PLUMBERS LOCAL NO. 8
HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION
PLAN A

Dated October 1, 2021

USING THIS SUMMARY

This booklet is a summary of your Health and Welfare Plan.

INTRODUCTION. This is a summary of your Health and Welfare Plan. It explains, in a summary fashion:

- How to file a claim;
- How you become eligible for coverage, maintain coverage, and lose coverage under the Plan;
- The benefits provided by the Plan;
- The medical services and supplies not covered by the Plan;
- How the Plan coordinates benefits when you have other health insurance;
- How the Plan is administered; and
- Important definitions used in the Plan.

This booklet applies to coverage of those eligible to participate in benefits we refer to as Plan A of the Plumbers Local No. 8 Health and Welfare Plan. A separate booklet issued by the Fund describes coverage for those eligible to participate in Plan B of the Plumbers Local No. 8 Health and Welfare Plan. See the explanation given on page 1 for more details.

The actual terms of the Plan document control over this summary, in the case of a conflict.

THE TERMS OF THE PLAN CONTROL OVER THIS SUMMARY. Please note this important point: Because this is only a summary of your Plan, if anything in this summary conflicts or appears to conflict with the actual terms of the Plan, the actual terms of the Plan will control. If ever you have questions about what the Plan provides specifically, you should call the Plan Administrator at (816) 361-0666. You are always welcome to review the actual Plan document. A copy of the actual Plan document, including both Plan A and Plan B provisions, is available at the Fund Office, 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri, 64130.

Plan benefits may change from time to time.

PLAN BENEFITS AND OTHER RULES WILL CHANGE FROM TIME TO TIME. We change the terms of the Plan from time to time, to modify, add or eliminate certain Plan provisions. These amendments are made in writing, and are consecutively numbered. This booklet reflects changes made through Amendment 25 to the Plan, as amended and restated effective June 1, 2011. Later Amendments will be summarized for you in letters we will send to you after the Amendments are adopted. **You should keep all such letters with this booklet.**

HOW TO FILE A CLAIM

Who Should File:

Claims for Plan benefits are typically filed by your Doctor or the Hospital or other health care provider which treated you. However, for any benefits to be paid, both the provider's claim form (if the provider is filing a claim on your behalf), ***and*** a Plan claim form ("pink form"), must be filed. If the provider is not filing a claim on your behalf, then you must simply submit a claim on a Plan claim form. Plan claim forms are available from the Fund Office at 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130. In any case, a new Plan claim form must be filed for each calendar year or benefits will not be paid.

Payments will be made directly to a PPO Provider unless payment has already been made by you or an insurance carrier. With respect to claims for expenses incurred for services rendered by a non-PPO Provider, payments will be made directly to you.

When to File:

We require that a claim be filed within **one year** of the later of the date the expense was incurred or the date you were discharged from the Hospital. ***Claims filed after these dates will not be paid.***

What to File:

Claims filed by your health care provider normally include all the information we need. If they do not, we typically will deal with the provider to obtain the necessary information, although we may contact you if necessary.

On those occasions where you file a claim directly with us (for example, for reimbursement of medical supplies), we'll need:

- A completed claim form (claim forms are available from the Fund Office)
- A receipt, bill or statement (NOT merely the cash register receipt) from the provider showing:
  - the full name of the person needing the item;
  - the date the item was purchased or the service was provided;
  - the amount of the charge;
- For equipment (crutches, wheelchairs, etc.) a statement from your Doctor indicating that the equipment was necessary.

NOTE: Where you purchase supplies on behalf of a covered family member and wish to obtain reimbursement, include the Eligible Employee's (an "Eligible Employee" is an Employee who is covered by the Plan) or Retired Employee's name and Social Security number either on the form or on an attached piece of paper. Many persons covered under the Plan have the same name, so we need to know who

	the Eligible Employee or Retired Employee is, in order to make sure the claim is paid properly.
Claim Processing and Appeal Procedures:	Specific information relating to claims processing and instructions for filing an appeal are explained in detail in the Claims and Appeals Procedures Appendix, which begins on page 89.
Billing Errors:	If you discover an error in a bill you receive from a Hospital (for example, if you are charged for services that were not performed or for medication that was not administered) you should report that error to the Fund Office. Upon correction of the bill by the Hospital, we will pay you one-third of any amount the correction saves the Plan.
Occupational Injuries and Sicknesses:	In case you incur an injury or Sickness that might have arisen from or in connection with your occupation, you should not only pursue your Worker's Compensation claim, but should also submit claims to the Plan Administrator. That way you will have timely claims on file with the Plan Administrator in case your Worker's Compensation claim is denied.
Fraudulent Claims:	If we determine that in making a claim for benefits you knowingly made a false representation involving more than $100, including the concealment of a material fact, your coverage under the Plan and that of your Dependents will be suspended for the first Six-Month Coverage Period next following the date of our determination. See page 72 for a definition of Six-Month Coverage Period. The determination date will be the date 30 days after you receive written notice of our determination, or if you appeal that decision, the day of any adverse ruling by us. You may appeal the determination to us upon written application to the Plan Administrator. We will make no payment of any benefits to the extent that it is unjustified by reason of your false representation.
One-Year Limitation on Legal Action:	You or your representative may not bring any legal action against the Plan, or a representative or fiduciary of the Plan, more than one year from the later of: (a) the date your claim is first filed, or (b) the date the Plan renders a decision on your claim or, if you timely file an appeal with the Plan, on your internal appeal. Refer to Section 12 of the Claims and Appeals Procedures Appendix for a statement of the requirement that you may not bring a lawsuit against the Plan unless you fully pursue your right to internal appeal under that Appendix.

SCHEDULE OF BENEFITS

Major Medical Coverage

Major Medical Coverage provides medical benefits, such as...	Co-payment Rates	
	Covered Charges above the Deductible Amount	
	If Services are rendered by a PPO Provider	**80%**[1,2]
	If Services are rendered by a Non-PPO Provider (Outpatient)	**55%**[1,2]
	If Services are rendered by a Non-PPO Provider (Inpatient)	**0%**[2,3]
	Annual Deductible	**$500**[2] (per person, per year; up to three such amounts per family)
	Out-of-Pocket Maximum Services rendered by a PPO Provider each calendar year	**$5,900**[4], (per person) **$11,800**[4] (per family)
…extended care facility benefits…	Extended Care Facility	**60 days** (per calendar year)
...home health care/infusion therapy...	Home Health Care/Infusion Therapy (Combined)	**60 visits** (per calendar year)
...hospice care...	Hospice Care benefit	**210 days** (lifetime)

[1]See the Section of this booklet concerning Coordination of Benefits, Subrogation, Reimbursement, and Set-Off for circumstances in which the co-payment rates may be reduced for Dependent Spouses who are eligible for other medical and prescription drug coverage.

[2]See the Section of this booklet concerning Medical Benefits for circumstances in which the co-payment rates and the deductible amounts may be waived for medically necessary screening and diagnostic testing for COVID-19.

[3]Inpatient services rendered by a non-PPO Provider due to an Emergency Medical Condition or where there is no inpatient PPO Provider capable of treating a particular condition will be covered at the PPO Provider co-payment percentage.

[4]The Out-of-Pocket Maximum is coordinated with the Prescription Drug Benefit Out-of-Pocket Maximum and is subject to change each year to correspond with the applicable dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code, increased by the premium adjustment percentage determined by the Secretary of Health and Human Services for the calendar year.

…Preventive Health Services…	Preventive Health Services	**100% Deductible Waived** (PPO Providers only)
…Retail Telehealth Services…	Retail Telehealth Services	**100% Deductible Waived** (through Blue KC Virtual Care mobile app or website only)
...and a Prescription Drug benefit.	Deductible Amount	**$50** (per individual, per calendar year)
	Generic Drug Co-payment Amount	The greater of **$5** or **20%** of the discounted cost[5]
	Brand Name Drug Co-payment Amount Where a Generic Drug is Not Available	The greater of **$20** or **20%** of the discounted cost
	Brand Name Drug Co-payment Amount Where a Generic Drug is Available	The greater of **$35** or **30%** of the discounted cost (for a 34-day supply) and the greater of **$70** or **30%** of the discounted cost (for a 90-day supply)**[6]**
	Out-of-Pocket Maximum each calendar year	**$2,250[7]** (per person) **$4,500[7]** (per family)

[5]The generic drug co-payment amount may be waived for a period of up to six months. See the Section of this booklet concerning Prescription Drug Benefits for a description of the Plan's generic drug co-payment waiver program.

[6]If you choose to purchase a brand name drug when a generic equivalent is available, you will have to pay the difference between the cost of the brand name drug and the generic drug in addition to the regular co-payment amount. The amount of the difference will not apply towards the Prescription Drug Benefit Out-of-Pocket Maximum.

[7]The Prescription Drug Benefit Out-of-Pocket Maximum is coordinated with the Out-of-Pocket Maximum for medical benefits and is subject to change each year to correspond with the applicable dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code, increased by the premium adjustment percentage determined by the Secretary of Health and Human Services for the calendar year.

The Plan also provides additional benefits, such as ...	**Additional Benefits**		
...dental benefits...	Maximum benefit	**$1,500**[8] (per calendar year)	
	Payment rates		
	Type I Procedures	**90%**	
	Type II Procedures	**80%**	
	Type III Procedures	**60%**	
...vision care benefits...	Maximum vision exam benefit	**$70**[9]	
	Maximum benefit for materials		
		Single	Pair
	Single vision lenses	**$30**	**$60**
	Bifocal lenses	**$40**	**$80**
	Trifocal lenses	**$50**	**$100**
	Lenticular lenses	**$50**	**$100**
	Extra charge for tinted lenses	**$10**	**$20**
	Frame		**$100**
	(See page 44 re contacts)		
...hearing aid benefits...	For each ear, at intervals of at least 60 months	**$1,000**	
...weekly disability benefits...		**$200**	
...death benefits (for survivors of active Employees and Retired Employees only)...	Active Employees and Retired Employees entitled to the Maximum benefit	**$10,000**	
	All other Retired Employees	**$1,000**	
...and accidental death and dismemberment benefits.	Principal sum	**$5,000**	
Generally, the benefits available to Retired and Disabled Employees and their	Generally speaking, Retired and Disabled Employees and their Dependents are eligible for the same benefits to which active Employees and their Dependents are eligible, except that Retired and Disabled Employees and their Dependents are not eligible for:		

[8]Expenses for pediatric dental care for an Eligible Child under age 19 are not subject to the maximum annual dental coverage benefit of $1,500.

