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
2902 Blue Ridge Blvd.
P.O. Box 300019
Kansas City, Missouri 64129
(This address is sometimes referred to as the Fund Office.)
Telephone: (816) 531-0334
www.mokansheetmetal.org

The Trustees of this Plan are:

Union Trustees

Mr. Robert Eslinger
Financial Secretary
Sheet Metal Workers Local Union No. 2
2902 Blue Ridge Boulevard
P.O. Box 300378
Kansas City, Missouri 64130-0378

Mr. Ken Alexander
Business Manager
Sheet Metal Workers Local Union No. 2
2902 Blue Ridge Boulevard
P.O. Box 300378
Kansas City, Missouri 64130-0378

Mr. James Flach, Jr.
Business Representative
Sheet Metal Workers Local Union No. 2
2902 Blue Ridge Boulevard
P.O. Box 300378
Kansas City, Missouri 64130-0378

Mr. Curtis E. Chick
Business Manager
Sheet Metal Workers Local Union No. 2
P.O. Box 471
Fulton, Missouri 65251

Employer Trustees

Mr. William Basore
W.C. Wiedenmann & Son, Inc.
875 North Jan-Mar Court
Olathe, Kansas 66061

Mr. James J. Hausman
Hausman Metal Workers
1229 S. 15th Street
Post Office Box 1256
St. Joseph, Missouri 64502

Mr. Paul Russell
Cates Sheet Metal Ind. Inc.
15555 W. 108th Street
Lenexa, Kansas 66219

Mr. Jerry Schaefer
A2MG, Inc.
4715 W. 40 Hwy
Blue Springs, MO 64015

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.** Presently the agent for service of legal process is Ms. Kristie Arthur at the Fund Office. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon her. Also, service of legal process may be made on a Plan 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 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 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 for Plan A. These Plan benefits are shown in BENEFIT SUMMARIES, Section 2, for Employees and Retirees. Group Life Insurance and Accidental Death and Dismemberment are insured by an insurance company as chosen by the Board of Trustees. The complete terms of the insured benefits are set forth in the group insurance policies with the insurance company.

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 14. If your claim is denied or partly denied, please refer to Section 14-5 of this booklet, How to Appeal a Denial of Claim. If you have any questions about an Appeal please contact the Fund Office.

SECTION 2.

Mo-Kan Sheet Metal Workers Welfare Fund
January 2008 Benefit Summary

Plan A

Benefit	**In-Network**	**Out-of Network**
Deductible	$500/$1000	$500/$1000
Calendar Year Out-of-Pocket maximum (includes deductible)	$1300/$2600	$2100/$4200
Co-insurance	20%	40%
Individual Lifetime Max	$1,500,000	$1,500,000
Office Visits	20% after deductible	40% after deductible
Co-Payments		
Inpatient (waived if admitted twice in six months)	$300 co-pay and 20% after deductible	$600 co-pay and 40% after deductible
Emergency Room	$100 co-pay and 20% after deductible	$100 co-pay and 40% after deductible
Routine Physical Exam (newborn to adult)	100% up to $500 then 20% after deductible	100% up to $500 then 40% after deductible
Routine Immunizations	Covered for children to age 25 at 100%	40% after deductible
Mammogram	One annual routine exam after age 35 covered at 100%	40% after deductible
Cervical Cancer Screening	One test per year, covered at 100%	40% after deductible
Prostate Exam &PSA Test	One test per year covered at 100%	40% 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)	$10 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 $50	
Mail Order Generic(90 days)	$20 co-pay	
Mail Order Brand (90 days)	50% up to $100	
Smoking Cessation Program $500 annual max $2000 lifetime. Does not apply to RX out of pocket maximum.	$10.00 OTC 50% up to $50.00 for RX Both require a prescription	
OTC program Examples: Prilosec, Claritin	$10.00 generic $20.00 mail order	
Out of Pocket Max for RX	$1,000 Ind. $2000 family	
Laboratory and X-Ray	First $150 of Lab and X-Ray	First $150 of Lab and X-Ray

Benefit	**In-Network**	**Out-of Network**
	covered at 100% then 20% after deductible	covered at 100% then 40% after deductible
Lab	100% benefit if collected and tested at a Lab One collection facility.	40% after deductible
Supplemental Accident This benefit pays the first $300 of an accident claim.	$300 per calendar year	$300 per calendar year
Mental Illness		
Inpatient	20% after deductible	40% after Deductible
Outpatient	20% after deductible	40% after deductible
Chemical Dependency ($30,000 maximum inpatient per lifetime) ($50 maximum per visit)	50% after deductible	60% after deductible
Valley Hope Association	10% after deductible	
Chiropractic Treatment $1000 maximum per calendar year (includes x-rays)	20% after deductible	40% after deductible
Physical Therapy $5,000 limit	20% after deductible	40% after deductible
Hospice	20% after deductible	40% after deductible
Home Health Care (100 visit limit)	20% after deductible	40% after deductible
Bereavement Counseling (maximum 6 visits in 12 months)	$50 co-pay per visit	Not covered
All other covered services	20% after deductible	40% after deductible
Dental (maximum for Preventive, Basic and Restorative is $1550)	**Freedom Network Dental available for Kansas City area.**	
Deductible	$25	
Coinsurance	20%	
Preventative 2 cleanings per calendar (Class I)	100%	100%
Basic (Class II)	20% after deductible	20% after deductible
Major (Class III)	20% after deductible	20% after deductible
Orthodontia (Class IV) ($1,800 lifetime maximum)	50% after deductible	
Vision		
Maximum Calendar year (can be used for Lasik)	$300 per person	
Frames and lenses for safety glasses with permanent side shields only once per calendar year.	50% up to $70	This benefit payable only to actively working Participants upon presentation of a signed authorization form available from the Fund Office.
Hearing Aide Benefit	$1550 Maximum per person per 3 consecutive year period.	

Benefit	In-Network	Out-of Network
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……$250.00 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 $200 in HRA credit		

**When obtaining services from a provider not contracted with Mo-Kan Sheet Metal Workers Welfare Fund, you may be responsible for charges in excess of Allowable Charges, as determined by Mo-Kan Sheet Metal Workers Welfare Fund. Additional service area restrictions may apply.

Preferred Health Professionals provide a wide range of doctors and hospitals. You can find these physicians at www.phpkc.com or you can call 1-800-544-3014. The Beech Street network can be accessed at www.beechstreet.com or by calling 1-800-432-1776.

