Morbidities means the presence of high-risk obesity-related medical complications.

Under the program, the Plan will pay for physician visits, nutritional counseling, and an exercise program under the current program. You will be directed into a select few Medically Managed Weight Loss Programs associated with a hospital that is In-Network. No supplements or food will be reimbursed.

The Plan also provides the following Bariatric Surgery Policy at recommended and approved facilities, as listed. All of the following must be met in order to receive Benefits:

1. You must obtain prior authorization from the Fund Administrator and Blue Cross Blue Shield;
2. You must be covered under the Plan for at least one (1) year;
3. You must be enrolled as an active participant in the Wellness Connections Program;
4. You must attend and complete a 16-week Medical Weight Loss Program (including, but not limited to, the demonstration of social support system, the physiological evaluation and approval, and the requisite BMI) that includes exercise and is approved by the Fund Administrator;
5. You must lose 10 percent of your excess body weight prior to consideration for the bariatric surgery; and
6. You must obtain services from an approved Participating Provider and Hospital.

SECTION 6. DENTAL EXPENSE BENEFIT

This Benefit will be payable if You or Your Eligible Dependent incur Covered Dental Charges from a Dentist or Physician which exceed the Deductible amount.

6-1. YOUR BENEFITS

Benefits are payable for Covered Dental and orthodontics charges at the current Reasonable and Customary allowance. The Maximum Payment is also shown in the Benefit Summary.

6-2. THE DEDUCTIBLE

The Deductible is the dollar amount, as shown in the Benefit Summary, which You and You Dependent(s) are responsible to pay before Dental Expense Benefits are payable. Only Covered Dental Charges may be used to satisfy the Deductible. This dollar amount will not be reimbursed by the Fund.

The Deductible applies only once in a Calendar Year. Any expenses incurred in the last 3 months of a Calendar Year which are used to satisfy the Deductible, in part or in full, will also be applied to reduce the Deductible for the following Calendar Year.

6-3. EXPENSES THAT ARE COVERED

1. Oral evaluation, either periodic or new patient, two (2) times per Calendar Year;
2. Adult cleaning (including periodontal maintenance) over age 15, payable two (2) times per Calendar Year;
3. Child cleaning, for Dependents under age 15, payable two (2) times per Calendar Year;
4. Bite wing X-rays, payable two (2) times per calendar year, maximum eight (8) bite wings x-rays;
6. Full mouth x-ray and/or PANO, payable one (1) time in 36 months;

   all other x-rays when deemed Medically Necessary.
7. Child fluoride, is covered for Dependents under age 26, payable two (2) times per Calendar Year;
8. Sealants, limited to Dependents under age 26, payable for permanent molars only, that are virgin teeth, once in a lifetime;
9. Oral and maxillofacial surgery, including but not limited to, extractions;
10. Fixed or removal space maintainers for missing primary teeth;
11. Treatment of temporomandibular joint disorder (TMJ);
12. General anesthesis/sedation is covered for extraction of impacted wisdom teeth, two (2) or more surgical extractions, and/or multiple extractions in more than one quadrant;
13. Periodontal scaling and root planning is covered once every 36 months;

14. Full mouth debridement is covered once every 36 months;
15. Replacement of major dental work, crowns, crown build up, inlays/onlays, bridges, partials, and denture, is payable once in five (5) years from date of placement;
16. The incurred date of service of major dental work is based on the preparation date;
17. Inlays and crowns;
18. Initial installation of full or partial dentures or fixed bridgework;
19. Repair or re-cementing of crowns, inlays and fixed bridgework;
20. Repair and relining or dentures;
21. Fillings;
22. Root canal and all other Endodontic treatment;
23. Local anesthesia is covered for restorative work, but it is not covered for preventive and or periodontal maintenance; and
24. Occlusal guard is covered, one (1) per calendar year.

Covered Orthodontic Charges

Orthodontic care, treatment, service, and supplies (including retainers), including fixed and removable space maintainers (other than for missing primary teeth).

6-4. EXPENSES THAT ARE NOT COVERED

No benefits are payable under this Section for expenses incurred for dental care or services:

1. For which Benefits are payable under any other part of this Plan;
2. Due to any Injury or Illness which results from war, declared or undeclared, including armed aggression resisted by the forces of any country or combination of countries, or any act incident to war, while You or Your Dependent(s) are covered under this Plan;
3. Incurred for treatment of any Injury or Illness that is employment-related or covered under any Workers' Compensation law, Occupational Disease law, or similar law;
4. Charges that You or Your Dependent(s) are not required to pay;
5. Paid for or reimbursable by or through the government of a nation, state, province, country, municipality, or other political subdivision, or any instrumentality or agency of such a government;
6. Made by any person, Hospital, or entity which would normally not make a charge for the services, supplies, or treatments rendered, regardless of the existence of coverage or of the patient's financial condition;
7. Adult fluoride is not covered for Dependent(s) age 26 and older;

8. Temporary/Interim services;
9. Cosmetic services;
10. Oral hygiene instruction, nutritional counseling, and/or tobacco counseling;
11. Unspecified dental procedures;
12. Any type of take home products;
13. Items that are being paid under the medical portion, but not related to any type of accident: Gingival flap procedure, Osseous surgery, bone replacement graft, guided tissue regeneration, surgical stent, biopsy of oral tissue, excision of lesion and/or benign tumor, and removal of cyst(s);
14. Sterile tray;
15. Desensitizing medicaments;
16. Therapeutic drug injection;
17. Fees which are in excess of the Reasonable and Customary charges for services, supplies, or treatment;
18. Behavior management;
19. Fluoride gel carrier;
20. Replacement of lost or broken retainers; and
21. Missed appointments.

See the Exclusions and Limitations Section for additional exclusions.

SECTION 7. ROUTINE VISION EXPENSE BENEFIT

This Benefit will be payable if You and Eligible Dependent(s) incur Covered Vision Charges.

Claim forms for vision expenses can be obtained from the Fund Office. **Remember:** ATTACH ITEMIZED BILLS TO YOUR CLAIM FORMS.

7-1. YOUR BENEFITS

Benefits are payable up to a maximum Benefit as shown in the Benefit Summary. This Plan will recognize Coordination of Benefits provisions of other plans, using the rules located in Section 10 of this SPD.

Frames and lenses for safety glasses once per calendar year are available at 50% up to $70.00. This Benefit is payable only to actively working Participants.

7-2. EXPENSES THAT ARE COVERED

"Covered Vision Charges" means **only** expenses incurred for complete examinations performed by and materials prescribed by a licensed optometrist or ophthalmologist, including:

1. Dilation of pupils and/or relaxing focusing muscles by drops;
2. Refraction for vision and examination for pathology;
3. New or replacement frames and/or lenses, including the fitting and verification of lens accuracy; and
4. Lasik eye surgery, for adults over the age of 19 or if Medically Necessary. Prior Authorization is required for Medical Necessity determinations.

7-3. EXPENSES THAT ARE NOT COVERED

No Benefits are payable under this Section for:

1. Professional services or materials connected with;
    a. Orthoptics or vision training;
    b. Subnormal vision aids;
    c. Aniseikonic lenses; and
    d. Nonprescription sunglasses.
2. Medical or surgical treatment of the eyes, except for lasik eye surgery;
3. Expenses incurred as the result of any Injury or Illness that is employment-related or covered under any Workers' Compensation Law or similar law;
4. Services received through or required by any governmental agency or program, whether Federal, State, or a subdivision thereof;

5. Any services or materials for which duplicate Benefits are payable by any other group benefit plan containing Benefits for vision care. This Plan will coordinate its Benefits with the Safety Fund of any Local Union participating in the Welfare Fund, subject to all of the other provisions of the Vision Expense Benefit; or
6. Charges for services or materials which are covered or partly covered under any provision of the basic Plan or the Comprehensive Major Medical Expense Benefits of this Plan.