[9]Expenses for pediatric vision care for an Eligible Child under age 19 are not subject to the maximum annual vision examination benefit of $70.

Dependents are the same as the benefits provided to active Employees and their Dependents.

- Hearing aid benefits,
- Weekly disability benefits,
- Accidental death and dismemberment benefits, and
- Refractive eye surgery, including radial keratomy.

However, this provision does not apply to persons entitled to Medicare. See below for a description of benefits available to persons entitled to Medicare.

Generally, Employees and Dependents entitled to Medicare are eligible for the benefits described at right.

Persons eligible for Medicare on a *primary* basis. (Refer to pages 48 and 49 for circumstances in which this Plan is primary to Medicare.)

Medicare Part A

Maximum payment for each Hospitalization	First **$696** of inpatient Hospital deductible

Medicare Part B

Payment Rate	**20%** of Allowable Expenses over the Deductible Amount

Medicare Part C

Payment Rate	Co-payments or percentages for Allowable Expenses, up to amounts payable under Part A and Part B above

Medicare Part D	No payment

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COVERAGE AND CONTRIBUTIONS

IN GENERAL. In this Section we explain the coverage and contribution rules of Plan A, including its "half-credit," "hour bank," and self-payment provisions, which may help you to continue your coverage when you might otherwise lose it.

PLAN A AND PLAN B. Though many of the provisions in the Plumbers Local No. 8 Health and Welfare Plan apply to all participants, some of the coverage and benefit provisions apply only to those eligible to participate in benefits we refer to as "Plan A" and others only in benefits we refer to as "Plan B." Consistent with our authority to amend the Health and Welfare Plan, we have the power to determine from time to time, in our discretion, adjustments in benefits of Plan A, Plan B, or both, appropriate in view of the contributions the Fund is receiving. Employees for whom the hourly contribution rate required by the applicable Collective Bargaining Agreement is equal to or greater than the contribution rate required for participation in Plan A (or who have elected to pay such contribution rate under the rules for making employees' contributions beginning on page 24) are eligible to participate in that Plan. Employees for whom the hourly contribution rate required by the applicable Collective Bargaining Agreement is equal or greater than the contribution rate required for participation in Plan B (but less than the contribution rate required for participation in Plan A) are eligible to participate in Plan B. In determining an Employee's hourly contribution rate, any rate that will take effect within 12 months of the date as of which a determination of the rate is made may be treated as the current rate. You can obtain more detail about these rules by writing or calling the Plan Administrator at the address or phone number you will find on page 60.

Please refer to the Special Enrollment Rights Notice at the end of this booklet for additional material.

SPECIAL ENROLLMENT RULES. The special enrollment rights under this Section apply without regard to the dates on which an individual would otherwise be eligible to enroll under the Plan or any of its levels of coverage. See pages 4 through 10 for the Plan's benefit eligibility rules for Employees and Dependents.

Special enrollment may be available during the year for those who lose other health coverage.

Special Enrollment Due to Loss of Coverage.

- Employee loses coverage: a current Employee and any Dependent (including the Employee's Spouse) each are eligible for special enrollment in any benefit package under the Plan, subject to its eligibility rules conditioning Dependent enrollment on enrollment of the Employee, if –
  - the Employee and Dependents are otherwise eligible to enroll in the benefit package;
  - when coverage under the Plan was previously offered, the Employee had coverage under any group health plan or health insurance coverage; and

- the Employee ceased to be eligible for coverage under the group health plan or health insurance coverage, excluding, however, a loss of eligibility due to the failure of the Employee or Dependent to pay premiums on a timely basis.

- Dependent loses coverage: a Dependent of a current Employee (including the Employee's Spouse) and the Employee each are eligible for special enrollment in any benefit package under the Plan, subject to its eligibility rules conditioning Dependent enrollment on enrollment of the Employee, if –

  - the Dependent and the Employee are otherwise eligible to enroll in the benefit package;

  - when coverage under the Plan was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

  - the Dependent ceased to be eligible under the group health plan or health insurance coverage, excluding, however, a loss of eligibility due to the failure of the Employee or Dependent to pay premiums on a timely basis.

For those who lose other health coverage, the Employee has 30 days to request enrollment.

- Deadlines: an Employee has 30 days after an event described in the preceding clauses of this Section to request enrollment for the Employee or the Employee's Dependent. Nonetheless, in the case of a loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Employee may make the election no later than the 30th day after a claim is denied due to the operation of the lifetime limit on all benefits. Eligibility for benefits under the Plan shall begin on the first day of the first calendar month beginning after the date the Plan Administrator receives the request for special enrollment.

Special enrollment may be available during the year in the event of marriage, birth, adoption, or placement for adoption.

Special Enrollment for Certain Dependents.

- General: Individuals described in the following bullet point may enroll for coverage in a benefit package under the terms of the Plan, subject to the rules it sets forth.

- Individuals eligible for special enrollment: an individual may qualify for enrollment in a benefit package under the Plan if the individual is otherwise eligible for coverage in a benefit package under the Plan and is described in any of following items:

  - Current Employee only: A current Employee is described in this provision if another person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption;

  - Spouse of an Employee only: An individual is described in this item if either:

- the individual becomes the Spouse of a participant; or

- the individual is a Spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption;

- Current Employee and Spouse: A current Employee and an individual who is or becomes a Spouse of such an Employee, are described in this item if either:

  - the Employee and the Spouse become married; or

  - the Employee and Spouse are married and the child becomes a Dependent of the Employee through birth, adoption, or placement for adoption;

- Dependent of a participant only: An individual is described in this item if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption;

- Current Employee and new Dependent: A current Employee and an individual who is a Dependent of the Employee, are described in this item if the individual becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption; or

- Current Employee, Spouse, and a new Dependent: A current Employee, the Employee's Spouse, and the Employee's Dependent are described in this item if the Dependent becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

An individual has 30 days after the marriage, birth, adoption, or placement for adoption to request enrollment.

- Application and effective date:

  - An individual may request enrollment for the individual or the individual's Dependent within 30 days after the date of the marriage, birth, adoption, or placement for adoption.

  - In the case of a marriage, eligibility for benefits under the Plan shall begin on the first day of the first calendar month beginning after the date the Plan Administrator receives the request for special enrollment. Eligibility for benefits under the Plan shall begin in the case of a Dependent's birth on the date of birth and in the case of a Dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption.

Special enrollment may be available during the year due to an individual's loss of eligibility for Medicaid or coverage under CHIP, or an individual's becoming eligible for premium assistance with respect to this Plan under Medicaid or CHIP.

Special Enrollment Due to Medicaid or the Children's Health Insurance Program ("CHIP") Eligibility. A current Employee and any Dependent (including the Employee's Spouse) each are eligible for special enrollment in any benefit package under the Plan, subject to its eligibility rules conditioning Dependent enrollment on enrollment of the Employee, if the individual is otherwise eligible for coverage in a benefit package under the Plan and either:

- Loses eligibility for either Medicaid or coverage under CHIP; or
- Becomes eligible to participate in a premium assistance program with respect to this Plan under Medicaid or CHIP.

An individual has 60 days after becoming eligible for or losing coverage under either Medicaid or CHIP to request enrollment.

An Employee has 60 days after an event described above to request enrollment for the Employee or the Employee's Dependent.

HIPAA Controls. The Plan's rules on special enrollment shall be interpreted and applied consistent with the requirements of the Health Insurance Portability and Accountability Act and its regulations.

Your coverage begins on the first day of either a One-Month or a Six-Month Coverage Period.

COMMENCEMENT OF COVERAGE. Your coverage as an Employee under this Plan begins on the first date of a One-Month Coverage Period or a Six-Month Coverage Period, whichever occurs first.

You and your eligible Dependents, if there are any, for whom the applicable Collective Bargaining Agreement allows an election of Plan A coverage will be eligible for Plan A coverage in a calendar month only if:

- you have properly elected Plan A coverage, as provided under the rules for making employees' contributions beginning on page 24, and the election applies to that month; and
- you make timely contributions on your behalf to the Fund for that month, as provided under the rules for making employees' contributions beginning on page 24.

You may elect to decline coverage for yourself and your Dependents.

Generally, you and your eligible Dependents must be enrolled to be covered by the Plan. You may also affirmatively elect to decline coverage for yourself and/or your eligible Dependents, in which case you and/or your Dependents will not have coverage under this Plan unless you subsequently enroll in the Plan by filing a properly completed enrollment form with the Plan Administrator. An election to decline coverage or to subsequently re-enroll in the Plan can be made on a prospective basis only.

Establishing "One-Month Coverage Periods."

One-Month Coverage Periods. If you satisfy the rules described in the next paragraph for taking advantage of One-Month Coverage Periods, and, in a month in which you are not covered under the Plan, have at least 100 Credited Hours, you will be covered under the Plan for the following two months. After that, and until you are no longer eligible for coverage under the One-Month Coverage Period rules, your

entitlement to coverage will be determined under the "Skip-Month Rule." The Skip-Month Rule provides that if you have a One-Month Eligibility Period for a month, you will have a One-Month Coverage Period for the second month that follows it. A One-Month Eligibility Period is a calendar month in which you have at least 100 Credited Hours.