Mo-Kan Sheet Metal Workers Welfare Fund
January 2008 Benefit Summary

Plan B

Benefit	**In-Network**	**Out-of Network**
Deductible	$1500/$3000	$3000/$6000
Calendar Year Out-of-Pocket maximum (includes deductible)	$5000/$10,000	$10,000/$20,000
Co-insurance	30%	50%
Individual Lifetime Max	$1,000,000	$1,000,000
Office Visits	30% after deductible	50% after deductible
Co-Payments		
Inpatient (waived if admitted twice in six months)	$300 co-pay and 30% after deductible	$600 co-pay and 50% after deductible
Emergency Room	$200 co-pay and 30% after deductible	$200 co-pay and 50% after deductible
Routine Physical Exam (newborn to adult)	100% up to $500 then 30% after deductible	100% up to $500 then 50% after deductible
Routine Immunizations	Covered for children to age 25 at 100%	50% after deductible
Mammogram	One annual routine exam after age 35 covered at 100%	50% after deductible
Cervical Cancer Screening	One test per year, covered at 100%	50% after deductible
Prostate Exam &PSA Test	One test per year covered at 100%	50% 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)	$10 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 $50	
Mail Order Generic(90 days)	$20 co-pay	
Mail Order Brand (90 days)	50% up to $100	
Smoking Cessation Program $500 annual max $2000 lifetime. Does not apply to RX out of pocket maximum.	$10.00 OTC 50% up to $50.00 for RX Both require a prescription	
OTC program Examples: Prilosec, Claritin	$10.00 generic $20.00 mail order	
Out of Pocket Max for RX	$1,000 Ind. $2000 family	
Laboratory and X-Ray	First $150 of Lab and X-Ray covered at 100% then 20% after deductible	First $150 of Lab and X-Ray covered at 100% then 40% after deductible

Benefit	In-Network	Out-of Network
Lab	100% benefit if collected and tested at a Lab One collection facility.	50% after deductible
Supplemental Accident This benefit pays the first $300 of an accident claim.	$300 per calendar year	$300 per calendar year
Mental Illness		
Inpatient	30% after deductible	50% after Deductible
Outpatient	30% after deductible	50% after deductible
Chemical Dependency ($30,000 maximum inpatient per lifetime) ($50 maximum per visit)	50% after deductible	60% after deductible
Valley Hope Association	10% after deductible	
Chiropractic Treatment $1000 maximum per calendar year (includes x-rays)	30% after deductible	50% after deductible
Physical Therapy $5,000 limit	30% after deductible	50% after deductible
Hospice	30% after deductible	50% after deductible
Home Health Care (100 visit limit)	30% after deductible	50% after deductible
Bereavement Counseling (maximum 6 visits in 12 months)	$50 co-pay per visit	Not covered
All other covered services	30% after deductible	50% after deductible
Wellness Program Opportunity to earn up to $200 in HRA credit		

**When obtaining services from a provider not contracted with Mo-Kan Sheet Metal Workers Welfare Fund, you may be responsible for charges in excess of Allowable Charges, as determined by Mo-Kan Sheet Metal Workers Welfare Fund. Additional service area restrictions may apply.

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Mo-Kan Sheet Metal Workers Welfare Fund
January 2008 Benefit Summary

Plan D Single Coverage

Benefit	In-Network	Out-of Network
Deductible	$2500.00	$5000.00
Calendar Year Out-of-Pocket maximum (includes deductible)	$5000.00	$10,000.00
Co-insurance	30%	50% after deductible
Individual Lifetime Max	$1,000,000	$1,000,000
Office Visits	30% after deductible	50% after deductible
Co-Payments		
Inpatient (waived if admitted twice in six months)	$300 co-pay and 30% after deductible	$600 co-pay and 50% after deductible
Emergency Room	$100 co-pay and 30% after deductible	$100 co-pay and 50% after deductible
Routine Physical Exam	100% up to $500 then 30% after deductible	100% up to $500 then 50% after deductible
Mammogram	One annual routine exam after age 35 covered at 100%	50% after deductible
Cervical Cancer Screening	One test per year, covered at 100%	50% after deductible
Prostate Exam &PSA Test	One test per year covered at 100%	50% after deductible
Prescription Drugs	**30%**	Member pays out of pocket and then sends receipts to WellDyne/Rx West for reimbursement. Only reimbursed contracted amount.
OTC program Examples: Prilosec, Claritin	$10.00 generic $20.00 mail order	
Smoking Cessation Program $500 annual max $2000 lifetime. Does not apply to RX out of pocket maximum.	$10.00 OTC 50% up to $50.00 for RX Both require a prescription	
Laboratory and X-Ray	First $150 of Lab and X-Ray covered at 100% then 20% after deductible	First $150 of Lab and X-Ray covered at 100% then 40% after deductible
Lab	100% benefit if collected and tested at a Lab One collection facility.	50% after deductible
Supplemental Accident This benefit pays the first $300 of an accident claim.	$300 per calendar year	$300 per calendar year
Mental Illness		
Inpatient	30% after deductible	50% after Deductible
Outpatient	30% after deductible	50% after deductible

Benefit	In-Network	Out-of Network
Chemical Dependency ($30,000 maximum inpatient per lifetime) ($50 maximum per visit)	50% after deductible	60% after deductible
Valley Hope Association	10% after deductible	
Chiropractic Treatment $1000 maximum per calendar year (includes x-rays)	30% after deductible	50% after deductible
Physical Therapy $5,000 limit	30% after deductible	50% after deductible
Hospice	30% after deductible	50% after deductible
Home Health Care (100 visit limit)	30% after deductible	50% after deductible
Bereavement Counseling (maximum 6 visits in 12 months)	$50 co-pay per visit	Not covered
All other covered services	30% after deductible	50% after deductible
Wellness Program Opportunity to earn up to $200 in HRA credit		

**When obtaining services from a provider not contracted with Mo-Kan Sheet Metal Workers Welfare Fund, you may be responsible for charges in excess of Allowable Charges, as determined by Mo-Kan Sheet Metal Workers Welfare Fund. Additional service area restrictions may apply.

Preferred Health Professionals provide a wide range of doctors and hospitals. You can find these physicians at www.phpkc.com or you can call 1-800-544-3014. The Beech Street network can be accessed at www.beechstreet.com or by calling 1-800-432-1776.

ADDITIONAL INFORMATION

To access a list of providers available in the Kansas City area, please visit the Preferred Health Professionals' website at www.phpkc.com or call Preferred Health Professionals' Customer Service Department at (913) 685-6300 or toll-free at (800) 544-3014; and in the Omaha, Nebraska area, please visit the Beechstreet website at www.beechstreet.com or call Beechstreet's Customer Service Department at (800) 432-1776.

The following notice is required each year under the Women's Health and Cancer Rights Act (WHCRA).

Under the Women's Health and Cancer Rights Act, group health plans that provide medical and surgical benefits in connection with mastectomy, like this Plan, must provide benefits for certain reconstructive surgery. This benefit covers reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all states of mastectomy, including lymphedemas. This coverage is subject to the plan's deductible and coinsurance provisions which are described in Your Summary Plan Description (SPD).

For more information about MO-KAN Sheet Metal Workers Welfare Fund, 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.

SECTION 3. DEFINITIONS

The following terms have the meaning defined below when used in the Summary Plan Description and Certificate of Credible Coverage with the first letter of the term capitalized.

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 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 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.

The following explains what the Allowable Charge is for different providers:

1. For Hospitals, other institutional health care facilities, or suppliers of medical goods and services, which are Participating Providers.

   The Allowable charge is the lesser of:

   a. The amount the Participating Provider has agreed to accept as payment in full at the time of claim payment;
   b. The PPO's basic fee schedule amount for the same services or supplies; or
   c. The Participating Provider's billed charges.