See the Exclusions and Limitations Section for additional exclusions.

SECTION 8. EXCLUSIONS AND LIMITATIONS

REGARDLESS OF LANGUAGE CONTAINED ELSEWHERE IN THIS PLAN, THE FOLLOWING ARE NOT BENEFITS UNDER THIS PLAN. THE ONLY EXCEPTION TO THIS IS WHERE SUCH ITEMS ARE SPECIFICALLY INCLUDED (UP TO THE CORRESPONDING DOLLAR AMOUNT AND/OR COVERAGE PERCENTAGE) IN THE SCHEDULE OF HEALTH BENEFITS, IN THE COVERED SERVICES SECTION, OR AS THE LAW REQUIRES. THE FUND WILL NOT PAY ANY AMOUNT FOR THE ITEMS LISTED IN THIS SECTION.

8-1. EXCLUSIONS

Covered Services do not include, and no Benefits will be provided for any of the following services, supplies, equipment, or care; or for any complications, related to, or received in connection with such services, supplies, equipment, or care that are:

1. For services or supplies received if there is no legal obligation for payment or for which no charge had been made; or for services or supplies received where a portion of the charge has been waived. This includes, but is not limited to full or partial waiver of any applicable Deductible, Co-insurance, or Co-payment amounts.
2. Subject to Our Approval in Advance requirement and such approval was not obtained.
3. For injuries or illnesses related to Your job to the extent You are covered or are required to be covered by a workers' compensation benefit, whether or not You file a claim. If You enter into a settlement giving up Your right to recover future medical Benefits under a workers' compensation benefit, medical Benefits that would have been compensable except for the settlement will not be Covered Services.
4. Not Medically Necessary, as determined by Us at Our sole discretion.
5. Experimental or Investigative as determined by Us at Our sole discretion, except as specifically provided under Clinical Trials.
6. For military service connected disabilities or conditions for which You or Your Dependent(s) are legally entitled to services or for which You have no obligation to pay.
7. For You as an Armed Service Retiree or Your Dependent(s) in a military Hospital.
8. For injuries or illness sustained in the course of the attempt or commission of an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed or, if filed, that a conviction result. Proof beyond a reasonable doubt is **not** required for an act to be deemed illegal. This exclusion does not apply if the injury resulted from being a victim of domestic violence, or from a medical condition (including both physical and mental health conditions).
9. For Custodial, convalescent, or respite care, including but not limited to meals delivered to Your home, companionship, and homemaker services, that do not require services of licensed professional nurses even if provided by skilled nursing personnel.
10. For music therapy, remedial reading, recreational therapy, and other forms of special education.

11. For cosmetic or reconstructive procedures, and any related services or medical supplies, which alter appearance but do not restore or improve impaired physical function. A cosmetic service may, under certain circumstances, be considered restorative in nature. In order for Benefits to be available for such restorative surgery, the services must be necessary to correct a loss of physical function or alleviate significant pain; or, must be necessary due to a malappearance or deformity that was caused by physical trauma, Accidental Injury, surgery, birth defect, function disorder, or congenital anomaly, and the proposed surgery or treatment must be Pre Authorized. Examples of excluded services include, but are not limited to, removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes and cosmetic rhinoplasty, whether done as an independent procedure or done in conjunction with any other surgical procedure.
12. For any equipment or supplies that condition the air, heating pads, hot water bottles, personal care items, wigs and their care, items for comfort and convenience, spas, whirlpools, Jacuzzis, inversion tables, and any other primarily non-medical equipment, warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring.
13. For hypnotism, hypnotic anesthesia, acupuncture, acupressure, biofeedback (including neurofeedback), rolfing, massage therapy, aromatherapy, and other forms of alternative treatment.
14. For screening exams or tests (unless covered in another Section of the Plan); examinations or programs for or in connection with insurance, licensing, or employment; exercise programs or equipment such as, but not limited to, bicycles, ellipticals, or treadmills; examinations or programs for or in connection with adoption; examinations or treatment ordered by a court or an employer; or premarital blood testing.
15. Related to sex transformations.
16. For collection and storage of autologous (self-donated) blood, umbilical cord blood, or any other blood or blood product in the absence of a known disease or planned surgical procedure.
17. Provided by You, Your Immediate Family Members, or members of Your immediate household.
18. For drugs and medicines that do not require a prescription for their use, drugs and medicines approved by the FDA for Experimental or Investigative use, or prescription drugs purchased from a Physician for self-administration outside a Hospital.
19. Chemosurgery or skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes, and/or which are performed as a treatment of scarring secondary to acne or chicken pox including, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.
20. For staff consultations required by Hospital rules and regulations.
21. For hairplasty or hair removal, regardless of reason or diagnosis.
22. For or related to the surgical insertion of a penile prosthesis, including the cost of the prosthesis, regardless of diagnosis.

23. For orthotics unless otherwise specified.
24. For foot orthotics, including shoes.
25. For corrective shoes unless permanently attached to a brace.
26. For lodging or travel to and from a health professional or health facility.
27. For interest charges, document processing or copying fees, mailing costs, collection fees, telephone consultations, and charges when no direct patient contact is provided including, but not limited to, Physician team conferences, charges for missed appointments, charges for completion of forms, or other non-medical charges.
28. Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions; and services and supplies for smoking cessation programs and treatment of nicotine addiction.
29. For learning disabilities, developmental delays, or mental retardation. For covered services related to autism, Preauthorization is required.
30. Health services which are related to complications arising from treatments or services otherwise excluded under the Plan.
31. Mental Illness and/or chemical dependency services when using methadone treatment as maintenance and provided in connection with or to comply with involuntary treatment outpatient, partial hospitalization or residential treatment, police detentions, and other similar arrangements.
32. Mental Illness and/or chemical dependency services received from a Non-Participating Provider provided in connection with or to comply with involuntary inpatient commitments after the Covered Person has been screened and stabilized.
33. For non-prescription internal feedings and other nutritional and electrolyte supplements. This does not apply to the treatment of phenylketonuria or any inherited disease of amino or organic acids.
34. For personal care and convenience items.
35. Occupational therapy provided on a routine basis as part of a standard program for all patients.
36. Received for, or in preparation for, any treatment (including drugs) for infertility and any related complications. "**Infertility**" as used herein means any medical conditions causing the inability or diminished ability to reproduce. Treatment for infertility shall include, but not be limited to, reversal of sterilization, all artificial insemination, in vitro fertilization, in vivo fertilization, embryo transplants, gamete intra fallopian transplant (GIFT), zygote intra fallopian transplant (ZIFT) and related tests and procedures, surrogate parenting, not Medically Necessary amniocentesis, and any other experimental fertilization procedure or fertility drugs.
37. For the reversal of sterilization, all artificial means of conception including but not limited to sperm collection and/or preservation, artificial insemination, in vitro fertilization, in vivo fertilization embryo transplants, gamete intra fallopian transplant

(GIFT), zygote intra fallopian transplant (ZIFT) and related tests and procedures, surrogate parenting, not Medically Necessary amniocentesis, and any other experimental fertilization procedure. "**Infertility**" as used here means any medical condition causing the inability to reproduce.