EXAMPLE

Fred Trimka met the requirements for having a One-Month Coverage Period and had 100 Credited Hours in October 2020, giving him coverage for the months of November and December 2020. He then has more than 100 Credited Hours in November 2020, and so is entitled to coverage, using the Skip-Month Rule, for the month of January 2021. But, he has only 74 Credited Hours in December 2020, so that is not a One-Month Eligibility Period for him and he has no coverage in February 2021.

Apprentices who fail to work the 100 Credited Hours required for a One-Month Eligibility Period may be able to obtain or extend coverage under the "half-credit" provisions.

Half Credits for Apprentices. Generally, the eligibility rules described in this Section apply with equal force to apprentices who are Employees. However, if you are an apprentice and you fail to work the 100 Credited Hours required for a One-Month Eligibility Period you may be able to obtain or extend your coverage under these "half-credit" provisions. Under these half-credit provisions, you will be credited with one-half of a Credited Hour for each hour you spend attending daytime training classes in the apprenticeship training program sponsored by the Plumbers Local No. 8 Joint Apprenticeship Committee. (See pages 7 and 73 for rules that apply specifically to apprentices.)

When you can take advantage of the one-month coverage rules.

Requirements for Taking Advantage of the One-Month Coverage Periods. We have designed these one-month coverage rules to permit Employees who have not previously had coverage under the Plan to obtain it without waiting to qualify by having a Six-Month Eligibility Period, and to permit those persons who were once covered and are returning to the Plan to take advantage of this opportunity. Coverage under the one-month coverage rules is available to an individual only once in his lifetime. Moreover, once you have reached the August 1 or February 1 that is at least six months after you first earned a One-Month Eligibility Period under these rules, your entitlement to coverage under the Plan will be determined solely under its six-month coverage rules. They are described below.

Generally, coverage under the Plan is determined in Six-Month Coverage Periods.

Six-Month Coverage Periods. With the exceptions described above for new Employees and those returning to the Plan after a period without coverage, coverage is generally determined in six-month units called Six-Month Coverage Periods. Six-Month Coverage Periods run from:

- August 1 to January 31; and
- February 1 to July 31.

Once you have earned a Six-Month Coverage Period, your coverage will continue for the whole of the period, so long as you remain ready, willing and available for work in a bargaining unit represented by Local No. 8.

EXAMPLE

Michael Palermo has not previously used these one-month coverage rules, but has previously been covered under the Plan. He returns to covered employment and is credited with at least 100 hours worked for the month of October 2020. The first February 1 or August 1 that occurs at least six months after the end of October 2020, is August 1, 2021. On and after that date, his coverage will be determined, not under the one-month coverage rules, but solely under the Plan's six-month coverage provisions.

You need 600 hours of contributions in a Six-Month Eligibility Period to earn a Six-Month Coverage Period.

Earning a Six-Month Coverage Period. A Six-Month Eligibility Period entitles you to coverage for the Six-Month Coverage Period that begins one month after the end of the Six-Month Eligibility Period. Six Month Eligibility Periods under the Plan run from:

- January 1 to June 30; and
- July 1 to December 31.

You need 600 hours of contributions for bargaining unit work in such a period for it to be a Six-Month Eligibility Period. For example:

SIX MONTH ELIGIBILITY PERIOD		**SIX MONTH COVERAGE PERIOD**
600 or more hours from July 1, 2020 through December 31, 2020	entitles you to coverage for:	February 1, 2021 through July 31, 2021
600 or more hours from January 1, 2021, through June 30, 2021	entitles you to coverage for:	August 1, 2021 through January 31, 2022

When and how we credit "Bargaining Unit Work."

Crediting Hours of Bargaining Unit Work. Generally speaking, hours of bargaining unit work in a month are "credited" as of the last day of the month, even if the Employer fails to pay the contributions required on account of such work (although see page 12 for a special rule regarding termination of coverage for failure of the Employer to pay its required contributions). An Employee's hours will be credited to the calendar month for which they are reported on the Employee's Employer's monthly fringe benefit reports, even if they were in fact worked in the preceding or following calendar month.

There are special rules regarding when apprentices become covered.

Special Rule for Apprentices. An apprentice who is an Employee is *deemed* to have a Six-Month Eligibility Period for the six-month period preceding the first February 1 or August 1 after the date he begins active participation in the apprenticeship training program sponsored by the Plumbers Local No. 8 Joint Apprenticeship Committee, regardless of the number of hours actually credited to him in that six-month period. Note that under the eligibility provisions described above, coverage for an apprentice can begin before that February 1 or August 1.

There are special rules regarding how much certain Employers must contribute to the Plan.

Special Minimum Contribution Requirement. If:

- You and your
  - parent,
  - sibling, or
  - child
- both own a ten percent or greater interest in your Employer, or
- Your Spouse owns a ten percent or greater interest in the Employer,

you will have no coverage unless, in addition to your satisfying other eligibility requirements, the Employer pays the Fund a minimum monthly contribution equal to the amount the Employer would have been required to pay, pursuant to the Collective Bargaining Agreement between the Employer and Local No. 8, had the Employee performed 160 hours of bargaining unit work during the month.

There are ways you can establish a Six-Month Eligibility Period although you may not have sufficient hours of bargaining unit work in that six-month period.

Establishing "Six-Month Eligibility Periods" Other Than By Bargaining Unit Work. There are a number of ways you can establish a "Six-Month Eligibility Period" in order to continue your coverage, even if you did not have 600 hours of bargaining unit work in the preceding six-month period. Here's a summary of these methods; more precise explanations are contained in the actual Plan document. Call the Fund Office for more detailed explanations of these methods.

You may be able to obtain extended coverage if you fail to work the hours required for a Six-Month Eligibility Period because of unemployment or total disability.

- **Hour Bank Credits**. This Section describes how you can obtain extended coverage if you fail to work the 600 Credited Hours required for a Six-Month Eligibility Period because of unemployment or total disability. (In the case of total disability, these hour bank provisions will apply only if you have already used the special disability half-credits described on page 10.) Whether you will be able to obtain this extended coverage will depend, in part, upon how many hours you have in the Plan's "hour bank." No accounts are maintained for this purpose by the Plan. Referring to having hours in the hour bank is simply a convenient way of describing the fact that a record of the

number of hours you have worked is kept by the Plan and, under some circumstances, hours you earned in previous six-month periods may be used so that you can have extended coverage.

If you work more than 1400 Credited Hours in a calendar year, the excess will be credited to you in the hour bank.

If you work more than 1400[10] Credited Hours in a calendar year, the excess will be credited to you in the hour bank. For example, if you work 1750 Credited Hours in a calendar year, you would receive 350 hours of hour bank credit. The number of hours credited to you under the hour bank provision is determined by taking into account your hours beginning January 1, 1976. The mere fact that you have less than 1400 Credited Hours in a calendar year would not mean that you would lose hour bank credits. For example, if you had 500 hours in the hour bank on December 31 of one year and then had 1300 Credited Hours in the next calendar year, you would keep the 500 hours; nothing would be subtracted. Note that in some cases you might not be permitted to utilize hour bank credits to continue your coverage. See pages 12 and 13, on delinquent contributions, for a description of one such case. For purposes of hours credited to the hour bank, neither half-credit hours nor allocated hours are counted. See page 9 for circumstances in which your hour bank hours may be canceled.

You may withdraw hours from the Plan's "hour bank," to make up the necessary hours to continue coverage.

- **Hour Bank Withdrawals**. Hours will be withdrawn from the hour bank whenever you need them to make up all or part of the minimum number required for a Six-Month Eligibility Period. Assume for example, that you have 1000 hours in the hour bank and that you have 400 Credited Hours in a six-month period beginning January 1 or July 1. The extra 200 hours that you need to make this a Six-Month Eligibility Period would be withdrawn from the hour bank so you would have 800 hours left.

  Except as provided in the provisions on delinquent contributions, and in the part of this Section dealing with disability coverage, you will be able to withdraw hours and have them credited to help you earn a Six-Month Eligibility Period if, during those six months:

  - you were working in a bargaining unit represented by the Union;
  - you were seeking such work;
  - you were totally disabled; or
  - you had some combination of these.

[10]If you at any time obtained coverage under the Plan's one-month coverage rules, this 1400 hour figure will be changed to 1600 for each of the first three calendar years that occur after you obtained such coverage and in which you had at least 1400 Credited Hours. These calendar years need not be consecutive.

You could, for example, withdraw hours if you had been working in a bargaining unit represented by the Union for part of the six-month period beginning January 1 or July 1 and had been seeking such work for the rest. For purposes of this Section you will be regarded as totally disabled during any period in which, as a result of illness or injury, you are unable to perform bargaining unit work and are not performing any other work for wage or profit. However, if you are receiving disability coverage as described on pages 17 through 18, you may not use hour bank withdrawals to obtain coverage beyond a period of 29 months from the date such disability coverage began. See the Qualified Uniformed Service provisions beginning on page 19, for circumstances in which you can withdraw hours to maintain coverage while you are performing Qualified Uniformed Service.

The maximum number of hours you can have in the hour bank at any one time is 1200.

- **Hour Bank Maximum.** The maximum number of hours you can have in the hour bank at any one time is 1200. The result is that a participant who had 1100 hours in the hour bank at the end of a calendar year and worked 2000 hours in the next year would have only an additional 100 hours credited to him in the hour bank.

NOTE: If you do not have enough hours left in the hour bank to give you extended coverage, you may still be eligible to continue your coverage under COBRA (see page 18 and the COBRA Coverage Appendix).

If you lose coverage, you must provide monthly notification of your wish to maintain your hour bank balance.

- **Cancellation of Hour Bank Balances.** Your hour bank account balance will be maintained for a period of at least six months after you lose coverage under the Plan. After that, your hour bank account balance will be canceled unless you continue to meet the notification requirements of this Section. For this purpose, you will not be considered to have coverage under the Plan while you are continuing your coverage under COBRA. At the expiration of this six-month period, you may delay the cancellation of your hour bank account balance only by notifying the Plan Administrator, on a monthly basis, of your desire that your account balance be maintained. The deadline for providing such notice is the first day of the month for which you wish your account balance to be maintained. If you fail to provide such notice within a 30-day grace period following this notification deadline, your hour bank account balance will be reduced to zero. This notification requirement does not apply to any months in which you are performing Qualified Uniformed Service.