2. For Hospitals, other institutional health care facilities or suppliers of medical goods and services which are Non-Participating Providers.

   The Allowable Charge is an amount that is within the Usual, Customary and Reasonable Charges in the locality for a medical service, good, or supply items.

3. For Physicians or other covered professionals practicing within the scope of their license, who are Participating Providers.

The Allowable Charge is the lesser of:

a. The amount the Participating Provider has agreed to accept as payment in full at the time of claim payment;
b. The Fund’s basic fee schedule amount for the same services or supplies; or
c. The Non-Participating Provider’s billed charges.

4. For Physician’s or other covered professionals practicing within the scope of their license, who are Non-Participating Providers inside the PPO service area.

   The Allowable Charge is the lesser of:

   a. The PPO basic fee schedule for the same services or supplies provided by Participating Providers; or
   b. The provider’s billed charges.

5. For Physicians or other covered professionals practicing within the scope of their license, who are Non-Participating Providers outside the PPO Service Area.

   The Allowable Charge is an amount that is within the Usual, Customary and Reasonable Charges in the locality for a medical service, good, or supply items.

6. For Participating pharmacies.

   The Allowable Charge is the lesser of:

   a. The negotiated rate, if applicable; or
   b. The Usual and Customary Charge if a Non-Participating Pharmacy is used.

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 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.

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.

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 CREDIT means credits earned under the Wellness Program as described in Section 13.

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 act as the governing body of the Fund.

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 who lives with the Member, an adopted Child of Member or Members spouse, a Child under the age of 18 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 Court appointed legal guardian, not including a foster child, provided proof of the guardianship is submitted with the enrollment card.

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, 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.

CUSTODIAL CARE means care furnished mainly to train or assist in personal hygiene or other activates of normal daily living such as dressing, feeding and walking, rather than to provide medical treatment.

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.

DENTAL TREATMENT PLAN means a Dentist's written plan describing the periodic treatment or any other course of treatment for which the Covered Dental Charges are expected to total at least $250.

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 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.

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 United States Food and Drug Administration 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 trail, 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.

FULL-TIME STUDENT means a student currently enrolled in an accredited post-secondary educational institution maintaining full-time status as defined by that institution.

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.

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 are classified as follows:

1. **Participating Hospital** means a Hospital that contracts with the PPO to provide the Hospital services described in the Plan and accepts the Allowable Charges as full payment for Covered Services except for Co-payments, Coinsurance and Deductibles, if any. See definition of Participating Hospital.
2. **Non-Participating Hospital** means a Hospital that does not have a Participating Provider Hospital contract with the PPO. See definition of Participating Hospital.

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

HUSBAND means male spouse in a legally recognized marriage, other then common law, under applicable law.

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 educating a temporary or permanent status in an existing 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 means any service(s) provided by any provider not contracted with the Fund.

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 FACILITY means a facility licensed or certified in the State in which it is providing care which is a Hospital, a psychiatric Hospital, an outpatient surgery facility, urgent

care facility, a community mental health center or a specialized facility for treatment of alcoholism or drug abuse that has entered into a written contract with the PPO to provide services to the Members which is in effect at the time services are provided.

PARTICIPATING HOSPITAL means a Hospital licensed or certified in the State in which it is providing care and which has an agreement with the Fund to provide services to Fund Members and their enrolled Dependent(s) which is in effect at the time services are provided.

PARTICIPATING PHYSICIAN means a Physician licensed or certified in the State in which he/she is providing care and who has an agreement with the PPO to provide services to the Fund Members and their enrolled Dependent(s) which is in effect at the time services are provided.

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.

PREDETERMINATION/PRE-TREATMENT PLAN OR PREAUTHORIZATION. See AUTHORIZATION.

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.

QUALIFIED MEDICAL EXPENSE means

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.

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.

Skilled Nursing Facilities are classified as follows:

1. **Participating Provider Skilled Nursing Facility** means a Skilled Nursing Facility that contracts with the PPO to provide the Skilled Nursing Facility Covered Services.
2. **Non-Participating Provider Skilled Nursing Facility** means a Skilled Nursing Facility which does not have a contract with the PPO.

SPOUSE means the legally recognized marital partner of a Member under applicable law. The Fund Office may require documentation proving a legal marital relationship.

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

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

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 RESONABLE 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.

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

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

WIFE means the female spouse of a member.

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 behalf if the Member 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:

1. You will become eligible for coverage under this Plan on the first day of the month which <u>follows</u> a period of 6 consecutive months beginning with Your initial date of employment;
2. You worked an average of 80 hours per month with contributing Employers during such 6 consecutive month period;
3. You had at least some employment in 4 of the 6 months; and
4. You are in good standing with the Union.

Initial Eligibility --- Non- Bargaining Employees

If Your employment is not subject to a Collective Bargaining Agreement:

1. 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. You or Your Dependents' Employer stops contributing toward Your or Your Dependents' coverage under another plan; or
3. You acquire a new Dependent(s) through marriage, birth, adoption, or placement for adoption.

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;
3. The date You elect not to accept work with a contributing Employer for which You are qualified and able to perform;

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 this Plan terminates;
7. The date You are no longer a Member of an eligible group;
8. The date a change is made in this Plan to terminate coverage for Your group;
9. 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
10. 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 USERA.

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.

4-2. DEPENDENT ELIGIBILTY AND TERMINATION

Eligible Dependents

Only Your lawful Spouse (excluding Common-Law and Legally Separated Spouses), and each unmarried Child if such Child is at least 50% dependent upon You for support and maintenance are eligibly for Dependent coverage. However, the Plan will cover Your natural Child if You have a Court Order making You legally responsible for medical coverage even if the Child is not at least 50% dependent upon You for support and maintenance. The Fund has certain procedures that must be followed before it can recognize a Court Order or a Qualified Medical Child Support Order (QMCSO). For a free copy of the QMCSO procedures, contact the Fund Office.

Child includes:

1. Your natural Child;
2. Any Step-child living in the Member's household;
3. Your adopted Child. An adopted Child shall be considered to be an Eligible Dependent from the date of placement in the Member's home. Coverage for an adopted Child will be on the same basis as other Dependents, provided, however, that no coverage will be provided in connection with medical conditions that existed prior to the date of placement, if the adopted Child is not enrolled in the Plan within 30 days of the birth or adoption.
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, nephew and the Child's parents are deceased or unable to care for the Child.

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. Any married Child;
4. Anyone eligible for coverage as an Employee; or
5. A Child who has attained the limiting age.

The limiting age is:

1. The Child's 19th birthday;
2. The 25th birthday if the Child is a full-time student as defined by any accredited high school, trade school, college or university and is at least 50% dependent on You for

support. Full-time students are those students that provide proof of full-time enrollment and attendance every semester after their initial enrollment date; or

3. An unmarried Child who is a Dependent 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 19, 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.

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.

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

If both parents are Covered under the Plan and are legally 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;
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 Divorced or Legally Separated.

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 will continue for 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.

You must apply for coverage within 60 days of the date You lose eligibility for the Fund Benefits as an Active Employee. You will be notified of the amount of the required monthly contribution as determined from the time by the Board of Trustees. 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.**

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
6. With respect to a Dependent Spouse and former Step-children, the date You become Divorced or Legally Separated.