38. For health services and associated expenses for elective pregnancy termination, except when the life of the mother would be endangered if the fetus was carried to term.
39. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation, or small for gestational age.
40. For speech therapy for conductive hearing loss due to otitis media and ear infections.
41. Except as specifically provided in the Plan's TeleHealth program, Physician Services charges incurred as a result of virtual office visits on the Internet, including those for prescription drugs. A virtual office visit on the Internet occurs when a Covered Person is not physically examined.
42. For services or supplies received from any provider in a country where the terms of any sanction, embargo, boycott, Executive Order, or other legislative or regularity action taken by the Congress, President, or an administrative agency of the United States would prohibit payment or reimbursement by Us for such services.
43. Expenses incurred outside the United States during an absence from the United States for a period for 60 days or more, unless such absence is related to Your employment under an applicable Collective Bargaining Agreement or Participation Agreement.
44. Pregnancy and maternity benefits for Dependent Children.
45. For saliva testing.

8-2. LIMITATIONS

Benefits for Covered Services will be coordinated with any Benefits, which could be paid by Part A of Medicare even if a Covered Person is eligible for Medicare, but failed to enroll or maintain his eligibility. If an individual is enrolled in Part B of Medicare, Benefits for Part B services will be coordinated with any Benefits paid by Medicare. This limitation will not apply if the Employer, by law, is not permitted to allow the Plan to be secondary to Medicare.

SECTION 9. SPECIAL PROVISIONS AND LIMITATIONS

Several important provisions and limitations of the Plan may have an impact on the Benefits payable to You and Your Dependent(s). Please read the following information carefully.

9-1. MATERNITY BENEFITS

Maternity Benefits for You or Your Dependent Spouse are paid in the same way benefits are paid for any Illness. The expenses are paid when incurred, in general, and there are no waiting periods which differ from waiting periods for any other Benefits of the Plan. **Pregnancy and maternity Benefits for Dependent Children are, however, specifically excluded from the coverage of this Plan.**

In accordance with the Newborns' and Mothers' Health Protection Act, group health plans offering group coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. For more information, see the Covered Services section.

9-2. REASONABLE AND CUSTOMARY CHARGES

The descriptions of Benefits in this booklet say that Benefits will be paid based on Reasonable and Customary charges. "**Reasonable and Customary**" means a general level of fees charged by other Physicians or Hospitals in the same geographical area for services which are similar. It is important for You to be aware that this may result in Benefits being calculated on less than the full charge, with the amount of the charge above what is Reasonable and Customary becoming an out-of-pocket expense.

9-3. CLAIM AUDIT

When You or Your Dependent(s) incurs a claim for which $10,000.00 or more in Benefits will be payable from the Plan, this claim may be audited, or reviewed, by the Fund to be sure that the charges reported by the Hospital, Physician, laboratory, or any other provider involved are accurate. The purpose of this audit is to ensure that claims with many charges are made and processed properly. Any Benefits due will be paid as usual. However, a short delay may result when a claim is audited.

9.4 COOPERATION WITH MEDICAL MANAGEMENT

The Fund desires to provide You and Your Dependents with a health care benefit plan that financially protects You from significant health care expenses as well as provides you with quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used. The Fund has contracted with a medical management company to identify and assist individuals with conditions requiring extensive or on-going medical services and/or prescription

medications. The program is not intended to diagnose or treat medical conditions, guarantee benefits, make payments, or validate eligibility for Plan coverage. The program focuses on making recommendations regarding the appropriateness and medical necessity of specified health services, which may be grounds for denying benefits under the Plan. You and/or your Dependents will be required to cooperate with the Case Management program, if applicable, or Benefits may not be payable under the Plan.

9-5. RESCISSION

Coverage under the Plan will not be Rescinded with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact.

If the Plan Rescinds coverage in accordance with this provision, the Plan will provide You (and each affected participant) with at least 30 days' advance written notice before Rescinding coverage.

SECTION 10. COORDINATION OF BENEFITS

10-1. PURPOSE OF COORDINATION OF BENEFITS ("COB")

Many individuals have group health care coverage through more than one plan or Source of Coverage at the same time. COB allows plans to work together so that the total amount of all Benefits paid will never be more than the Allowable Expense for the covered Benefit. This helps to keep down the costs of health care coverage. The COB rules are intended to prevent duplicate payments from different plans that otherwise cover a Participant for the same Covered Expenses. The rules determine which is the Primary Plan and which is the Secondary Plan.

If You or Your Dependent(s) are also covered by another source of coverage, the total amount received from all sources will never be more than 100% of "Allowable Expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit on his or her health coverage.

IT IS THE MEMBER'S RESPONSIBILITY TO NOTIFY AND UPDATE THE FUND OFFICE OF ANY INFORMATION REGARDING COORDINATION OF BENEFITS. FAILURE TO PROVIDE TIMELY INFORMATION COULD IMPACT PAYMENT BY THE FUND.

10-2. DEFINITIONS

Certain terms used in this Section have a special meaning, as follows:

1. **"Allowable Expense"** means any necessary, Reasonable and Customary (or the negotiated fee schedule of this plan, whichever is less) charge for services, supplies, or treatment covered, in whole or in part, by a Source of Coverage will be viewed as benefits paid, whether or not a claims is filed under the Source of Coverage.

   The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

   When Benefits are reduced under a Primary Source of Coverage because You or Your Dependent(s) do not comply with the policy or plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and arrangement with preferred provider organizations (PPO) or health maintenance organizations (HMO).

2. **"Claims Determination Period"** means the period January 1st through December 31st of any Calendar Year, or that portion of a Calendar Year during which You or Your Dependent are covered under this Plan.

3. **"Source of Coverage"** refers to any of the following plans and policies which provide full or partial medical, dental, or vision Benefits or services provide full or partial medical, dental, or vision Benefits or services on an insured or uninsured basis:

    a. Group or blanket insurance or any other group-type coverage;

    b. Service plan contracts, group practice, and other group prepayment plans;

    c. Union welfare plans, employer or employee organization plans, or labor management trusted plans;

    d. Governmental programs or coverage required or provided by law. However, "Source of Coverage" does not include any government program coverage with which this Plan is not allowed, by law, to coordinate.

    e. Automobile "No-Fault" contract, as mandated by applicable state law; (However, if You, or Your Dependent, fail to obtain such No-Fault coverage, this Plan will NOT pay the Benefits required to be provided as basic reparations Benefits under such law);

    f. Group automobile "fault" contract, but only the medical benefits written;

    g. Individual or family health insurance policy; and

    h. Individual or family hospital indemnity coverage.

If both Spouses are both Employees and each is eligible for Plan Benefits, Benefits will be determined according to the provisions of the Section in which case this Plan will also be a Source of Coverage.

10-3. WHICH SOURCE OF COVERAGE PAYS FIRST?

The Source of Coverage under which Benefit are payable first is the Primary Source. All other Sources are called Secondary Sources. The Secondary Sources pay any remaining unpaid Allowable Expenses. No Source of Coverage pays more than it would have without this provision.

10-4. ORDER OF BENEFIT DETERMINATION RULES

General

When there is a basis for a claim under this Plan and another Source of Coverage, this Plan is a Secondary Plan, unless:

1. The other Source of Coverage has rules coordinating its Benefits with those of this Plan; and both the other Source of Coverage's rules and this Plan's rules require that benefits under this Plan be determined before those of the other Source of Coverage; or
2. There is a statutory requirement establishing that the Plan is the Primary Source and such statutory requirement is not pre-empted by ERISA; or
3. The other Source of Coverage is Tri-Care and the Member is not in active military service.

If a Source of Coverage which would be primary under this Plan's COB rules denies coverage because of the application of a rule which is unique to that plan and which is not a rule of this Plan, then this Plan will provide only that coverage which it would have provided if the Source of Coverage had granted primary coverage. In other words, this Plan will not recognize "excess" or "always secondary" COB provisions of the other plans.