In addition, you may be able to allocate hours worked in one six-month period, to a prior six-month period, in order to

- **Allocating Hours From One Six-Month Period to Another.** If you fail to have a Six-Month Eligibility Period due to insufficient hours, but you continue to perform bargaining unit work bargaining unit work in the next six-month period beginning January 1 of July 1, you may allocate up to 200 hours from that next six-month period to the preceding six-month period, in

maintain your coverage.

order to make that preceding six-month period a Six-Month Eligibility Period. However, you must actually work the hours to be allocated before they will be allocated, and you must work them in the first two months of that next six-month period. Once allocated, the hours will not also be credited with respect to that next six-month period.

EXAMPLE

Bob Mitchell has just 400 Credited Hours for the six-month period ending June 30, 2021. However, Bob continues to perform bargaining unit work in the six-month period beginning July 1, 2021, and works a total of 350 hours in July and August, 2021. Bob elects to allocate 200 of his hours worked in July and August to the preceding six-month period, to increase his hours in that preceding six-month period to 600. Bob is thus able to maintain his coverage for the Six-Month Coverage Period beginning August 1, 2021. Note that the 200 allocated hours are then deducted from his Credited Hours for the July 1 to December 31, 2021, six-month period, so that those same hours are not credited in two separate six-month periods.

We may also credit you with a certain number of hours, if necessary, if during a Six-Month Eligibility Period you were disabled...

- **Special Disability Credits.** If you fail to work the 600 Credited Hours required for a Six-Month Eligibility Period because of a total disability, you will be credited with 40 hours for each full two-week period that you are totally disabled. If you are totally disabled for all of a six-month period beginning January 1 or July 1, you will receive 600 Credited Hours for that six-month period. If you are disabled for a period of less than two consecutive calendar weeks, you will receive no Credited Hours on account of the disability. You will receive no more than 1,200 consecutive Credited Hours on account of total disability. For this purpose, you are totally disabled during any period in which, as a result of illness or injury, you are unable to perform bargaining unit work and are not performing any other work for wage or profit. However, for any period in which you are receiving disability coverage as provided on pages 17 through 18, you will not be entitled to half-credits under any circumstances.

...or on certain family or medical leave.

- **FMLA Leave.** An Eligible Employee who is on a leave of absence pursuant to the Family and Medical Leave Act ("FMLA Leave") will be credited by the Plan with hours during the leave for which the Employer makes contributions on his behalf. The Employer shall make contributions on such an eligible Employee's behalf as if he continued working during the FMLA Leave the same number of hours per calendar week he averaged with all Employers during the 12 consecutive calendar months immediately preceding the calendar month in which the leave began.

Coverage under the Plan may terminate at one of a number of times.

TERMINATION OF COVERAGE. Your or your Dependent's coverage under this Plan terminates at 12:01 AM on whichever of the following days occurs first:

- If you are covered under the One-Month Coverage provisions of the Plan, as described on pages 4 and 5, and do not meet the Six-Month Coverage Period provisions of the Plan, as described on pages 5 and 6, the first day of the second calendar month following any calendar month that is not a One-Month Eligibility Period, as defined on page 71;

- If you are covered under the Six-Month Coverage Period provisions, the February 1 or August 1 next following a six-month period beginning on January 1 or July 1 that is not a Six-Month Eligibility Period for you;

- The first day immediately following the date you cease to be either an Employee, or ready, willing and available for work, with an Employer, in a bargaining unit represented by Local No. 8 (unless you are not ready, willing and available for work due to FMLA leave, as defined on page 10 or because you are an organ transplant donor); or if the reason you are not ready, willing and available for work is because you are working for an employer in a collective bargaining unit represented by another union, the first day immediately following the date you become eligible for coverage under another employer group health plan provided, however, that you must provide written documentation of your coverage commencement date under such other plan;

- For a Dependent, the first day immediately following the day that he or she ceases to be a Dependent (in any case, coverage as a Dependent terminates whenever the coverage of the Dependent's Employee-Sponsor terminates);

- If your Employer is required to make the minimum contribution described on page 7, the first day of the month immediately following the month in which your Employer fails to make the minimum contribution;

- If your Employer fails to timely pay its contributions to the Fund, the date prescribed by the coverage termination rule on page 12;

- In the case of your Dependents, the first day of the month following the date of your death;

- The date you enter (or, in the case of your Dependent, the date you or the Dependent enters) the armed forces on active duty;

- The date the Plan is terminated; or

- If you have elected Plan A coverage, as provided under the rules for making employees' contributions set forth on pages 24 and 25, the first day of the month for which you fail to make a timely employee contribution.

In addition, if your Dependent is covered pursuant to a qualified medical child support order, coverage may also terminate upon the expiration of the terms of the qualified medical child support order or upon your enrollment under comparable health coverage.

Notwithstanding the foregoing, if you were covered under the Plan on March, 1, 2020, your coverage will not terminate solely on account of your failure to be credited with the 100 hours necessary for any One-Month Eligibility Period occurring between March 1, 2020, and December 31, 2020, or the 600 hours necessary for the Six-Month Eligibility Periods that run from January 1, 2020, to June 30, 2020 or from July 1, 2020, to December 31, 2020.

There are special rules described below concerning how certain persons may keep their coverage after it would otherwise have terminated.

You will find below a number of special rules that describe how you or your Dependents, or both you and your Dependents, may be able to keep your coverage, even though it might otherwise have been lost pursuant to the rules described above. For example, if you are disabled or are unable to find bargaining unit work, you may obtain coverage because of the hour bank, or by allocating hours from one six-month period to a preceding nonqualifying six-month period. You may also be eligible to continue coverage under COBRA (see pages 18 and 19) or on account of Qualified Uniformed Service (see pages 19 through 22). However, whenever you or your Dependents are covered under any of the self-payment options described below, the coverage will terminate in accordance with the rules governing the option under which the coverage is provided.

We will terminate coverage for you and your family if your Employer fails to pay its required contributions to the Plan.

TERMINATION OF COVERAGE DUE TO EMPLOYER'S FAILURE TO PAY CONTRIBUTIONS. If your Employer's contribution due the Fund remains unpaid, in whole or in part, for a period of 90 days after the date it is due, your and your Dependent's coverage will terminate on the 91st day after the date the contribution is due if:

- You are employed by the Employer on the date the Employer's contributions become 90 days past due; or

- You are employed by or return to work for the Employer after any of the Employer's contributions become 90 days past due and before the Employer has paid all amounts due the Plan.

Note that termination of your coverage in accordance with this provision is not a "qualifying event" entitling you to continue coverage under the COBRA continuation provisions of the Plan.

We may reinstate your coverage if your Employer pays its required

Reinstatement of Coverage. Coverage terminated pursuant to this rule is subject to reinstatement under either of the following circumstances:

contributions within a certain period of time.

- Your coverage will be reinstated, unless it is otherwise terminable in accordance with the Plan, upon your Employer's payment of all amounts due the Plan. However, coverage will not be reinstated unless your Employer makes such payment within one year of the date the earliest unpaid contributions were due. The amounts due the Plan include all overdue contributions, interest, attorneys' fees and costs incurred by the Fund in efforts to recover the overdue contributions, and any other charges or penalties we assess, or such lesser amount as we may agree to accept in satisfaction of your Employer's obligation. If your coverage is restored the restoration will be effective retroactive to the date of its termination.

- If you cease work for your Employer after termination of your coverage and your Employer does not make the payment described above before the end of the One-Month or Six-Month Coverage Period in which your coverage was terminated, your coverage will not be reinstated until the first day of the One-Month or Six-Month Eligibility Period, whichever is applicable. In determining whether you have a One-Month or Six-Month Eligibility Period we will not take into account hour bank credits or certain other hours you may have worked. Call the Fund Office for a complete explanation of these rules.

Exceptions. The date contributions are due from your Employer may be deferred to a date specified by us in accordance with a written deferred contribution payment program we approve. We may agree with your Employer that we will apply this coverage termination rule with respect to a contribution due from your Employer for work performed at one or more, but less than all, worksites at which your Employer employed Employees. For example, if Employees A and B simultaneously work for an Employer at worksites X and Y respectively, and the Employer is 90 days overdue with respect to contributions due for work at site X but is current with respect to contributions due for work at site Y, we may agree with the Employer that we will not apply this Section to Employee B.

CONTINUING COVERAGE
OTHER THAN AS AN ELIGIBLE EMPLOYEE

You may be able to continue your coverage on a self-pay or subsidized basis even if coverage would otherwise be terminated.

INTRODUCTION. You and your Dependents may be entitled to continue, for a limited period of time, coverage under the Plan *on a self-pay* or *partially subsidized basis* beyond the date on which coverage would otherwise terminate. In addition, under certain circumstances your and/or your Dependents' coverage may be continued *at no cost*. This Section describes generally how the following categories of persons may continue coverage where coverage would otherwise be terminated:

- Retired Employees and their Dependents;
- Disabled Employees and their Dependents;
- Dependent children covered by a medical child support order;
- Eligible Employees performing certain uniformed service, and their Dependents.

The paragraph below discusses the Plan's coverage continuation rules in more detail. Also, these rules are described with particularity in the Plan document. Please call the Fund Office if you have questions about whether you qualify to continue coverage.

You may continue your coverage while retired.

RECEIVING COVERAGE WHILE RETIRED. If you:

- Are a Retired Employee,
- Are receiving an early or normal pension from the Plumbers Local No. 8 Pension Fund,
- Performed, or were ready, willing and available to perform, bargaining unit work, or had Qualified Uniformed Service, in five calendar years of six calendar years immediately preceding the year in which you retired, and
- Have at least 15 years of vesting service, as defined in the Pension Plan, (five years if in 2001 or an earlier year you earned, and have since retained, at least one year of service for vesting, as defined in the Plumbers Local No. 8 Pension Plan),

you and your Dependents may continue coverage at a cost we will determine from time to time.