*If when You attain age 65 or are eligible for Medicare, 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.

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. That 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, contributions made on Your behalf will be credited to Your hours recorded 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.

Military Service

If You are inducted into the Armed Forces of the United States, 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 Section 4-5.

Upon Your discharge from the Armed Forces, You may be reinstated as a fully covered Employee 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 Employee.

Uniformed Services Employment And Reemployment Rights As 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. 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 and Dependent again becomes covered under the Plan; or
    d. The day Health Coverage has been continued for the period of time provided in part 1(a) or (b) above (or any longer period provided in the Plan).

Reemployment (following Service in the Uniformed Service)

Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then existing Health Coverage provided by Your Employer.

4-5. CONTINUATION OF COVERAGE (SELF-PAY) AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Who may elect COBRA, and when?

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 the section titled CONTINUATION PERIOD, if coverage would otherwise terminate due to a Qualifying Event. This provision does not apply to Accidental Death and Dismemberment, Loss of Time or Life Insurance.

"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;
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); or
7. With respect to Your Dependent Child, his ceasing to satisfy the Plan's definition of an eligible Dependent.

Certain newborns, newly adopted Children, and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed in more detail below.

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, 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 <u>Divorce or Legal Separation,</u> or Your <u>Dependent Child losing eligibility for coverage</u> 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, <u>YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.</u> 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.

Election Period

You and/or Your Dependent(s) may 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; or
2. The date You and/or Your Dependent(s) are notified of Your right to elect the continuation coverage.

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.

Special considerations in deciding whether to elect COBRA

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 an additional 11 months if at the time of the Qualifying Event or within 60 days of the Qualifying Event described in 1a. or 1b., You or Your Dependent is determined to be disabled by the Social Security Administration.

Written notice and proof of disability must be provided to the Fund Office within 60 days of the date the Social Security Administration makes the determination. This extended period of continuation coverage applies to You and Your Eligible Dependent(s).

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.

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 second Qualifying Event

If Your Dependent's coverage is continued for reasons listed under Item 1. of this section, and, during the initial Continuation Period, a Qualifying Event occurs which entitles the Dependent to continue coverage under Item 2. of this section, Your Dependent may elect to continue coverage up to a combined maximum of 36 months. You must notify the Fund Office of this second Qualifying Event in writing in order to extend the period of COBRA coverage.

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.

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.

Note: 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 note 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:

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

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.**

More information about special enrollment of qualified beneficiaries

A Child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA 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 Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A Child of the covered Employee who is receiving Benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Fund Office during the covered Employee's period of employment with a contributing employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

4-6. TERMINATION OF 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.

Note: 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.

Family and Medical Leave Act

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. The Family and Medical Leave Act requires Employers to maintain health care coverage under any health plan for the length of the leave as if You were still employed. In addition, the Act states that if You take a family or medical 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 the federal law and the required payments are made to the Fund.

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 QMSCO pursuant to the Plan's procedures and notify the Employee and each alternate recipient of the determination.

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.

If You have any questions or need assistance obtaining a Certificate of Creditable Coverage, contact the Fund Office.

SECTION 5. COVERED SERVICES

This Section describes the Benefits for Covered Services available under the Plan. All Covered Services are subject to the condition, limitations and exclusions of the Plan.

Covered Services under the Plan are set forth in this Section. All Covered Services are subject to Deductible, Co-payment, and Coinsurance requirements and the limitation and exclusion 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; and
5. Received in accordance with the requirements of the Plan.

5-1. BENEFITS

We provide Benefits for Covered Services in excess of the Deductible, Co-payments and Co-insurance. All Covered Services are subject to the maximums and other limits and conditions specified in the Plan.

Benefits are different depending on whether Covered Services are received from a Preferred Provider or a Non-Preferred Provider. Benefits for Covered Services will be greater if Covered Services are received from Preferred Providers. It is Your responsibility to ensure that You use Preferred 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 Preferred 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 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 Preferred Providers and Non-Preferred Providers. The amount You pay for Covered Services received from Preferred Providers or Non-Preferred 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. INDIVIDUAL LIFETIME MAXIMUM

The amount of Benefits provided under the Plan shall not exceed the individual Lifetime Maximum shown in the Benefit Summary. This maximum shall not be affected by any break in coverage; nor shall it be affected by a change in status from Dependent to Employee, or vice versa.

5-6. 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 Preferred 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 Non-Preferred Provider or Preferred Providers

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

5-7. COVERED SERVICES DESCRIPTIONS

5-7(1). ACCIDENT-RELATED 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 with in 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.

We provide Benefits for:

Tooth Extractions

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

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

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.

Dental prostheses over an implant are not covered unless the dental implant was due to an Accidental Injury or due to a correction of a defect diagnosed with 31 days of birth.

Dental implants and bone grafts must be Approved in Advance by Us.

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.

5-7(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.

5-7(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.

5-7(4). ANESTHIA

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 5 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.

5-7(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 preformed and read in the Chiropractic office. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Summary.

5-7(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, 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 VA or Defense;
5. An institutional review board in MO 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.

5-7(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.

5-7(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 Outpatient Prescription Drug Benefit.

5-7(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 in 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; and
4. Mechanical equipment for the treatment of chronic or acute respiratory failure (ventilators and respirators).

When Medically Necessary, an electrically operated bed or wheelchair may be covered at the discretion of the Trustees 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, or 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.

Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Summary.

The Benefit limit for renting Durable Medical Equipment will not exceed the reasonable purchase cost.

5-7(10). Elective Sterlization

We provide Benefits for elective sterilization.

5-7(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 Preferred 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.

5-7(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 6. 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 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 are subject to the same Coinsurance provisions as other Covered Services.

5-7(13). Hearing Aide

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

5-7(14). HOME HEALTH SERVICES

We provide Benefits for home health services provided in the home or other outpatient setting. Covered Services may be limited to a Calendar Year maximum if indicated in the Benefit Summary and are subject to all the following conditions:

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

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

5-7(15). HOSPICE SERVICES

Hospice Care services are covered when provided by a Participating Provider and You have less than 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.

5-7(16). IMMUNIZATIONS FOR CHILDREN

We provide Benefits for routine and necessary childhood immunizations for covered Dependent Children. Covered Services include: (1) at least 5 doses of vaccine against diphtheria, pertussis, tetanus; (2) at least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib); (3) at least 3 doses of vaccine against Hepatitis B; (4) 2 doses of vaccine against measles, mumps, and rubella; (5) 1 dose of vaccine against varicella; (6) at least 4 doses of vaccines and dosages as may be prescribed by the State Department of Health.

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

5-7(17). 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 19. Most self-injectables are processed under Your Outpatient Drug Benefit; however, selected self-injectables may be processed under Your medical benefit.

Covered Services for infusion therapy and injectables are subject to the home health Benefit visit limit, if any, when provided by a home health agency in conjunction with home health services that have been Approved in Advance by Us.

5-7(18). 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; 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.

5-7(19). LABORATORY AND X-RAY (PLAN A ONLY)

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 an Injury that is not employment-related.