Rules

This Plan determines its **Order of Benefits** using the first of the following rules which applies:

1. **Employee/Dependent.** The Benefits of the Source of Coverage which covers the individual as an Employee (that is, other than as a Dependent) are determined before those of the Source of Coverage which covers the individual as a Dependent. If a Dependent is eligible under this Plan as both an Employee Member and as a Dependent Child, then claims are coordinated for this participant, processing first as an Employee, then as a Dependent, according to the rules herein.
2. **Dependent Child/Parents not Legally Separated or Divorced.** Except as stated in Rule 3, when this Plan and another Source of Coverage cover the same Child as a Dependent of different individuals, referred to as "Parent" or, collectively, "Parents:"
    a. The Benefits of the Source of Coverage of the Parent whose birthday falls earlier in the year (month and date) are determined before those of the Source of Coverage of the Parent whose birthday falls later in that year; but
    b. If both Parents have the same birthday, the Benefits of the Source of Coverage which covered a Parent longer are determined before those of the Source of Coverage which covered the other Parent for a shorter period of time.

    However, if the other Source of Coverage does not have this "birthday rule," but instead has a rule based upon the gender of the Parent, and if, as a result, the Sources of Coverage do not agree on the Order of Benefits, the rule in the other Source of Coverage will determine the Order of Benefits.

    The "birthday rule" does not use the years of the Parents' birth in determining which has the earlier birthday.
3. **Dependent Child/Parents Legally Separated or Divorced.** If two (2) or more Sources of Coverage cover a natural Child of the Member, adopted Child of the Member, or Child for which the Member has been appointed permanent legal guardian in accordance with the Plan, as a Dependent Child of Divorced or Legally Separated Parents, Benefits for the Child are determined in this order:
    a. First, the Source of Coverage of the Parent with custody of the Child;
    b. Then, the Source of Coverage of the Spouse of the Parent with the custody of the Child;
    c. Then, the Source of Coverage of the Parent not having custody of the Child; and
    d. Finally, the Source of Coverage of the Spouse of the Parent not having custody of the Child.

However, if the specific terms of a Court Decree state that one of the Parents is responsible for the health care expense of the Child, and the entity obligated to pay or provide the Benefits of the Source of Coverage of that Parent has actual knowledge of those terms, the Benefits of that Plan are determined first. The Source of Coverage of the other Parent shall be the Secondary Source. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any Benefits are actually paid or provided before the entity has the actual knowledge.

Notwithstanding the foregoing paragraphs in this Rule 3, for a Step-Child of the Member, any other available Source of Coverage for the Step-Child will be determined before the Source of Coverage which covers the Member so that any other available Source of Coverage will be the Primary Source and the Plan will be the Secondary Source, regardless of whether or not the other available Source of Coverage is elected. If there is no other available Source of Coverage for the Step-Child, the Plan will be the Primary Source.

3. **Joint Custody.** If the specific terms of a Court Decree state that the Parents shall share jointly custody, without stating that one of the Parents is responsible for the health care expenses of the Child, the Source of Coverage covering the Child shall follow the Order of Benefit Determination Rules outlined in Rule 2 above ("the birthday rule").

4. **Active/Inactive Employee.** The Benefits of a Source of Coverage which covers the individual as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Source of Coverage which covers the individual as a laid off or Retired Employee (or as that Employee's Dependent). If the other Source of Coverage does not have this rule, and if, as a result, the Sources of Coverage do not agree on the Order of Benefits, this Rule 4 is ignored.

5. **Continuation Coverage.** If an individual whose coverage is provided under a right of continuation pursuant to Federal or State Law is covered under another Source of Coverage, the following shall be the Order of Benefit determination:

   a. First, the Benefits of the Source of Coverage covering the individual as a employee, member, or subscriber (or as that person's Dependent); and

   b. Second, the benefits under the continuation coverage.

6. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of Benefits, the Benefits of the Source of Coverage which covered an Employee, Member, or Subscriber longer are determined before those of the Source of Coverage which covered the Employee, Member, or Subscriber for the shorter term. **This applies to any covered Spouse and any Dependent Child covered under a parent's policy.**

10-5. EFFECT ON BENEFITS

COB applies to this Plan when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Source as to one or more other Sources of Coverage. In that event, the Benefits of this Source of Coverage may be reduced under this COB provision. Such other Source or Sources of Coverage are referred to as "the other Sources" immediately below.

Reduction in this Plan's Benefits

The Benefits of this Plan will be reduced when the sum of:

1. The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
2. The Benefits that would be payable for the Allowable Expenses under the other Sources of Coverage, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

When the sum above exceeds those Allowable Expenses in a Claim Determination Period, the Benefits of this Plan will be reduced so that they and the Benefits payable under the other Sources of Coverage do not total more than those Allowable Expenses. When the Benefits of this Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of the Plan.

If another Source of Coverage pays Benefits that should have been reduced because of COB, the amount by which the Benefits should have been reduced may be paid to the other Source. Amounts so paid will be deemed Benefits paid under this Plan.

If a payment of any amount has been made that is in excess of that permitted by COB, this Plan has the right to recover such amount from any party that has received such payment.

The Plan may, without the consent of or notice of the eligible person, release to or obtain from any other insurance company, organization, or person any information it deems necessary in order to apply this COB provision.

If You are actively employed, age 65 or older, and are eligible for Part A of Medicare, You may continue to have coverage under this group Plan as primary.

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB section, the Plan may recover the excess or overpayment from the Participant on whose behalf it has made payments, from a Provider, from any group insurer, plan, or any other person or organization contractually obligated to such Participant with respect to such overpayments.

SECTION 11. LIFE INSURANCE

11-1. ACTIVE EMPLOYEES

If You die from any cause while You are insured under the Plan, the proceeds will be paid to Your beneficiary.

Beneficiary

You may name anyone You wish as Your beneficiary. You may change Your beneficiary at any time by completing the proper form. The change will be effective when the Fund Office receives the completed form. The Fund Office has these forms on hand. You should contact the Fund Office for a form if You get married or Divorced or otherwise wish to change Your beneficiary. It is important to keep this information up-to-date. The Fund Office will pay benefits according to the beneficiary designation on file with the Fund Office at the time of Your death.

Total and Permanent Disability

If You become Totally and Permanently Disabled before age 65, Your Life Insurance will continue at no cost to You for 12 months from the date on which premiums were paid on Your behalf. Coverage will further continue during such disability, without payment of premium, if You send written proof of Your disability to the Fund no later than 12 months after the start of Your disability. Written proof must show that Your disability:

1. Began while You were covered under this Plan;
2. Began before You reached the age of 65; and
3. Has lasted at least nine (9) consecutive months, and that such disability will presumably continue to exist.

Premiums will be waived every 12 months if You submit proof of continuing Total and Permanent Disability each year, within three (3) months of the anniversary date that the initial proof of Your disability was received by the Fund Office.

Life Insurance --- Total and Permanent Disability

The amount of Life Insurance that will be continued while You are Totally and Permanently Disabled will be the amount which was in force at the time premium payments were discontinued on Your behalf as a result of Your disability.

The Meaning of Totally and Permanently Disabled

Totally and Permanently Disables means that, due solely to Illness or Injury, You are permanently prevented from performing the material and substantial duties of Your occupation or any other occupation for which You are qualified by reason of education, training, or experience for pay, profit, or compensation.

Continuation of Benefits

Benefits will continue under this extension until the earliest of:

1. Thirty-one (31) days after the date You are no longer Totally and Permanently Disabled;
2. The date You fail to furnish the Fund Office with proof of Your continued disability (which must be within 3 months of the anniversary date that the initial proof of disability was received by the Fund Office); or
3. The date You fail to be examined by a Physician designated by the Fund, if so requested by the Fund. Such an examination will not be required more than once a year after Your insurance has been continued under this extension for two (2) full years.