NOTE: For purposes of the 15 year requirement, a tradesman will be deemed to have a year of vesting service if for a calendar year

- he worked in one or more bargaining units represented by the Union or any other job classification for which an Employer has agreed to make contributions to this Plan during the year, and

- he would, had he been eligible to participate in the Pension Plan, have earned (and retained under the Pension Plan's Rule of Parity) a Year of Service for Vesting for that year.

Generally, Retiree Coverage begins after your regular coverage expires.

Commencement of Retiree Coverage. Your coverage as a Retired Employee (and the coverage of your Dependents, under this Retiree Coverage rule) will begin on the first day of the month after your regular coverage expires, so long as you enroll and any required payment is made. Your regular coverage expires when coverage you have *earned* by virtue of your bargaining unit work ends, that is, at the end of the One-Month or Six-Month Coverage Period, whichever is applicable. You may not use hour bank credits for purposes of continuing your non-Retiree Coverage.

We will determine the cost of your Retiree Coverage. We may charge more for persons who are not entitled to Medicare.

Payment for Retiree Coverage. We will from time to time set the cost of Retiree Coverage. In our discretion, we may require from time to time different levels of payments for different categories of Retired Employees, their Dependents, or both. Payment for Retiree Coverage must be made monthly, and each payment is due by the first day of the month for which Retiree Coverage will be provided. We will terminate your Retiree Coverage if your payment is more than 30 days late. If your Retiree Coverage terminates due to your failure to timely make a payment, coverage will not be reinstated until you again earn a Six-Month Coverage Period.

You must enroll for Retiree Coverage within thirty days after you or your Dependents become eligible.

Enrollment for Retiree Coverage. If you are eligible to enroll yourself (and, where applicable, your Dependents) for Retiree Coverage, then you must enroll yourself and eligible Dependents within 30 days after becoming eligible for this coverage. In order to enroll, you must complete certain forms provided by the Fund Office (and, where applicable, provide proof of marriage), and pay the first monthly premium, if one is due. If you fail to timely enroll yourself or your Spouse or if you allow Retiree Coverage to lapse, you will not be permitted to reinstated your coverage or that of your Spouse, as the case may be, unless:

(a) failure to timely enroll yourself or your Spouse is due to reasonable cause;

(b) you again have a qualifying work period, in which case upon subsequent retirement you will again be afforded the opportunity to continue your coverage and that of your Spouse;

(c) you decline coverage for yourself and your Dependents because you are covered under another group health plan and you subsequently lose such coverage due to loss of eligibility under the other group health plan. Such an election must be made within 30 days of the loss of coverage;

(d) you are Medicare-eligible and you decline coverage for yourself and your Dependents because you are covered under a Medicare Supplemental insurance policy and you subsequently lose or terminate such coverage. In that event, you may elect coverage under this Section for yourself and your Dependents you're your loss or termination of coverage under the Medicare Supplemental insurance policy. Such an election must be made within 30 days of the loss of coverage; or

(e) you decline coverage for your Spouse because your Spouse is covered under another group health plan or Medicare supplemental insurance policy, and your Spouse subsequently loses or terminates such coverage. In that event, you may elect spousal coverage under this Section upon your Spouse's loss of coverage under the other plan or policy. Such an election must be made within 30 days of your Spouse's loss of coverage, and you must be covered under the Plan as a Retired Employee at the time the election is made.

The reinstatement rights described in subsections (c) and (d) above are available only one time per Retired Employee.

We may terminate Retiree Coverage in any one of several circumstances.

Termination of Retiree Coverage. Retiree Coverage will continue until the earliest of the following dates:

- the first day after the 30-day grace period, described above, for payment of the cost of Retiree Coverage;
- in the case of your Dependent, the date the Dependent ceases to be a Dependent;
- the first day of the month immediately following the date of your death (that is, your Dependent's coverage terminates on the first day of such month), except that with respect to your surviving Spouse, coverage may continue for up to an additional 9 months after your death;
- the date you (or, in the case of your Dependent, you or the Dependent) enters the armed forces on active duty;
- the date you are reemployed in the plumbing industry, other than in one or more bargaining units represented by Local No. 8, and except as a plumbing inspector who does not work with the tools of the trade;
- if you are reemployed in one or more bargaining units represented by Local No. 8, the last day of the 12th consecutive month of such employment;
- the date you are reemployed in the employee benefits industry if you were at any time a full time Employee of the Fund, the Plumbers Local No. 8 Pension Fund, or both; or

- the date the Plan is terminated.

Special rules apply to reinstating Retiree Coverage after you return to bargaining unit work and then again retire.

In the event you lose your coverage as a Retired Employee under the Plan because you are *re-employed*, as provided above, in one or more bargaining units represented by Local No. 8, and your employment later ceases, you and your Dependents may then have your Retiree Coverage reinstated but only if you meet the requirements for payment for that coverage. In any other case if you lose your coverage as a Retired Employee, you will not again be eligible for Retiree Coverage under the Plan.

NOTE: It is our hope and intention to continue indefinitely the Retiree Coverage described above. Nonetheless, as is true of other coverage under the Plan, we reserve the right to cut back or terminate this coverage at any time.

You may also continue your coverage if you become totally disabled.

CONTINUING COVERAGE WHILE TOTALLY DISABLED. If you:

- are a Totally and Permanently Disabled Employee (see pages 73 and 74 for the definition of "Totally and Permanently Disabled"), and
- performed, or were ready, willing and available to perform, bargaining unit work, or had Qualified Uniformed Service, in five calendar years of the six calendar years immediately preceding the year in which you are disabled,

you and your Dependents may continue coverage at a cost we will determine from time to time.

Your disabled Employee coverage begins when you become Totally and Permanently Disabled.

Commencement of Disabled Employee Coverage. Your coverage as a Totally and Permanently Disabled Employee (and the coverage of your Dependents, under this coverage rule) will begin when you are Totally and Permanently Disabled (see pages 73 and 74 for the definition of "Totally and Permanently Disabled").

Termination of Disabled Employee Coverage. Coverage as a disabled Employee will continue until the earliest of the following dates:

- the date your total and permanent disability ceases;
- in the case of your Dependents, the first day following the date the Dependent ceases to be a Dependent;
- the first day of the month immediately following the date of your death (that is, your Dependent's coverage terminates on the first day of such month);
- subject to the Plan's provisions on Qualified Uniformed Service, the date you (or, in the case of your Dependent, you or the Dependent) enters the armed forces on active duty;
- 29 months after coverage under this provision begins; or

- the date the Plan is terminated.

If you are entitled to disability coverage under this Section because you are receiving a disability pension from the Pension Plan, you will be entitled at the end of the 29-month coverage period to continue your coverage, subject to the rules that apply to continuing coverage for Retired Employees, including but not limited to any requirements for monthly payments the Trustees may impose from time to time by administrative action.

NOTE: If you are receiving coverage under this Disabled Employee Coverage provision, you will not be entitled to the "half-credits" described on page 10. In addition, you may not use "hour bank" withdrawals, described on pages 8 and 9, or "allocated hours," described on pages 9 and 10, to extend your Disabled Employee coverage beyond the 29-month period described above.

We have the right to cut back or terminate this coverage.

NOTE: It is our hope and intention to continue indefinitely the disabled Employee coverage described above. Nonetheless, as is true of other coverage under the Plan, we reserve the right to cut back or terminate this coverage at any time.

Limited Continuation Coverage for Certain Surviving Spouses. A special rule provides an alternative method of continuing coverage for the surviving Spouse of an Employee, disabled Employee, or Retired Employee, where the Spouse was covered by Plan A on the date of the Employee's death, and the surviving Spouse is entitled to Medicare at the time of that death, or becomes entitled to it within nine months after the first day of the month following the date of such death. Under that rule, the surviving Spouse may continue coverage under Plan A for up to an additional nine months following the date coverage would otherwise be lost due to the Employee's death. We may require a monthly payment for this coverage. If we do, failure to pay the monthly charge when due may result in its loss, and coverage lost in that way may not be reinstated.

We have the right to cut back or terminate this coverage.

NOTE: It is our hope and intention to continue indefinitely the surviving Spouse coverage described above. Nonetheless, as is true of other coverage under the Plan, we reserve the right to cut back or terminate this coverage at any time.

In addition, you may be entitled to continue under a special federal law known as "COBRA."

CONTINUING COVERAGE UNDER COBRA. Certain Eligible Employees, Retired Employees, and Dependents who would otherwise lose coverage for reasons such as:

- death of the Eligible or Retired Employee;
- termination of the Eligible Employee's employment;
- reduction of the Eligible Employee's work hours;
- divorce or legal separation of the Eligible or Retired Employee and his Spouse; or

- a child's ceasing to qualify as an Eligible Child under the Plan,

There is a special COBRA Appendix at the back of this booklet which explains your COBRA coverage rights in greater detail.

may continue coverage on a self-pay basis pursuant to the federal law with the acronym "COBRA." A person who qualifies for this "COBRA coverage" may purchase either continued health coverage, or continued health, vision and dental coverage. An explanation of how COBRA works is in the COBRA Coverage Appendix at the back of this booklet. That Appendix also explains when you might be eligible for special subsidized COBRA rates.

Medical child support orders...

MEDICAL CHILD SUPPORT ORDERS. Medical child support orders may create or recognize the right of a child of an Employee or Retired Employee to be covered under this Plan. Typically such orders are issued in divorce proceedings, though they may be issued outside of divorce proceedings to address issues such as whether a child who is not financially dependent on the Employee may be covered, the child's enrollment in the Plan by the parent who is not the Employee, that parent's right to information, enrollment by a state agency, termination of enrollment, and the right of the custodial parent, the provider or a state agency to submit claims and receive payments. You may obtain from the Plan Administrator, without charge, a copy of the Plan's procedures governing qualified medical child support order determinations.

and certain military service may also result in special coverage continuation or reinstatement rights.