5-7(20). 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. The newborn inpatient co-pay will be waived.

Dependent daughters are not covered for maternity services.

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.

5-7(21). MENTAL ILLNESS AND CHEMICAL DEPENDENCY

We provide Benefits for the treatment of Mental Illness and Chemical Dependency.

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): (2) 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 residential care and structured, intensive treatment.

"**Residential Treatment Program**" means a program certified by the Department of Mental Health involving residential care and structured, intensive treatment.

Chemical Dependency is limited to a Lifetime Maximum Benefit. Please refer to Your Benefit Summary for details.

Mental Illness Services

Services for inpatient Hospital and out patient treatment will be covered to the same extent as any other illness.

5-7(22). 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 may be limited to an Organ Transplant Lifetime maximum, if indicated in the Benefit Summary.

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 Non-Preferred Provider level;
2. The Coinsurance level for Organ Transplant Services received for Non-Preferred Providers will always be paid at the Non-Preferred 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 up to the recipient's Organ Transplant Benefit Maximum, if any. This means that both the donor and recipient's transplant related services will be combined and will apply to the recipient's Lifetime Organ Transplant Maximum, if any;
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 and will reduce the recipient's Lifetime Organ Transplant Maximum, if any; 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 and subject to the Lifetime Organ Transplant Maximum, if any.

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.

5-7(23). OSTEOPOROSIS

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

5-7(24). OUTPATIENT 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.

For Participating Providers, 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;
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 Food and Drug Administration; 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 us in the United States by the Federal Food and Drug Administration (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 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 Food and Drug Administration to be ineffective;
4. Medications for cosmetic purposes, such as but not limited to, isotretinoin, tretinoin (Retin-A), topical minoxidil, and finarteride;
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, growth hormones prescribed for anyone over age 18;
12. Blood or blood storage;
13. Lifestyle enhancing drugs, unless otherwise specified;
14. Fertility drug; and
15. Drugs and devices that are intended to induce an abortion.

5-7(25). OUTPATIENT SURGERY AND SERVICES

We provide Benefits for outpatient surgery provided under the direction of a Physician at a Hospital or an outpatient facility. These services must be pre-certified in advance by Us.

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 of the loss of 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 fall 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 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, 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.

Covered Services for all therapy services combined are limited to a Calendar Year maximum if indicated in the Benefit Summary.

5-7(26). PHYSICIAN SERVICES

We provide Benefits for Physician services unless otherwise noted.

Non-Preferred Provider

All services received from Non-Preferred Providers are subject to the Deductible and Co-insurance indicated in the Benefit Summary.

5-7(27). 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.

5-7(28). 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 then 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 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.

5-7(29). RADIATION THERAPY

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

5-7(30). Reconstructive Surgery/Prosthetic Devices Following a Mastectomy

We provide Benefits for prosthetic devices and/or reconstructive surgery following a mastectomy. Covered Services are limited to:

1. Reconstructive surgery on the breast on which the mastectomy was performed;
2. Reconstructive surgery on the unaffected breast that is required to produce a symmetrical appearance; and
3. Breast prostheses. No time limit will be imposed on a Covered Person for the receipt of a prosthetic device or reconstructive surgery following a mastectomy.

5-7(31). Routine Preventive Care

We provide Benefits for routine preventive care as required by Federal Law. Covered Services are limited and may be received from Preferred or Non-Preferred Providers. If the services are preformed by a Non-Preferred Provider these services will be reduced to the Out-of-Network Co-insurance. Please check Your Benefit Summary for details on coverage.

We also provide Benefits for routine preventive care received from Preferred or Non-Preferred Providers to evaluate and manage a well person's health status according to the Covered Person's age. Covered Services are limited to a Calendar Year Maximum if indicated in the Benefit Summary.

5-7(32). 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. Covered Services may be limited to a Calendar Year Maximum if indicated in the Benefit Summary. 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.

5-7(33). Supplemental Accident Expense Benefit (Plan A Only)

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 **GENERAL EXCLUSIONS TO HEALTH BENEFITS**, Section 8, for limitations under this Plan.

5-7(34). 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.

SECTION 6. DENTAL EXPENSE BENEFIT - PLAN A ONLY

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. This Benefit is only available on Plan A.

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. PREDETERMINATION

You or Your Dependent(s) may undergo treatment for which the total estimated charges exceed $250. In this case, the Dentist must perform his initial examination, including X-rays and any necessary study models, and provide a Treatment Plan which lists all procedures needed to fully complete the treatment on claim forms, including his fee(s) for the procedure(s) with ADA codes. Before the treatment begins (unless it is of an emergency nature), the Dentist must submit the Treatment Plan to the Fund Office. Benefits can then be determined prior to the beginning of the treatment.

6-4. EXPENSES THAT ARE COVERED

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

7. Child fluoride, is covered for Dependents under age 15, payable 2 times per Calendar Year;
8. Sealants, limited to Dependents under age 15, payable for permanent molars only, that are virgin teeth, once in a life time;
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 anesthesia / sedation is covered for extraction of impacted wisdom teeth, 2 or more surgical extractions and/or multiple extractions in more than on 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 dentures, is payable once in 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 recementing of crowns, inlays and fixed bridgework;
20. Repair and relining or dentures;
21. Fillings;
22. Root canal and all other Endodontic treatment; and
23. Local anesthesia is covered for restorative work, but it is not covered for preventive and or periodontal maintenance.

Covered Orthodontic Charges

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

6-5. 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 15 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, 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.

SECTION 7. VISION EXPENSE BENEFIT

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

If You are in Plan B, You will be eligible for safety glasses only.

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.

Frames and lenses for safety glasses with permanent side shields once per calendar year are available at 50% up to $70.00 per Calendar Year. This Benefit is payable only to actively working Participants upon presentation of a signed authorization form available from the Fund Office.

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.

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. Non prescription 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 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.

SECTION 8. EXCLUSIONS AND LIMITATIONS

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 Worker's 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 Worker's Compensation Benefit, medical Benefits that would have been compensable except for the settlement with not be Covered Services.

4. Not Medically Necessary.

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 a felony, and/or acts of aggression.

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 in Our opinion even if provided by skilled nursing personnel.

10. For music therapy, remedial reading, recreational therapy, and other forms of special education for conditions related to autistic disease of childhood or hyperkinetic syndromes.

11. For cosmetic purposes, other than to correct birth defects or to correct a defect incurred through an Accidental Injury. Removal or replacement of a breast implant that was

initially done for augmentation or for cosmetic purposes. Cosmetic rhinoplasty whether 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, 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 for or in connection with insurance, employment, extracurricular school activities or any recreational activates; exercise programs or equipment such as, but not limited to, bicycles or employment, licensing, insurance, or adoption; examinations precedent to engaging in recreational activates; examinations or treatment ordered by a court or an employer; or premarital blood testing. In addition, immunizations and medications required for travel and work-related activates are not covered.

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 know 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 Hosptial.

19. Chemosurgery or skin abrasion procedures associated with the removal of scars, tattoos, 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 the treatment of obesity or morbid obesity, including but not limited to Mason Shunt, banding, gastroplasty, intestinal bypass, gastric balloons, stomach stapling, jejunal bypass, wiring of the jaw, as well as related office visits, laboratory services, prescription drugs, medical weight reduction services of a similar nature whether or not it is part of a

treatment plan for another illness. This exclusion also applies to any complications arising from any of the above.