If You die during the extension of Your insurance under this provision, the following items should be sent to the Fund Office within one (1) year of Your death:

1. Written notice of Your death; and
2. Written proof that You have remained continuously disabled from the last anniversary of receipt of the initial proof until Your death.

11-2. RETIRED EMPLOYEES

Benefits for Retired Employees and their Dependents are reflected in the Benefit Summary. **No Accidental Death and Dismemberment or Loss of Time Benefits are available to Retirees.**

The amount of the Life Insurance Benefit for Retired Employees is based on the career employment requirements and the amounts are shown in the Benefit Summary

In no event will any Retired Employee be eligible for a Life Insurance Benefit and a Special Life Insurance Benefit.

Exception

The Special Life Insurance Benefit coverage will continue for the lifetime of eligible Retirees who qualify in accordance with the LONG TERM SERVICE RETIREE rule, found in Section 4-3.

11-3. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (AD&D)

(24-Hour Coverage for Active Employees only)

This Benefit will be payable if, while eligible, You sustain any of the losses listed below as a result of an accident. For Benefits to be payable, the loss must take place within 120 days from the date of the Injury. This Benefit is payable in addition to any other Benefits You may receive under this Plan.

Who Will Receive Benefits

For loss of life, Benefits will be paid to the beneficiary You name. For any other loss, the Benefits will be paid to You.

FOR LOSS OF:	**THE BENEFIT IS:**
Life…….....	$10,000.00
Two Hands…….……......	$10,000.00
Two Feet…….….....	$10,000.00
Sight of Two Eyes……	$10,000.00
One Hand and One Foot…….……..	$10,000.00
One Hand and Sight of One Eye……..	$10,000.00
One Foot and Sight of One Eye……...	$10,000.00
One Hand or One Foot……...	$5,000.00
Sight of One Eye……	$5,000.00

If You suffer more than one loss in any accident, payment will be made only for the loss for which the largest amount is payable.

Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively. **Loss of sight** means the total and irrecoverable loss of sight.

Beneficiary

You may name anyone You wish as Your beneficiary. You may change Your beneficiary at any time by completing the proper form. The change will be effective when the Fund Office receives the completed form.

Losses That Are Not Covered

No Benefit is payable under this AD&D Section if Your death or any loss is caused directly or indirectly, wholly or partly, by:

1. Bodily or mental Illness, or disease of any kind;
2. Infections (except pyogenic infections which result from an accidental bodily injury and bacterial infections which result from the accidental ingestion of contaminated substances, which occur as a result of an accidental injury on the exterior of the body);
3. Suicide or attempted suicide;

4. Intentional self-inflicted injury;
5. Participation in, or the result of participation in, the commission of an illegal act or a felony, riot, or civil commotion;
6. War or act of war (including any armed aggression resisted by the armed forces of any country or combination of countries), whether declared or undeclared; or any act related to war or insurrection;
7. Service in the military, naval, or air force of any country while such country is engaged in war;
8. Police duty as a member of any military, naval, or air organization; or
9. Duty as a security guard or as a part of a security patrol.

SECTION 12. LOSS OF TIME BENEFIT
(For Active Employees Only)

This Benefit will be payable if, while eligible, You become disabled and cannot work. This means that as a direct result of an Injury or Illness, You are unable to perform any and every duty pertaining to Your employment and that You are not engaged in any other work for remuneration or profit during such period. This also means that You are not receiving any compensation wages from Your Employer, unemployment compensation, or any other Benefit payments of any kind or have entitlement to social security disability or retirement Benefits. Benefits are only payable when the disability is caused by an Injury or Illness that is not employment-related.

12-1. YOUR BENEFITS

The amount of Your weekly Benefit is shown in the Benefit Summary and Your Benefits will be payable after the waiting period ends, as shown in the Benefit Summary.

The maximum period for which Benefits are payable, per any continuous 12 month period, is shown in the Summary of Benefits.

You do not have to be confined to Your home to receive Benefits. However, You must be under the regular care of a Medical Doctor ("M.D.") or Doctor of Osteopathy ("D.O.") for the cause of the disability.

12-2. DISABILITIES THAT ARE NOT COVERED

In addition to the EXCLUSIONS AND LIMITATIONS, Section 8, no Benefits are payable under this Section for a period of disability during which You are not under the regular care of a M.D. or D.O. for the disability which resulted in the inability to work. A period of disability will not be considered as having started more than three (3) days before the date You first saw a M.D. or D.O. for the condition which caused the disability.

SECTION 13. HEALTH AND WELLNESS PROGRAM

13-1. YOUR BENEFITS

Members and their Spouses are eligible to receive a monetary incentive credit for participating in an annual physical exam with their physician and timely returning a form to the Fund Office. In order to be eligible for the monetary incentive credit, the Member or Spouse must see their physician of choice for a physical examination and have their physician fill out the Fund's form. **The Member or Spouse will then send the form to the Fund Office—it must be received by the Fund Office before the end of each calendar year to qualify for that year's credit**. The monetary incentive will then be credited to the Member's Wellness Benefit Account ("WBA"). For more information, or to download and print a copy of the form, visit the website www.mokansheetmetal.org and click on the "Wellness Center" tab.

13-2. GYM MEMBERSHIP PROGRAM

If you participate in the annual physical exam, Members and their families are also eligible to receive a gym membership reimbursement.

Individual Membership	**Family Membership**
8 times a month = 50% up to $40.00	12 times a month = 50% up to $80.00
12 times a month = 100% up to 40.00	18 times a month = 100% up to $80.00

The Fund will only reimburse for the actual gym membership fee. Any additional fees Your gym may charge are not payable under this benefit. If You are new to the program, You may start receiving Your refund after You complete Your first annual physical exam and provide proper documentation to the Fund Office, and every year after that You participate in the annual physical exam program.

For more information on annual physicals, please visit www.mokansheetmetal.org, or contact the Fund office.

SECTION 14. WELLNESS BENEFIT ACCOUNT

This Benefit is available to You and Your Spouse and is voluntary. Retired Participants in the Plan are also eligible.

The Mo-Kan Sheet Metal Welfare Fund Wellness Benefit Account ("WBA") is a Benefit program that allows you to obtain reimbursement of certain Reimbursable Expenses not otherwise reimbursed or reimbursable in full by any other accident or health plan. This Benefit is paid for with tax free funds provided by the Fund into Your WBA for participating in the Mo-Kan Wellness Program. Currently, You can only earn credit in the WBA by participating in the Wellness Program.

14-1. HOW TO PARTICIPATE IN THE WBA Program

You and Your Spouse may participate in the WBA Program by enrolling and timely providing the Fund office with a completed physician physical form before the end of the calendar year for which the benefit applies. More information can be found on the website, www.mokansheetmetal.org.

14-2. BENEFITS

You and Your Spouse can earn Benefit Credits, as described above. The ways to earn Benefit Credits and the dollar value of the Benefit Credits may vary from time to time, and are listed in the Benefit Summary. Information about the WBA Program is also available at our website, www.mokansheetmetal.org.

14-3. HOW YOUR WELLNESS BENEFIT ACCOUNT ("WBA") WORKS

The Fund Administrator will set up a WBA for You once You complete the initial eligibility requirement of seeing your physician of choice for an annual physical, and completing and timely submitting the physician physical form. Your may be reimbursed for certain Reimbursable Expenses incurred by You during the Plan Year (calendar year), up to Your WBA account balance. Your account balance is an accounting entry only and is not representative of any separately identifiable Trust asset. Payments are made at Your request, and amounts credited will be deducted from your existing WBA balance. Amounts credited to your WBA can be rolled over from year to year but cannot be withdrawn if employment is terminated. You must be a Member in good standing with your Local for You or Your Spouse to participate and receive payments from your WBA.