CONTINUATION AND REINSTATEMENT OF COVERAGE ON ACCOUNT OF QUALIFIED UNIFORMED SERVICE. Apart from the rights to continued Plan coverage described in the preceding Sections, you may be entitled to continue certain aspects of your Plan coverage during a period of Qualified Uniformed Service. You also may have certain service spanning rights following a period of Qualified Uniformed Service. The specific rules are set forth below.

Coverage for up to 24 months may be available for members of the armed forces.

- Persons Eligible for Continued Coverage. If you are absent from the employment of your Employer on account of a period of Qualified Uniformed Service, you may elect to continue Employee and Dependent health, dental and vision coverage on a self-pay basis or by making the special election provided in the paragraph below, for the 24-month period beginning on the date on which you are first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the day after the date on which you fail to apply for or return to a position of employment, if the failure to apply or return terminates your right to reemployment rights under applicable federal law regarding uniformed service.

- Cost of Continued Coverage. We will determine from time to time the monthly charge for continued coverage. It will be the same for all similarly situated individuals electing the same type of coverage under this provision. For the first 30 days of any single period of Qualified Uniformed Service, the only amount you are required to pay is the amount, if any, you would pay if you had not entered Qualified Uniformed Service. For other periods your charge will be determined in the same manner as

COBRA charges except that the rules regarding special subsidized rates will not apply. All or part of this charge may be avoided by the Employee's election to use any remaining days in a Six-Month or One-Month Coverage Period and any of his balance in the hour bank to qualify for continuing coverage until the remaining days and his hour bank balance are exhausted.

- Benefits Subject to Continuation. Any election you make applies to you and your Dependents who otherwise would lose coverage under the Plan. No separate election may be made by a Dependent. The coverage that you are allowed to continue on behalf of yourself and your Dependents will be the same as the health, dental, and vision coverage provided generally to Employees and their Dependents under the Plan.

For the most part, COBRA rules apply.

- Coordination with COBRA. Except as provided to the contrary in this Section on Qualified Uniformed Service, the application, notice and payment provisions of the Plan's COBRA provisions will apply to coverage during a period of Qualified Uniformed Service.

Members of the military may be able to avoid loss of coverage when they return to covered employment.

- Service Spanning Rules. Qualified Uniformed Service may result in a loss of coverage during the period of Qualified Uniformed Service under the Plan's termination of coverage provisions. Nonetheless, the following rules shall apply following Qualified Uniformed Service if an Employee is then working for an Employer in a collective bargaining unit represented by the Union, or is ready, willing and available for such work:

Coverage periods may be treated as if they accrued back-to-back.

  - The six-month period beginning January 1 or July 1 in which Qualified Uniformed Service begins and the six-month period beginning January 1 or July 1 in which Qualified Uniformed Service ends, if different and not back-to-back, shall be deemed to be back-to-back. For example, if an Employee's Qualified Uniformed Service begins on April 1, 2021 and he or she returns from Qualified Uniformed Service on October 1, 2022, both the six-month period beginning January 1, 2021 and the one beginning July 1, 2022 shall be treated as if they occurred back-to-back.

You may be eligible for deemed Credited Hours.

  - If, in either or both the six-month period beginning January 1 or July 1 in which Qualified Uniformed Service begins or the six-month period beginning January 1 or July 1 in which Qualified Uniformed Service ends, you fail to be credited with at least 600 hours, and the sole reason you are not credited with 600 hours is Qualified Uniformed Service, you will receive "deemed Credited Hours" equal to the number necessary to bring the total hours credited in each such six-month period to 600.

  - To receive deemed Credited Hours under the bullet point immediately above, you must first exhaust any

hour bank withdrawals and allocated hours under the Plan.

- Deemed Credited Hours are not themselves available for addition to an Employee's hour bank or for allocation under the Plan's allocated hours provisions.

- As provided above, an Employee who elects to continue his coverage under the Plan during a period of Qualified Uniformed Service may also elect to forego application of the service spanning rules described above, and instead use any remaining days in a Six-Month or One-Month Coverage Period and any balance in the hour bank to qualify for the continued coverage until they are exhausted. After that, so long as his Qualified Uniformed Service continues, its cost shall be governed by the self-payment provisions described in the Cost of Continued Coverage provisions on pages 19 and 20. On his reemployment such an Employee shall have coverage under the Plan until he earns a new Six-Month Coverage Period, but only if each of the following requirements is met:

  - He has reemployment rights under the applicable federal law regarding uniformed service;

  - He is reemployed by an Employer who has an obligation to contribute to the Fund on his behalf; and

  - He pays for such coverage as if it were COBRA continuation coverage, subject to the rules on the cost and duration of COBRA continuation coverage and the timing of payments set forth in the Continuation of Coverage Under COBRA provisions on pages 18, 19, and 78.

You may be able to avoid exclusions and waiting periods.

- Assuming you are otherwise eligible to be covered under the Plan, any exclusions and waiting periods will be applied to you and your Dependents only to the extent they would have applied if coverage had not been terminated as a result of Qualified Uniformed Service. Exclusions and waiting periods will be applied, nonetheless, in the case of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

- Death, Accidental Death and Dismemberment, and Disability Benefits. These provisions on Qualified Uniformed Service apply to health, dental and vision benefits only. For purposes of applying the provisions of the Plan, and of any applicable insurance policy, regarding the Plan death benefits, accidental

death and dismemberment benefits, and weekly disability benefits, the rights and benefits of an Employee who is absent from employment on account of a period of Qualified Uniformed Service shall be equivalent to those of an Employee having similar seniority, status and pay who is on furlough or leave of absence for the period of Qualified Uniformed Service.

- Qualified Uniformed Service. An absence from employment is considered "Qualified Uniformed Service" only if the following rules are satisfied:

  - The service constitutes the performance of duty on a voluntary or involuntary basis under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which you are absent from employment for the purpose of an examination to determine your fitness to perform any such duty.

Service must be in one of the "uniformed services."

  - The service is in one of the "uniformed services." "Uniformed services" means the Armed Forces of the United States, the Army National Guard and the Air National Guard when engaged in active duty for training or inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

  - The Employee had coverage under the Plan at the time his service began.

  - The period of service does not exceed 60 months, or such other period as may be required by applicable law.

A member of your family may be able to make an election for you.

- Election by Family Members, Other Personal Representatives. Where the Plan Administrator determines that it is appropriate under the circumstances, any election you are required to make under these provisions on Qualified Uniformed Service while you are engaged in a period of Qualified Uniformed Service may be made by one of your family members or a personal representative. Any such election shall be binding on you and any Dependents to whom it pertains.

- Interpretation of Military Service Rules. The Plan's rules on military service shall be interpreted and applied to be consistent with the requirements of applicable federal laws on the rights of Employees who perform Qualified Uniformed Service.

We may enter into reciprocity

RECIPROCITY. The Trustees are authorized to enter into reciprocity agreements with boards of other health and welfare funds, subject to such conditions and limitations as the boards may agree upon. Such agreements may provide that each fund shall pay to the other all or a

agreements with other funds.

portion of contributions received on behalf of Employees who are temporarily working in the jurisdiction of the fund making the payments, but only if that fund incurs no obligation to accrue benefits or credits of any kind for such Employee. The Employee shall receive Credited Hours for all purposes under the Plan for his or her hours of service that generated the reciprocated contributions based on the ratio that the hourly rate of reciprocated contributions bears to the hourly contribution rate for this Plan.

EMPLOYEES' CONTRIBUTIONS

If you are currently eligible for coverage under Plan B, you may elect Plan A coverage if permitted by your Collective Bargaining Agreement.

ELECTION OF PLAN A COVERAGE BY CURRENTLY ELIGIBLE EMPLOYEES. If the applicable Collective Bargaining Agreement permits, and you are eligible for benefits under Plan B in December of a calendar year (the "Preceding Year"), you may elect, but only on a form provided by the Plan Administrator, Plan A Coverage for you and your eligible dependents, if any, for any months in the ensuing calendar year (the "Applicable Year") in which you are eligible for benefits under the Plan. For the election to be effective, the form must be completed and mailed to the Plan Administrator no later than December 20 of the Preceding Year. If you elect Plan A coverage for an Applicable Year, such election will continue in effect for years following the Applicable Year, unless you change or revoke such election, on a form provided by the Plan Administrator, during a subsequent annual enrollment or special enrollment period.

If you are newly eligible for coverage under Plan B, you may elect Plan A coverage if permitted by your Collective Bargaining Agreement.

ELECTION OF PLAN A COVERAGE BY NEWLY ELIGIBLE EMPLOYEES. If the applicable Collective Bargaining Agreement permits, and you are not eligible for benefits under Plan B in December of the Preceding Year, but you become eligible for benefits under Plan B in any of the 12 months immediately following that December, you may elect Plan A coverage, to apply to the months in the Applicable Year in which you and your eligible dependents, if any, are eligible for benefits under the Plan. That election, too, may only be made on a form provided by the Plan Administrator. For the election to be effective, the form must be completed and mailed to the Plan Administrator no later than the last day of the first month in the Applicable Year for which you initially become eligible. If you elect Plan A coverage for all or part of an Applicable Year, such election will continue in effect for years following the Applicable Year, unless you change or revoke such election, on a form provided by the Plan Administrator, during a subsequent annual enrollment or special enrollment period.

An election of Plan A coverage under this Section will apply to all eligible members of your family.

EFFECT OF AN ELECTION OF PLAN A COVERAGE. An election of Plan A coverage made in accordance with the provisions of this Section, determines the level of benefits for all eligible members of your family. It does so only for any months in the period subject to the election for which one or more of them is eligible for benefits under the Plan. The election does not confer eligibility for benefits for any person; it is, instead, one prerequisite for an otherwise eligible person's receiving Plan A coverage.

You are required to make contributions for Plan A coverage by payroll deduction.