22. For hairplasty or hair removal, regardless of reason or diagnosis.

23. For or related to the surgical insertion of a penile prosthesis including the cost of the prosthesis, regardless of diagnosis.

24. For orthotics unless otherwise specified.

25. For foot orthotics, including shoes.

26. For corrective shoes unless permanently attached to a brace.

27. For lodging or travel to and from a health professional or health facility.

28. For interest charges, document processing or copying fees, mailing costs, collection fees, telephone consultations, for 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.

29.Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy for alcoholism, chemical dependency, or other medical conditions, services and supplies for smoking cessation programs and treatment of nicotine addiction.

30. For learning disabilities, developmental delays, mental retardation, and autistic disorders.

31. Health services which are related to complications arising from treatments or services otherwise excluded under the Plan.

32. Mental Illness and/or chemical dependency services when: 1) using methadone treatment as maintenance, 2) provided in connection with or to comply with involuntary treatment outpatient, partial hospitalization or residential treatment, police detentions and other similar arrangements.

33. 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.

34. For non-prescription internal feedings and other nutritional and electrolyte supplements. This does not apply to the treatment of phynylketonuria or any inherited disease of amino or organic acids.

35. For personal care and convenience items.

36. Occupational therapy provided on a routine basis as part of a standard program for all patients.

37. Received for, or in preparation for, any treatment (including drugs) for infertility by any name called and any related complications. "**Infertility**" as used here 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.

38. 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.

39. 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.

40. For growth hormone therapy for the diagnosis of idiopathic or genetic short stature, intrauterine growth retardation or small for gestational age.

41. For speech therapy for conductive hearing loss due to otitis media and ear infections.

42. Except as specifically provided under 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 was not physically examines.

43. 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.

44. 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.

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) if You are not aware of them. 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.**

Group health plans offering group coverage generally may not, under Federal Law, 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 normal 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.

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 Dependants with a health care benefit plan that financially protects You from significant health care expenses as well as provide 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 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.

SECTION 10. COORDINATION OF BENEFITS

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

Many individuals have group health care coverage through more than one Plan 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.

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 health coverage's.

10-2. DEFINITIONS

Some of the words used in this Section have a special meaning to meet the needs of this Section. These words and their meaning when used are:

1. **"Allowable Expense"** means any necessary, Reasonable and Customary (or the negotiated fee schedule of this plan, whichever is less) item of expense 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 a Husband and Wife 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 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 which has its Benefits determined after those of the other Source of Coverage, unless:

1. The other Source has rules coordinating its Benefits with those of this Plan; and
2. Both those rules and this Plan’s COB Rules, require that this Plan’s Benefits be determined before those of the other Source.

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 which covers the individual as an Employee, (that is, other than as a Dependent) are determined before those of the Source which covers the individual as a Dependent.

2. **Dependent Child / Parents not Legally Separated or Divorced.** Except as stated in Rule 3, when this Plan and another Source cover the same Child as a Dependent of different individuals, called "Parents:"

    a. The Benefits of the Source of the Parent whose birthday falls earlier in a year are determined before those of the Source of the Parent whose birthday falls later in that year; but
    b. If both Parents have the same birthday, the Benefits of the Source which covered one Parent longer and determined before those of the Source which covered the other Parent for a shorter period of time.

    However, if the other Source 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 do not agree on the Order of Benefits, the rule in the other Source will determine the Order of Benefits.

3. **Dependent Child / Parents Legally Separated or Divorced.** If 2 or more Sources cover a Child as a Dependent Child of Divorced or Legally Separated Parents, Benefits for the Child are determined in this order:

    a. First, the Source of the parent with custody of the Child;
    b. Then, the Source of the Spouse of the Parent with the custody of the Child; and
    c. Finally, the Source 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 that Parent has actual knowledge of those terms, the Benefits of that Plan are determined first. The Source 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.

4. **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 covering the Child shall follow the Order of Benefit Determination Rules outlined in 2 above (“the birthday rule”).

5. **Active / inactive Employee.** The Benefits of a Source 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 which covers the individual as a laid off or Retired Employee (or as that Employee’s Dependent). If the other Source does not have this rule, and if, as a result, the Sources do not agree on the Order of Benefits, this Rule 5 is ignored.

6. **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, the following shall be the Order of Benefit determination:

    a. First, the Benefits of the Source covering the individual as a employee, member or subscriber (or as that person’s Dependent); and
    b. Second, the benefits under the continuation coverage.

7. **Longer / Shorter Length of Coverage.** If none of the above rules determines the order of Benefits, the Benefits of the Source which covered an Employee, Member or Subscriber longer are determined before those of the Source which covered the Employee, Member or Subscriber for the shorter term.

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. In that event the Benefits of this source may be reduced under this COB provision. Such other Source or Sources 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, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of this Plan will be reduced so that they and the Benefits payable under the other Sources do not total more that 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 Coordination of Benefits, 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 another Source of Coverage pays Benefits that should have been reduced because of Coordination of Benefits, the amount by which the benefits should have been paid 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 Coordination of Benefits, 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 Coordination of Benefits 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.

SECTION 11. LIFE INSURANCE – PLAN A ONLY

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 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 Permanent 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 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 3 months of the anniversary date the initial proof of Your disability was received by the current Life Insurance carrier.

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

This 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 with proof of Your continued disability (which must be within 3 months of the anniversary date the initial proof of disability was received by the current Life Insurance carrier); 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 2 full years.

If You die during the extension of Your insurance under this provision, the following items should be sent to the Life Insurance carrier within 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.

Conversion Privilege

If You are no longer eligible for group Life Insurance because You no longer belong to an eligible insured group or if You terminate Your employment, You may convert that Benefit to any form of individual Life Insurance usually offered by the Fund, except for Term Insurance.

You will not need a medical examination. You must, however, complete the application form, available from the Fund, and send it along with the first premium payment to the Fund no later than 31 days after Your group Life Insurance has terminated.

The face value of Your new policy cannot be more than the amount You had under the Plan. The rate You pay will depend upon Your age (at the nearest birthday to the date of the issue of the individual policy), Your class of risk at the time of Your conversion, and the face amount of Your new policy.

You may also convert if Your Life Insurance Benefits terminate because the policy terminates, or because Life Insurance Benefits for Your group terminate. In this case, however, You must have been covered under the Plan for at least 5 years. You may covert the LESSER of the following amounts:

1. The amount of Life Insurance You had under this Plan, less any new amount You may have or for which You may become eligible under another group plan within 31 days of the termination; or
2. The amount required by the State Law.

If You should die during the 31 day period after Your group Life Insurance has terminated, the Fund will pay the group Life Insurance Benefits to the last beneficiary You named, whether or not You applied for an individual Life Insurance policy.

11-2. RETIRED EMPLOYEES

Benefits for Retired Employees and their Dependents are as 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 described, 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 and 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 in consequences 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 a felony, or a riot, or a 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 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 – PLAN A ONLY
(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 3 days before the date You first saw a M.D. or D.O. for the condition which caused the disability.