14-4. HOW TO SEEK REIMBURSEMENT

To receive reimbursement for eligible Reimbursable Expenses, You must complete the Request For Reimbursement Form, available through the Fund Office and website www.mokansheetmetal.org, and submit the Form, along with an Explanation of Benefits and/or receipt of payment for the item for which You wish to be reimbursed, to the Fund Office. The

rules for substantiating Your reimbursement claim are stated on the Request For Reimbursement Form. Whenever possible, all claims received by the Fund Office will be processed for reimbursement within thirty (30) days. Upon completion of processing Your claim, You will be reimbursed the full amount of Your eligible expenses up to the available limit in Your WBA . You may submit claims for expenses incurred during the Plan Year (calendar year) up to 90 days after the Plan Year (calendar year) has ended. Any claims filed beyond the 90-day period where the expense was incurred in the prior Plan Year (calendar year) will not be considered or reimbursed from Your WBA.

14-5. REIMBURSABLE EXPENSES

You may seek reimbursement from your WBA for the following Reimbursable Expenses:

1. Plan deductibles and Co-insurance amounts;
2. Co-payments for medical treatment and prescription medications/drugs;
3. Medication/drugs which are Qualified Medical Expenses not otherwise covered under the Plan;
4. Amounts that exceed annual limits on medical, dental, vision, and hearing expenses;
5. Amounts that exceed the Fund's Reasonable and Customary fees for Medically Necessary procedures and/or treatment; and
6. Amounts for Retiree self-pay premiums and COBRA continuation coverage premiums.

SECTION 15. WORKING SPOUSE INCENTIVE

This is a voluntary program that offers a reimbursement for "working Spouses" of up to $200 for each month that the Spouse is enrolled in both a qualifying employer-sponsored health plan at their place of employment and this Plan. The amount of benefit equals the Spouse's monthly contribution amount for both Medical and Pharmacy coverage, up to the $200 limit. Vision and Dental contribution amounts are not eligible for reimbursement. Spouses apply for reimbursement on a monthly basis, and the incentive applies to both Medical and Pharmacy coverage only. Spouses must complete the Plan's "spousal verification form" when applying for reimbursement for the first time. Subsequent requests require the Member or Spouse to submit a reimbursement request form for each month reimbursement is requested. In order to receive reimbursement for any month, proof of payment must be provided by the Member or Spouse to the Fund. All other Plan rules, such as the Coordination of Benefits provisions, continue to apply to any Spouse health coverage. For more information, please visit www.mokansheetmetal.org.

SECTION 16. EMPLOYEE ASSISTANCE PROGRAM "EAP"

This is a program that offers professional consultation services for a variety of problems to all employees and dependents living in the employee's household. Services can include: assistance with emotional disorders, alcohol and drug abuse, marital, family and adolescent problems and financial crises that may affect your personal wellbeing and your job performance.

16-1. YOUR BENEFITS

EAP offers third party professional counseling services to help with difficult personal problems. This program is available to you and your Eligible Dependents at no cost. The EAP program includes: 24 hour emergency service, problem assessment, short term counseling and potential referral to network resources.

EAP counselors provide both Medical and Non-Medical EAP Benefits. Eligible Participants accessing EAP are offered up to eight consultations with an EAP Counselor. The goal of EAP is to provide short term, problem focused counseling that can often resolve personal problems without referral into the Mental Health & Substance Abuse Plan. If, however, it is determined that a referral to a provider outside of EAP is necessary, that referral will be facilitated at the earliest opportunity, even if the full eight visits have not been utilized. If you are referred outside of EAP, payment for services are not covered by EAP. You will be responsible for payment of services; or, if you are covered under the Mental Health & Substance Abuse Plan, there may be coverage under the terms of that plan. If you are referred outside of EAP, and you are enrolled in the Mental Health and Substance Abuse Plan, you will need to obtain pre-certification from BCBSKC/New Directions at 1-800-528-5763.

More information can also be found at our website, www.mokansheetmetal.org

SECTION 17. CLAIMS PROCEDURE

17-1. HOW TO FILE A CLAIM FOR BENEFITS

The majority of the time, the Provider will file a claim for You. If the provider fails or refuses to file a claim on Your behalf, please contact the Fund Office to obtain information regarding the appropriate procedure for self-filing. In-Network providers will have contractually obligated timely filing guidelines, which could include a six (6) month period. If You (or Your authorized representative) file a claim on your behalf, you have twelve (12) months from the date the service was incurred to file your claim. Failure to submit claims, bills, statements, and other required information within the 12-month period will result in the claim being denied.

17-2. HOW YOUR BENEFITS ARE DETERMINED

Under the Trust Agreement creating the Plan and the terms of the Plan, the Trustees have sole authority to make final determinations regarding any claim for Benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a Benefit from the Plan. If a decision of the Trustees is challenged in Court, it is the intention of the parties to the Trust, and the Plan provides, that such decision will be upheld unless it is determined to be arbitrary or capricious.

17-3. ACTION TAKEN ON YOUR CLAIM

If Your claim involves Urgent Care claim, You or Your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, taking into account medical exigencies, but no later than 72 hours after the Plan receives the claim. If the claim does not include sufficient information for the Fund Office to make an intelligent decision, You or Your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request. The Fund Office will inform You of its decision as soon as possible, but no later than 48 hours receiving the additional information or the end of the period afforded to provide the additional information.

If Your claim is one involving concurrent care, any reduction or termination of the course of treatment (other than by Plan amendment or termination) before the end of such treatment will constitute an adverse benefit determination. You will be notified of such a determination at a time sufficiently in advance of the reduction or termination to allow appeal. For any request to extend the course of treatment, the Fund Office will notify You of its decision, whether adverse or not, within 24 hours after receiving the claim (provided the claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments). You will be given time to provide any additional information required to reach a decision.

If Your claim is for a pre-service authorization, the Fund Office will notify You of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Fund Office for an

additional 15 days if the extension is required due to matters beyond the Fund Office's control and the Fund Office notifies You of such extension prior to the expiration of the initial 15-day period. You will have at least 45 days to provide any additional information requested of You by the Fund Office.
For any pre-service claim, if You fail to follow the Plan's procedures for filing such a claim, You will be notified of the failure and the proper procedures to be following in filing a claim for benefits as soon as possible, but no later than five (5) days (or 24 hours in the case of an urgent care claim) following the failure. This notification may be oral, unless otherwise requested in writing.

If You have filed a post-service claim for reimbursement of medical care services that already have been rendered, You will be notified of the Fund Office's decision on Your claim only if it is denied in whole or in part. This notification will be issued no more than 30 days after the Fund Office receives the claim. The Fund Office may extend this 30-day period one for up to 15 days if the extension is required due to matters beyond the Fund Office's control and the Fund Office notifies You of such extension prior to the expiration of the initial 30-day period. You will have at least 45 days to provide any additional information requested by You by the Fund Office, if the need for the extension is due to the Fund Office's additional information from You or Your health care providers.

For disability claims, You will be notified of an adverse benefit determination within a reasonable period of time, but no later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan determines that such extension is necessary due to matters beyond the Plan's control and notifies You of such extension prior to the expiration of the initial 45-day period. The Plan may request a second 30-day extension, as well. You will have at least 45 days to provide any additional information requested of You by the Fund Office.

An extension of the time periods above by the Fund Office will describe the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Any request for additional information from You will describe the required information necessary to make a determination.