EMPLOYEES' CONTRIBUTIONS: PAYROLL DEDUCTIONS. The applicable Collective Bargaining Agreement shall determine the amount of the contributions required of you for Plan A coverage. Contributions must be made by payroll deduction, and they must be deducted for the month in which Plan A coverage is provided. If your employer is delinquent in forwarding the contributions to the Fund, you may make direct payments as provided in this Section.

If your employer is delinquent in forwarding your contributions to the Fund, you may make a direct payment.

EMPLOYEES' CONTRIBUTIONS: DIRECT PAYMENT. Where you have an election of Plan A coverage in effect that applies to a particular month, but the required contributions are not made in full by payroll deduction for that month, you may make direct contributions to the Fund. Direct contributions shall be made on a monthly basis. Each payment must be made by the first day of the month in which Plan A coverage is provided – subject to a 30-day grace period.

If you make payment for Plan A coverage of an amount that is less than the amount due for that month's coverage but greater than 90% of the amount due, the Plan Administrator shall notify you of the deficiency. To maintain Plan A coverage for that month you must pay the deficiency within 30 days of the date the Plan Administrator notifies you of it.

You and your eligible Dependents will lose coverage under Plan A if you fail to make a timely payment.

FAILURE TO MAKE A CONTRIBUTION. Where you elected Plan A coverage for all or part of an Applicable Year, as provided in this Section, but failed to make a timely payment, as required, for a given month, you and your dependents shall be ineligible for Plan A coverage for that month, and for each of the subsequent months in that Applicable Year. In such an instance, the "continuing" election described in this Section will not apply in the year following the Applicable Year, and you must make a new election during a subsequent annual enrollment or special enrollment period if you wish to re-elect Plan A coverage.

CHANGES IN LEVEL OF COVERAGE DURING THE YEAR. See pages 1 through 4 for circumstances in which the Plan's special enrollment rules apply, permitting changes in the level of coverage other than at the times specified in this Section.

MEDICAL BENEFITS

MAJOR MEDICAL BENEFITS AND LIMITATIONS.

Benefits and Limitations. We will pay a percentage of your covered charges over the deductible amount. You should check the list of covered charges that begins on page 28 for maximum payments for treatment it describes. You will find a list of the Plan's exclusions on pages 55 to 57, and of its provisions requiring coordination of benefits with other plans, and subrogation and reimbursement where others may be responsible for your expenses, on pages 75 to 77 and in the Appendix which begins on page 106.

In certain circumstances, the co-payment rates and the deductible amounts will be waived for screening and diagnostic testing for COVID-19.

Temporary COVID-19 Relief. Notwithstanding the foregoing, effective March 18, 2020 through December 31, 2021, we will waive all co-payment amounts on medically necessary screening, diagnostic testing, and vaccination for COVID-19, including hospital, emergency department, urgent care and provider office visits where the purpose of the visit is to be screened, tested, and/or vaccinated for COVID-19. Covered services and items furnished during the office visit, urgent care visit or emergency room visit that result in the ordering or the administration of the COVID-19 test or vaccine will also be covered with no co-payment.

As a general rule, you receive larger benefits if you receive health care from a member of the Plan's Preferred Provider Organization ("PPO").

PREFERRED PROVIDER ORGANIZATION ("PPO").

Preferred Provider Service Organization. The Plan Administrator has contracted with Blue Cross and Blue Shield of Kansas City ("BCBSKC") to provide specific services on behalf of the Plan. BCBSKC is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSKC to use the Blue Cross and Blue Shield Service Mark in a portion of the States of Missouri and Kansas. BCBSKC is not contracting as the agent of the Association. BCBSKC does not serve as an insurer, but merely as an administrative service provider. BCBSKC does not assume any financial risk.

Co-payment Percentage. We will pay a higher percentage of covered medical expenses over the deductible amount for charges made by providers in the BCBSKC network ("Preferred-Care Blue") and other designated Blue Cross and/or Blue Shield Plan networks (the "Host Blue" networks) in the national BlueCard PPO Program, collectively referred to as the BlueKC PPO, than for other health care providers. Doing so allows us to take advantage of discounts offered by BlueKC PPO Providers. We will pay:

- **80%** of covered charges incurred at or charged by PPO Providers;

- **55%** of covered charges for services rendered by outpatient non-PPO Providers; and

- **0%** of covered charges incurred at or charged by inpatient non-PPO Providers (unless due to an Emergency Medical Condition).

Providers Within BCBSKC Operating Areas. Generally, the Preferred-Care Blue network operates in a portion of the states of Missouri and Kansas. If you obtain outpatient services or supplies within the BCBSKC Operating Area, but from other than a Preferred-Care Blue Provider, the co-payment percentage applicable to any resulting covered medical expenses will be only 55%. If you obtain inpatient services or supplies within the BCBSKC Operating Area, but from other than a Preferred Care Blue Provider, the Plan will not cover such expenses except, as described below in this Section, in a medical emergency or where there is no PPO Provider capable of treating a particular medical condition.

Providers Outside BCBSKC Operating Area. If you obtain medical services or supplies outside of the BCBSKC Operating Area through the national BlueCard PPO Program – either because you reside outside of those areas or because you obtain such services or supplies while traveling away from home – the co-payment percentage applicable to any resulting covered medical expenses will be 80%. If you obtain outpatient medical services or supplies outside of the BCBSKC Operating Area from other than a BlueCard PPO Provider, the co-payment percentage applicable to any resulting covered medical expenses will be 55%. If you obtain inpatient services or supplies outside of the BCBSKC Operating Area from other than a BlueCard PPO Provider, the Plan will not cover such expenses except, as described below in this Section, in a medical emergency or where there is no PPO Provider capable of treating a particular medical condition.

NOTE: A list of BlueKC PPO Providers is available to you online at www.bcbs.com. You may also obtain a copy of the list, without charge, by contacting the National Provider Finder number at (800) 810-BLUE (2583).

We will pay the PPO co-payment percentage if care is provided by a non-PPO Provider, but only for the treatment of an Emergency Medical Condition or if there is no PPO Provider able to treat a particular medical condition.

Medical Emergencies. If you incur medical expenses for the treatment of an Emergency Medical Condition from a non-Preferred Provider, we will pay such expenses at the co-payment percentage that would otherwise apply to PPO Providers. We will not pay such expenses once you can be transferred to a PPO Provider without risk to your life or health.

No PPO Provider. If there is no PPO Provider capable of treating a particular medical condition, the co-payment percentage that would otherwise apply to PPO Providers will apply.

The Major Medical coverage includes an annual deductible which you must meet before benefits become payable by the Plan.

Deductible Amount. The deductible amount is the amount of covered charges which you must pay before major medical benefits are payable under this part. The deductible amount is set forth in the Major Medical portion of the Schedule of Benefits. It applies only once per person in any calendar year, even though you may have several different Sicknesses or injuries. Only three such deductible amounts will apply per family in any calendar year. Thus, once each of three covered members of a family meets the deductible amount in a calendar year, all will have met it for that year. So that you will not have to work off a deductible amount late in one calendar year and soon again the following year, any expenses applied against the deductible amount in the last three months of a calendar year may also be applied against the deductible amount for the next calendar year.

Notwithstanding the foregoing, effective March 18, 2020 through December 31, 2021, we will waive all deductible amounts on medically necessary screening, diagnostic testing, and vaccination for COVID-19, including hospital, emergency department, urgent care and provider office visits where the purpose of the visit is to be screened, tested, and/or vaccinated for COVID-19. Covered services and items furnished during the office visit, urgent care visit or emergency room visit that result in the ordering or the administration of the COVID-19 test or vaccine will also be covered with no deductible.

Common Accident. If two or more members of your family are injured in the same accident, the medical expenses which result from the accident will be combined and only one deductible amount will be charged against all such expenses, regardless of the number of family members injured.

Generally, you will not be required to pay more than a maximum amount of medical charges during a year.

Out-of-Pocket Maximum. The Out-of-Pocket Maximum set forth in the Schedule of Benefits is the maximum amount of covered charges that you will be required to pay with respect to major medical claims incurred during a single calendar year. The Out-of-Pocket Maximum does not include expenses for services rendered by a non-PPO Provider, prescription drug expenses, premiums, balance-billed charges, or health care that is not covered by the Plan.

The Plan only pays benefits for covered charges. Covered charges include certain...

Covered Charges. Covered charges are those you incur for the following services and supplies, <u>as long as they are necessary for treatment of an injury or Sickness</u>:

...Hospital charges...

- charges made by a Hospital; except that the covered daily Room and Board charge will not exceed the Hospital's regular rate for a semi-private room or, if the Hospital does not have such a rate, 80% of the Hospital's minimum daily rate for private Room and Board (see page 56 for a limit on the number of emergency room visits for which payment will be made);

...Doctor's fees...	• Doctor's fees for diagnosis, second surgical opinions, treatment and surgery, including voluntary sterilization;
...physicians' assistants' and nurse practitioners' charges…	• charges made for treatment by a licensed physician's assistant or a certified nurse practitioner;
…nurses' charges…	• charges made by a Registered Graduate Nurse for private duty nursing services;
...charges for ambulance service, x-rays and lab tests, anesthesia, etc...	• charges for the following: local ambulance service, x-ray service, laboratory tests, anesthesia and administration of anesthesia, the use of radium and radioactive isotopes, oxygen, physiotherapy, and similar services and treatment;
...charges by a chiropractor, up to certain limits...	• charges made for x-rays and laboratory fees ordered by a chiropractor. Covered charges will also include up to $40 for each visit to a chiropractor, subject to a maximum number of 15 visits in a calendar year. The 15-visit per year limitation does not apply to visits necessary to treat an injury that occurred in the 12 months before the visit occurred. No payment will be made for charges incurred for maintenance therapy;
…charges for routine gynecological examinations…	• charges for routine gynecological examinations with no deductible or coinsurance requirements if performed by a Preferred Provider, limited to one examination per calendar year (if the examination is performed by other than a Preferred Provider, deductible and non-PPO coinsurance requirements will apply);
…charges for physician-ordered mammograms…	• charges for physician-ordered mammograms with no deductible or coinsurance requirements if performed by a Preferred Provider and if the patient is age 40 or older, limited to one set per calendar year (if the patient is under 40 or the mammogram is performed by other than a Preferred Provider, deductible and applicable coinsurance requirements will apply);
…charges for prostate antigen testing…	• charges for prostate antigen testing;
...charges for certain medical supplies and equipment...	• charges for medical supplies and equipment, excluding items such as air conditioners, filters, exercise bicycles, water beds, heating pads and hot water bottles, which are purchased by members of the general public for their comfort or convenience; provided that if the cost of renting a covered item is less than the cost of purchasing it, covered charges will include only the rental cost;
...charges for treatment of nervous and mental	• charges for outpatient treatment of alcohol and drug abuse, but only as provided on page 32;

disorders, and alcohol and drug abuse...