SECTION 13.
HEALTH REIMBURSEMENT ARRANGEMENT BENEFIT

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 Health Reimbursement Arrangement Plan ("HRA") is a Benefit program that allows you to obtain reimbursement of a certain Qualified Medical Expense not otherwise reimbursed or reimbursable in full by any other accident or health plan with tax free funds provided by your Employer into your HRA account for participating in the Mo-Kan Wellness Program. Currently you can only earn credit into the HRA by participating in the Wellness Program and meeting health and wellness goals set by Mo-Kan Wellness Program.

13-1. HOW TO PARTICIPATE IN THE HRA PLAN

You and Your Spouse may participate in the HRA Plan by enrolling and completing the Health Risk Assessment. The Health Risk Assessment includes completing a questionnaire about yourself and giving blood samples. You and Your Spouse may enroll in the HRA Plan by contacting the Fund Office.

13-2. BENEFITS

You and Your Spouse can earn Benefit Credits depending on Your level of participation in the HRA Plan. For example, completing the Health Risk Assessment will earn You Benefit Credits. There is not a cost to You in completing the Health Risk Assessment. You may earn additional Benefit Credits by meeting your personal health goal which is determined upon mutual agreement between Yourself and one of our health practitioners. 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 in Section 2.

13-3. HOW YOUR HRA ACCOUNT WORKS

The Fund Administrator will set up a HRA account for You once You complete the initial eligibility requirement of completing the Health Risk Assessment questionnaire. Your may be reimbursed for certain Qualified Medical Expenses incurred by You during the Plan year (calendar year) up to Your HRA account balance. Your account is an accounting entry and will not be representative of any separately identifiable Trust asset. Benefit Credits withdrawn at Your request will be deducted from your existing HRA account balance. HRA credits can be rolled over from year to year but can not 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 benefit credits from your HRA.

13-4. HOW TO SEEK REIMBURSEMENT

To receive reimbursement for eligible Qualified Medical Expenses, You must complete the Request For Reimbursement Form, available through the Fund Office and Your Employer, and submit said Form, along with an Explanation of Benefits and/or receipt of payment 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 30 days. Upon completion of processing Your claim, You will be reimbursed the full amount of Your eligible expenses up to the limit of available Benefit Credits in Your HRA account. You may submit claims for expenses incurred during the Plan year (calendar year) up to 90 days after the Plan year (calendar year). 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 HRA account.

13-5. QUALIFIED MEDICAL EXPENSES

You may seek reimbursement from your HRA account for the following Qualified Medical 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;
6. Amounts for Retiree self-pay premiums and COBRA continuation coverage premiums.

SECTION 14. CLAIMS PROCEDURE

14-1. HOW TO FILE A CLAIM FOR BENEFITS

You may submit a claim for Benefits up to 12 months after the date on which the expense was incurred. For example, assume You or Your Dependent incurs a medical expense on March 1, 2007. The claim must be filed by February 28, 2008. Failure to submit claims, bills, statements and other required information within the 12 month period will result in the claim being denied.

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. Different claim forms are used for medical, dental and vision Benefits. The medical claim forms are used for Loss of Time Benefits. Be sure to let the Fund Office know which one(s) You need.

Please check to see that the patient's portion of the claim form is completely filled out before You return it to the Fund Office. Return claims for medical, dental and vision expenses to the Fund Office with:

1. An itemized statement from the Hospital if You were confined;
2. Itemized statements for any medical, dental, or vision procedures performed showing location or facility where performed;
3. Bills for radiology, anesthesia, X-rays, lab work, etc.; or
4. Bills for medical, dental, or vision supplies.

You must notify the Fund Office if You have other medical, dental or vision coverage.

Claims for Loss of Time Benefits should be submitted as soon as possible and completed by Your Physician.

The Fund Office wishes to have Your claims paid promptly. You can help by making sure the information You submit is complete.

NOTIFY THE FUND OFFICE IF:

1. There is a change of address;
2. New Dependents are to be covered with proper documentation;
3. There is a marriage (date, Spouse's name, date of birth and copy of Marriage Certificate);
4. There is a change of beneficiary (a new change of beneficiary card must be completed and turned in to the Fund Office);

5. There is an accident which results in Workers' Compensation Benefits (advise the Fund Office of the date of the accident, the claim number and the duration of disability); or
6. An Injury resulting in a total and permanent disability is suffered.

IF Your eligibility terminates, You have the right to continue Your health coverage under COBRA and to convert Your Life Insurance to an individual policy.

14-2. MEDICAL EXPENSE INFORMATION

The itemized bill or statement for the medical expense incurred must be sent to the Fund Office within 90 days after the date the expense is incurred. Failure to submit the itemized bill, statement or other required information to the Fund Office within the time required shall not invalidate or reduce any claim if:

1. It was not reasonably possible to do so; and
2. Such proof was given as soon as reasonably possible.

However, all required documentation must be received in the Fund Office no later than 12 months from the date the expense was incurred. Failure to submit claims, bills, statements and any other required information within 12 months from the date the expense was incurred, will result in the claim being denied.

14-3. 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 is to be upheld unless it is determined to be arbitrary or capricious.

14-4. HOW YOU WILL KNOW WHAT ACTION HAS BEEN TAKEN ON YOUR CLAIM

If Your claim involves Urgent Care, You or Your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving 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 then must inform You of its decision within 48 hours of receiving the additional information.

If Your claim is one involving concurrent care, the Fund Office will notify You of its decision, whether adverse or not, within 24 hours after receiving the claim. 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. You will have at least 45 days to provide any additional information requested of You by the Fund Office.

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. 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.

14-5. HOW TO APPEAL A DENIAL OF A CLAIM

The Fund Office will provide You with written notice of the denial of Your claim. You 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.

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 the claimant's 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. Are entitled to have Your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment; 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 must issue a review 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 Claims. As long as the Board of Trustees regularly meets at least quarterly, not later than the next 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 meeting following the Plan's receipt of the request for review. If a special circumstance, such as a need to hold a hearing occurs, 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 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. Will inform You 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 statement of Your further rights under ERISA,
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,
6. If Your adverse determination is based on medical necessity or experimental treatment, an explanation of the specific or clinical judgment, and
7. 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.

14-6. 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 15. GENERAL INFORMATION

15-1. 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.

15-2. 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 claim. The Trustees may, but shall not be required to, delegate to their Plan Administrator the authority to authorize such payments pursuant to written rules of uniform application that they may adopt from time to time.

15-3. 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.

15-4. 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.

15-5. EXAMINATIONS

The Fund will have the right and opportunity through its medical representatives to examine any living insured during the pendency of a claim and so often as it may reasonably require. The Fund will also have the right to request an autopsy in case of death, where it is not forbidden by law.

SECTION 16. PLAN CHANGE OR TERMINATION

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.

SECTION 17. 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 are entitled to the following rights.

17-1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

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, Your Collective Bargaining Agreement 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 (EBSA);

2. Obtain, upon written request to the Fund Office, copies of documents governing the operation of the Plan, including insurance contracts, Your Collective Bargaining Agreement 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); and

3. Receive a summary of the Plan's annual financial report, which the Fund Office is required by law to furnish to each Participant.