Any notice of adverse benefit determination will be in writing (or orally, if it is an urgent care claim) and contain the following:

- The specific reasons for the adverse determination.
- References to the Plan provisions on which the determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures, including Your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination.
- Any internal rule, guideline, or protocol relied on in making the adverse benefit determination (or that such information is available free of charge upon request), and

- If the reason for denial is based on a lack of medical necessity or an experimental and investigational services exclusion or similar limitation, the scientific or clinical judgment for the determination (or that such information will be provided free of charge upon request).
- In case of an adverse benefit determination concerning an urgent care claim, a description of the expedited review process applicable to such claim.

17-4. HOW TO APPEAL A DENIAL OF A CLAIM

The Fund Office will provide You with written notice of the denial of Your claim. You (or Your authorized representative) have 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing, unless Your claim involves urgent care, in which case the request may be made orally and all necessary information may be transmitted between You and the Plan by telephone, facsimile, or other available similarly expeditious method.

In connection with Your right to appeal the Fund Office's initial determination regarding Your claim, You also:

1. Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to Your claim;
2. Will be given, at Your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for Benefits;
3. Will be given, at Your request, a review by the Board of Trustees, or a designated subcommittee thereof, that will not give deference to the initial adverse Benefit determination and that takes into account all comments, documents, records, and other information submitted by You relating to the claim, regardless of whether such information was submitted or considered in the initial Benefit determination;
4. If the denial was based in whole or in part on a medical judgment, You are entitled to have the Trustees consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment retained by the Plan, and this individual shall be independent of any professional who participated in the initial denial; and
5. May request in Your appeal petition to appear before the Board of Trustees, or a designated subcommittee thereof, for an oral presentation on the merits of Your appeal petition.

You will be given reasonable notice of the date and place of the hearing.

The Board of Trustees will issue a decision on Your appeal according to the following timetable:

1. Urgent Care Claims: Not later than 72 hours after receiving Your request for a review.
2. Pre-Service Claims: Not later than 30 days after receiving Your request for a review.

3. Post-Service and Disability Claims: As long as the Board of Trustees regularly meets at least quarterly, not later than the next regularly scheduled meeting of the Board of Trustees, unless the request for review is filed within 30 days preceding the date of the meeting, in which event not later than the date of the second regularly scheduled meeting following the Plan's receipt of the request for review. If a special circumstance exists, such as Your request for an oral presentation on the merits of Your appeal in front of the Board of Trustees or a designate , then a Benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the receipt of the request for review. The Fund Office shall notify You of the Board of Trustees' determination not later than 5 days after the determination is made.

The written notification of the decision of the Board of Trustees on the appeal will include:

1. The specific reason for the decision;
2. A reference to the plan provisions on which the determination is based,
3. A statement of Your right to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to Your claim,
4. A description of any voluntary appeal procedures offered through the Plan and a statement of Your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination,
5. Your right to receive, upon request and free of charge, a copy of any internal rule, guideline, or protocol, if any, relied upon in making the determination, and
6. If Your adverse determination is based on medical necessity or experimental treatment, an explanation of the specific or clinical judgment.

You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State Insurance Regulatory Agency.

You will not be required to file more than two appeals of an adverse benefit determination prior to bringing a civil action pursuant to section 502(a) of ERISA.

17-5. APPEALS AUTHORITY

Any parties to whom appeal authority is allocated shall have the greatest permissible discretion to construe the terms of the Plan and to determine all questions concerning eligibility, participation and Benefits. Any such decision shall be binding on all Employers, Employees, Retirees, Participants, Dependents and beneficiaries, and is intended to be subject to the most deferential standard of judicial review. Such standard of review is not to be affected by any real or alleged conflict of interest on the part of the designated decision maker.

SECTION 18. GENERAL INFORMATION

18-1. EFFECT OF MEDICAID

In determining or making benefit payments on an individual's behalf, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid) will not be taken into account.

18-2. RIGHT TO MAKE PAYMENT

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the provisions of the Plan.

The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan if, in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. No such payment or providing of services or equipment will be deemed to be an amendment to the Plan nor establish a precedent, nor shall it obligate such payments or providing of services or equipment in the case of any subsequent or prior claim. The Trustees may, but shall not be required to, delegate to their Fund Administrator the authority to authorize such payments pursuant to written rules of uniform application that they may adopt from time to time.

18-3. FACILITY OF PAYMENT

If You or Your Dependent(s) are not legally capable of giving a valid receipt for a benefit payment, the Fund has the right (if there is no legal guardian) to pay the party it believes is entitled to such payment. Once such a payment is made, the Fund has no further obligation with respect to the amount so paid.

18-4. BENEFICIARY

If a beneficiary is designated, the beneficiary's consent is not required to change the beneficiary.

If Your beneficiary predeceases You, such beneficiary's interest will automatically terminate.

If You name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries. If there is no living beneficiary when You die, payment will be made to Your surviving Spouse; if none, to Your surviving Children in equal shares; and, if none, to Your surviving siblings in equal shares. However, the payment may be made to the administrators of Your estate.

18-5. EXAMINATIONS

The Fund has the right to physically examine, at its own expense and through its medical representatives, any Participant whose Injury or sickness is the basis of a claim (whether pre-service, post-service, concurrent, urgent care, or otherwise). Such physical examination may be

made as often as the Fund may reasonably require while such claim is pending. The Fund will also have the right to request an autopsy in case of death, unless prohibited by law.

18-6. CLERICAL ERRORS

Clerical errors by the Plan, Fund, or the Employer will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

18-7. GOVERNING LAW

The Plan is governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Plan is governed by and subject to the laws of the State of Missouri. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Plan conflicts with such law, the Plan shall automatically be amended solely as required to comply with such state or federal law.

18-8. LEGAL ACTIONS

No Participant may bring an action at law or in equity to recover on the Plan until such Participant has exhausted the appeal process as set forth herein. No such action may be brought after the expiration of any applicable period prescribed by law.

18-9. NEGLIGENCE OR MALPRACTICE

The Fund does not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by the Fund. The Fund is not liable for any improper or negligent act, inaction, or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supply or medication.

18-10. NO WAIVER OF RIGHTS

On occasion, the Fund may, at its discretion, choose not to enforce all of the terms and conditions of this Plan. Such a decision does not mean the Fund waives or gives up any rights under this Plan in the future.

SECTION 19. PLAN CHANGE OR TERMINATION

In accordance with applicable law, the Trustees reserve the right to change or discontinue: (1) the types and amounts of benefits under this Plan, (2) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated, and (3) the amount of and ability to make self-payments.

Plan benefits and eligibility rules for active, retired, or disabled Participants:

1. Are not guaranteed;
2. May be changed or discontinued by the Board of Trustees;
3. Are subject to the rules and regulations adopted by the Board of Trustees;
4. Are subject to the Trust Agreement which establishes and governs the Fund's operations; and
5. Are subject to the provisions of any group insurance policy purchased by the Trustees.

The nature and amount of Plan Benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

The Trustees may amend the Plan terms without prior notice, unless required by law. Participants will be provided notice of changes to the Plan terms according to the applicable timeframes and methods as required by law.

SECTION 20. STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, 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:

20-1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Fund Office, 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 Fund Office may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

20-2. CONTINUE GROUP HEALTH PLAN COVERAGE

1. Continue health care coverage for Yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA Continuation Coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan and application of preexisting exclusions is not prohibited by law. You should be provided with a Certificate of Creditable Coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA Continuation Coverage, when Your COBRA Continuation Coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

20-3. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your Employer, Your Union, or

any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a Welfare Benefit or exercising Your rights under ERISA.

20-4. ENFORCE YOUR RIGHTS

If Your claim for a Welfare 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.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for Benefits that is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file 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 if, for example, it finds Your claim is frivolous.