17-2. CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

1. Continue health care coverage for Yourself, Spouse or Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event (You or Your Dependent(s) 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.); and
2. Reduce or eliminate exclusionary periods of coverage for preexisting conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided with a Certificate of Creditable Coverage, free of charge, from Your group health plan or health insurance issuer when:
    a. You lose coverage under the Plan;
    b. You become entitled to elect COBRA Continuation Coverage; or
    c. Your COBRA Continuation Coverage ceases.

You must request the Certificate of Creditable Coverage before losing coverage or within 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.

17-3. 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.

17-4. 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 Fund Office 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 Fund Office.

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 within 1 year of the denial. 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, for example, if it finds Your claim is frivolous.

17-5. 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 EBSA, U.S. Department of Labor, listed in Your telephone directory or at:

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 EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 800-998-7542 or contact the EBSA field office nearest You.

You may also find answers to Your Plan questions and a listing of EBSA field offices at the website of the PWBA at **http://www.dol.gov/dol/pwba/** .

SECTION 18. RIGHT OF RECOVERY

18-1. 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.

18-2. 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.

18-3. 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 19. PRIVACY OF PROTECTED HEALTH INFORMATION

19-1. 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 to the Trustees unless the Trustees certify that the Plan Documents have been amended to incorporate this section and agrees to abide by this section.

19-2. 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 the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). 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. 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.

19-3. RESTRICTIONS ON TRUSTEES USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 45 Code of Federal Regulations § 164.524.

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 45 Code of Federal Regulations § 164.526.

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 45 Code of Federal Regulations § 164.528.

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 45 Code of Federal Regulations Parts 160-64.

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.

19-4. 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.

SECTION 20. HOSPTIAL 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 6 months following the date of discharge from the Hospital or within 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.

For additional information regarding the Hospital and Medical Bill Audit Program refer to Appendix A on the following page.

SECTION 21. HOSPITAL CHECKLIST

You can obtain copies of this form as needed from the Fund Office. The following chart should help You record services that You are provided during a Hospital confinement. Use this form as a checklist during Your Hospital stay so that You may later compare Your Hospital bills against services that were actually provided. First indicate the date of Your stay and then check those services that You receive on that date.

Day of Hospital Stay		1st	2nd	3rd
1.	Did a Physician visit You?	___	___	___
2.	Did You have a consultation with a specialist?	___	___	___
3.	Did You have surgery?	___	___	___
4.	Were You in an intensive care unit?	___	___	___
5.	Did You receive anesthesia?	___	___	___
6.	Did You have blood samples taken for testing?	___	___	___
7.	Did You have X-rays taken?	___	___	___
8.	Did You have ultrasounds taken?	___	___	___
9.	Did You receive blood?	___	___	___
10.	Did You have any tests on Your heart?	___	___	___
11.	Did You receive any oxygen?	___	___	___
12.	Were You given any drugs?	___	___	___
13.	Did You have a dressing changed?	___	___	___
14.	Did You have a urine test?	___	___	___
15.	Did You receive any of the following:			
	Physical Therapy?	___	___	___
	Speech Therapy?	___	___	___
	Nutritional Counseling?	___	___	___
	Occupational Therapy?	___	___	___
	Respiratory Therapy?	___	___	___
	Intravenous Therapy?	___	___	___
16.	Did You receive radiation treatment?	___	___	___
17.	Did You have a scan taken?	___	___	___
18.	Did You have a test taken on Your blood, urine, or throat for a possible infection?	___	___	___

19. Were You transported by an ambulance? ___ ___ ___

20. Were You given any of the following to take home with You:

Drugs? ___ ___ ___

Crutches or walkers? ___ ___ ___

Canes? ___ ___ ___

Other ______________________ ___ ___ ___

21. What kind of room did You have:

Intensive Care? ___ ___ ___

Private? ___ ___ ___

Semiprivate? ___ ___ ___

Ward? ___ ___ ___

Patient's Name ____

Date of Admission ________________ ***Date of Discharge*** ___________________

Total Number of Days in Hospital ____

SECTION 22. APPENDIX A

1. The Trustees and administrative staff of the Fund shall not get involved in resolving any differences between You and the Hospital or medical provider with respect to disputed charges. You are solely responsible for handling billing discrepancies and obtaining proper documentation of corrected charges.

2. The Trustees have the sole right at any time to amend or modify these rules or terminate the Hospital and Medical Bill Audit Program entirely.

3. The following sets forth specific suggestions for Your or Your Dependent's careful and complete review of a Hospital or medical bill:

   a. Before leaving the Hospital make sure the Hospital either provides or arranges to send an itemized bill.

   b. If possible, list or make a note of the treatments, services or supplies given while in the Hospital or visiting a medical care provider, either daily or immediately upon discharge. A sample checklist follows this section and copies are available from the Fund Office.

   c. Match this list against the itemized bill to detect any discrepancies.

   d. Check the bill carefully for charges for treatments, services, or supplies that were not received, by going through the following or similar checklist:

      i. Does the bill show the correct number of days the patient occupied the room?

      ii. If intensive care was required, does the bill show the correct number of days the patient was confined to an intensive care unit?

      iii. Is there a room charge for the day of discharge even though the patient left before the day's charges began?

      iv. Is the charge for the correct type of room occupied (private, semiprivate, ward, etc.)?

      v. Does the bill include charges only for tests or X-rays that the patient actually received?

      vi. Are there charges for medication, injections, dressings, supplies, etc., that the patient did not receive? For quantities in excess of what the patient remembers receiving?

vii. Were medications that the Physician ordered billed throughout the entire stay even though the patient took them only for a limited period of time?

viii. Does the bill include charges for the purchase of humidifiers, bed pans, admission kits, etc. that the patient never received? That the patient was not allowed to take home?

ix. Does the bill include charges for a visit by the attending Physician when the patient only received care from a nurse or specialist?

x. If the patient received physical, radiation, inhalation, and/or occupational therapy, is the charge for the correct type of treatment? The correct number of hours of treatment?

xi. If the patient received a blood transfusion, was there a charge for blood that a donor, blood bank, or a Red Cross family or community assurance program replaced?

xii. If the patient was admitted to a maternity wing, does the bill include a charge for a labor room that may not have been used because of swift delivery?

xiii. If there are miscellaneous charges on the bill, the patient or participant should ask the Hospital to explain them in specific terms.

e. You, or Your Dependent, should circle any overcharges, report the overcharges to the Hospital or medical care provider's billing department and request a corrected bill. If You or Your Dependent properly identify the specific discrepancies in the bill, the Hospital or provider must drop the unsubstantiated charges, unless there is evidence in the medical file to the contrary. A copy of both the original bill and the adjusted bill will be used as proof that the Hospital or medical provider dropped the discrepancies.

f. Once a copy of the initial bill, with the overcharges circled, and a copy of the corrected bill have been submitted to the Fund Office, it will be possible for the Fund Office to determine the amount of the bonus payable. The Fund Office will issue a check after the Hospital repays the overcharge, if payment has already been made.