20-5. ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Fund Office. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Fund Office, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 21. RIGHT OF RECOVERY

21-1. WHEN THE FUND HAS A RIGHT OF RECOVERY

The following rule applies to any situation in which the Fund makes full or partial payment to or on behalf of You or Your Eligible Dependent(s) ("Covered Person") who subsequently recovers from any other source additional payments or Benefits in any way related to the Accident, Illness, or treatment for which the Fund made full or partial payment. Upon any such subsequent recovery by or on behalf of a Covered Person from any person, party, insurance company, firm, corporation, or government agency, by suit, judgment, settlement, compromise, or otherwise, the Fund, with or without the signing of a subrogation agreement, shall be entitled to immediate reimbursement to the full extent of Benefits paid to or on behalf of the Covered Person. The Fund, by payment of any Benefits, is granted a lien on the proceeds of any such recovery. The Fund shall first be reimbursed fully by or on behalf of such Covered Person to the extent of Benefits paid from the monies paid by any person, party, insurance company, firm, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the Covered Person. Any recovery from a third party by a Covered Person or any person or entity acting on behalf of a Covered Person, such as an attorney, is a Plan Asset; thus, the Plan designates the Covered Person or any person or entity acting on a Covered Person's behalf, such as an attorney, as a named fiduciary with respect to any amount recovered from a third party on behalf of a Covered Person.

21-2. OBLIGATION OF COOPERATION

All Covered Persons are obligated to cooperate with the Fund in its efforts to enforce its subrogation rights and to refrain from any action which interferes with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation agreement in the form prescribed by the Fund. No Covered Person shall make any settlement which specifically excludes or attempts to exclude any Benefits paid by the Fund. The Fund shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a Covered Person refuses to sign a subrogation agreement, refuses to reimburse the Fund in accordance with the Fund's rights, or takes any other action inconsistent with the Fund's subrogation rights. In such situations, the Fund's options shall include, without limitation, the right in appropriate cases to deny Benefits to a Covered Person who refuses to sign a subrogation agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and to offset wrongfully withheld sums against future benefit payments otherwise owed the Covered Person who retains such sums.

21-3. FUND HAS LIEN ON RECOVERY

The Fund's right of recovery shall be a prior lien against any proceeds recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Fund's recovery rights by allocating the proceeds exclusively to non-medical expenses damages. No Covered Person shall incur any expenses on behalf of the Fund in pursuit of the Fund's rights; specifically, no court costs nor attorneys' fees may be deducted from the Fund's recovery

without the prior express written consent of the Fund. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine".

SECTION 22. PRIVACY OF PROTECTED HEALTH INFORMATION

22-1. TRUSTEES' CERTIFICATION OF COMPLIANCE

Neither the Fund nor any health insurance issuer or business associate servicing the Fund will disclose Plan Participants' Protected Health Information ("PHI") to the Trustees unless the Trustees certify that the Plan Documents have been amended to incorporate this section and agree to abide by this section. The Board of Trustees certifies that the Plan contains and that the Board of Trustees agrees to abide by the provisions outlined herein.

22-2. PURPOSE OF DISCLOSURE TO TRUSTEES

The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Trustees only to permit the Trustees to carry out Plan administration functions for the Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Trustees of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of this section and HIPAA.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclosure Plan Participants' Protected Health Information to the Trustees unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants. Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Trustees for the purpose of employment-related actions or decisions or in connection with any other Benefit or employee Benefit Plan.

22-3. RESTRICTIONS ON TRUSTEES USE AND DISCLOSURE OF PHI

The Trustees will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.

The Trustees will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to Plan Participants' Protected Health Information.

The Trustees will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other Benefit or employee Benefit Plan.

The Trustees will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is consistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

The Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with HIPAA.

The Trustees will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with HIPAA.

The Trustees will track disclosures it may make of Plan Participants' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA.

The Trustees will make its internal practices, books, and records, relating to its use and disclosure of Plan Participants' Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

The Trustees will, if feasible, return or destroy all Plan Participant Protected Health Information in whatever form or medium (including in any electronic medium under the Trustees' custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Trustees will limit the use or disclosure of any Plan Participant Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

The Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI ("ePHI") that the Trustees create, receive, maintain, or transmit on behalf of the Plan.

The Trustees will ensure that any agent, including a subcontractor, to whom the Trustees provide ePHI (that the Trustees create, receive, maintain, or transmit on behalf of the Plan) agrees to implement reasonable and appropriate security measures to protect this information.

The Trustees shall report any security incident of which they becomes aware to the Plan.

- In determining how and how often the Trustees shall report security incidents to Plan, the Trustees and Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, the Trustees and Plan agree that this agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do <u>not</u> result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system: pings on a party's firewall, port scans, attempts to log on to a system or enter a database with an invalid password or username, denial-of-

service attacks that do not result in a server being taken off-line, and malware (*e.g.*, worms, viruses)

- The Trustees shall, however, separately report to the Plan any successful unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI of which the Trustees become aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration, or destruction of the Plan's ePHI; or (c) results in a breach of availability of the Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing (when so required by the Plan) within ten (10) business days after the Trustees become aware of the impact of such security incident upon the Plan's ePHI.

22-4. ADEQUATE SEPARATION BETWEEN THE TRUSTEES AND THE PLAN

The Fund employees who work in the Fund Office at 2902 Blue Ridge Blvd, Kansas City, Missouri 64129 may be given access to Plan Participants' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan for purposes relating to payment under, healthcare operations of, or other matters pertaining to the Plan in the ordinary course of business. These employees will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that the Trustees provide for the Plan. These employees will be subject to disciplinary action and sanctions, including termination of employment, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section to the Plan Documents. Trustees will promptly report such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the breach, violation, or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation, or noncompliance, and to mitigate any deleterious effect of the breach, violation, or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation, or noncompliance. The Trustees will ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

22-5. COMPLIANCE WITH GINA

Effective January 1, 2010, and notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act ("GINA"). In general, the Plan cannot set premiums on the basis of genetic information, request or require a Participant to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or collect genetic information about a Participant before the Participant is enrolled or covered under the Plan.

SECTION 23. HOSPITAL AND MEDICAL BILL AUDIT PROGRAM

This program is designed to provide You with a bonus if You discover and arrange for recovery of overcharges made on Your or Your Dependents' Hospital and medical bills. The rules for the program are as follows:

1. The bonus paid for recovering an amount that was initially overcharged on a Hospital or medical bill shall be 50% of the actual amount of the charge to the Fund reflecting PPO or other discounts that the Hospital or medical provider agrees is invalid as a result of negotiations between You and the Hospital or medical provider.
2. The maximum paid by the Fund in any Calendar Year to a Participant under this program will not exceed $575.00. Overcharges totaling less than $25.00 will not be considered for payment under this program.
3. For purposes of the bonus, only expenses which the Plan covers (which excludes such items as telephone bills, television rental, newspapers, etc.) shall be considered in determining the amount payable under this program.
4. Proof of eligibility for a bonus must be submitted to the Fund Office in the form of a copy of the initial itemized Hospital or medical bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital or medical provider dropped the discrepancy. Such proof must be submitted to the Fund Office within six (6) months following the date of discharge from the Hospital or within six (6) months following the date the medical care was received. Within 30 days after receipt of proof and verification that the overcharge has been adjusted and refunded to the Fund, the Fund shall disburse a check to You in the amount described above. It should be noted that such a bonus is considered income to You and should be reported to the Internal Revenue Service.
5. Any bonus paid will be limited to 50% of the actual amount paid to the Fund as a result of a recovery by the Participant, up to the Calendar Year maximum.