- charges for in-Hospital treatment of alcohol and drug abuse, but only as provided on page 32;
- charges for outpatient treatment of nervous or mental disorders, but only as provided on page 32;
- charges for in-Hospital treatment of nervous or mental disorders, but only as provided on pages 32 and 33;

…charges for dental services for treatment of an injury…

- charges for dental services rendered by a Doctor or dentist for the treatment of an injury to the jaw or to natural teeth, including the initial replacement of these teeth and any necessary dental x-rays;

...charges for certain oral surgery, nutrition counseling, infertility, eye surgery and mastectomy related expenses…

- charges made by a board-certified oral and maxillofacial surgeon, that is, a person certified as a Diplomat of the American Board of Oral and Maxillofacial Surgery for:
  - treatment of fractures, dislocations, or atrophy of the jaw;
  - cutting procedures for the treatment of diseases of the teeth, jaw or gums; and
  - treatment of temporomandibular joint disorders;
- charges for nutrition counseling given by a Registered Graduate Nurse or a Registered Dietitian;
- charges for the diagnosis and treatment of infertility, but only as provided on page 36;
- charges for refractive eye surgery, including radial keratomy, but only for active Employees whose vision in both eyes is 20/200 or worse, and limited to only one such surgery or treatment per eye during an Employee's lifetime;
- charges for the following services related to mastectomies:
  - reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas;

…Extended Care Facility charges…

- charges made by an Extended Care Facility, but only as provided on page 33;

…charges for home health care, infusion therapy, hospice

- charges for Home Health Care, but only as provided on page 33;

care, and organ transplants…

- charges for infusion therapy, but only as provided on page 33;
- charges for Hospice Care, but only as provided on page 34;
- charges for organ transplants, but only as provided on pages 34 through 36;

…physical therapists' charges…

- charges made for treatment by a physical therapist or physical therapist assistant who meets any applicable licensing, registration, or certification requirements of the state in which the services are rendered;

…charges for speech therapy and, under certain circumstances, services associated with cancer clinical trials.

- charges for speech therapy; and
- charges for routine patient services associated with cancer clinical trials approved and sponsored by the federal government, provided, however that routine patient services do not include:
  - the investigational service or supply itself;
  - services or supplies listed herein as exclusions;
  - services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs); or
  - services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Charges for maternity expenses are covered, but not on behalf of covered Dependent children.

Maternity. We will pay benefits for pregnancy, childbirth, miscarriage or abortion, on the same basis and subject to the same conditions and limitations that apply to any other medical condition (we will not, however, pay more than $180 for Doctor's fees for performing an elective abortion). These benefits will not be payable for expenses incurred by Eligible Children, unless the benefits qualify as Preventive Health Services as defined on pages 71 and 72. As is true of other benefits, these benefits will be paid only if you are covered by the Plan when the expenses are incurred.

The Plan does not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. In addition, the Plan does not require a Doctor to obtain authorization or precertification from the Plan Administrator for prescribing any length of stay described above. However, these rules do not prohibit the mother's or newborn's attending provider, in consultation with the mother, from discharging the mother or her newborn before the expiration of the time periods described above.

NOTE: Each of the benefits described in the following Sections is subject to rules on deductibles, co-payments, PPOs, medical necessity, and similar rules, which apply under the Major Medical provisions of the Plan.

We will pay charges for outpatient treatment of alcohol and drug abuse.

OUTPATIENT TREATMENT OF ALCOHOL AND DRUG ABUSE. We will pay for charges you incur for *out-of-Hospital* treatment of alcoholism or drug abuse while you are under the care of a Doctor or a clinical psychologist who is duly licensed or certified and who is working within the scope of such license or certification.

We will only pay for treatment that is:

- part of a structured program; and
- recommended and supervised by that Doctor or clinical psychologist.

We will also pay charges for in-patient treatment of alcohol and drug abuse.

IN-HOSPITAL TREATMENT OF ALCOHOL AND DRUG ABUSE. We will pay for charges you incur for the treatment of alcohol and drug abuse while you are an inpatient at a Hospital or Treatment Center that is a PPO Provider on the same basis as any other Sickness. Just as any other Sickness, we will not pay charges while you are an inpatient at a Hospital or Treatment Center that is a non-PPO Provider unless due to an Emergency Medical Condition.

We will also pay certain expenses for both outpatient treatment of nervous or mental disorders...

OUTPATIENT TREATMENT OF NERVOUS OR MENTAL DISORDERS. We will pay for the charges you incur for professional psychiatric services furnished outside the Hospital on the same basis as any other Sickness, if the services are provided by:

- an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery;
- a clinical psychologist who holds a Ph.D. or a Psy.D. in psychology, is duly licensed or certified, and is working within the scope of such license or certification; or
- another mental health provider, such as a Licensed Master Social Worker, a Licensed Clinical Social Worker, or a Licensed Professional Counselor, who is duly licensed or certified, and is working within the scope of such license or certification.

NOTE: Whether your condition constitutes a nervous or mental disorder will be determined by reference to that condition's symptoms, and not to its underlying causes.

...and inpatient treatment of nervous or mental disorders.

IN-HOSPITAL TREATMENT OF NERVOUS OR MENTAL DISORDERS. We will pay for charges you incur for the treatment of nervous or mental disorders while you are:

- an inpatient at a Hospital or Treatment Center that is a PPO Provider, or
- a participant in a Partial Hospitalization Program at a PPO Provider,

on the same basis as for any Sickness. "Partial Hospital Program" means a program for the treatment of nervous or mental disorders in which the patient does not reside at the Hospital 24 hours a day, but is treated at the Hospital as a resident in-patient during the daytime hours. Just as any other Sickness, we will not pay charges while you are an inpatient or a participant in a Partial Hospitalization Program at a Hospital or Treatment Center that is a non-PPO Provider unless due to an Emergency Medical Condition.

We will pay certain expenses for your confinement in an Extended Care Facility, up to the limit described in the Schedule of Benefits.

EXTENDED CARE FACILITIES. We will pay for charges you incur for confinement in an Extended Care Facility, where a physician certifies that hospitalization would be required absent such confinement. An "Extended Care Facility" means an institution or part of an institution that is primarily engaged in providing to its inpatients either skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation of persons who are injured, disabled or sick. If the facility is located where state or applicable local law provides for licensing of institutions of this kind, it must either be licensed under such a law or approved by the agency of the state or locality responsible for licensing institutions of this kind as having met the standards established by the state or locality. This provision does not cover expenses incurred for custodial care. We will not pay for confinement in an Extended Care Facility for more than the Maximum Number of Days per Calendar Year specified in the Schedule of Benefits.

We will also pay certain home health care and infusion therapy expenses, up to the limit described in the Schedule of Benefits.

HOME HEALTH CARE. We will pay for the cost of home health care visits made to you by a Registered Graduate Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a home health aide, a physical therapist, an occupational therapist or a speech therapist, if you are home bound. We will not, however, pay for services provided by a person who ordinarily resides in your household or is a member of your family. The maximum number of visits payable per calendar year for Home Health Care and infusion therapy (as described below) combined is 60. Four consecutive hours (or less) of Home Health services constitutes one home health visit. We will only pay for the cost of visits provided by a Home Health Agency and made in accordance with a home health care plan established by a Doctor within 10 days of hospitalization.

We will also pay certain costs associated with infusion therapy, up to the limit described in the Schedule of Benefits.

INFUSION THERAPY. We will pay for the cost of infusion therapy administered in your home by an R.N. or L.P.N., whether or not you are home bound. Infusion therapy involves the administration of medication through a needle or catheter, and is generally prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. The maximum number of visits payable per calendar year for infusion therapy and Home Health services (described above) combined is 60.

We will also pay certain hospice care expenses, up to the limit described in the Schedule of Benefits.

HOSPICE CARE. We will pay for covered Hospice Care charges you incur for the palliation or management of a terminal illness, but for no more than the maximum number of days shown in the Schedule of Benefits. Covered Hospice Care charges are limited to the following:

- Nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational and speech therapy;
- Medical social services, if under the direction of a physician;
- Personal care services and household services needed to maintain a safe and sanitary environment, but only if not provided by a person who ordinarily resides in your household or who is a member of your family;
- Drugs and other medical supplies, and the use of medical appliances;
- Physician's services;
- Short-term inpatient care in an appropriate inpatient facility, but only on an intermittent, nonroutine and occasional basis, and for no more than five consecutive days; and
- Counseling of your family with respect to the care of a terminally ill individual and the adjustment to his death.

We will pay for such covered Hospice Care charges only if:

- You have a life expectancy of six months or less;
- Such charges are incurred at a Hospice Care program certified as such under the federal Medicare program or by the Joint Commission of Hospital Services;

  A written Hospice Care plan is drafted by the program and approved by your Doctor, who agrees to work with the program in implementing the plan; and
- That plan provides for Hospice Care to be provided to you in your home, rather than in a Hospital.

We will not pay for Hospice Care charges that are not authorized in the treatment plan described above. Charges payable under both this provision and another provision of the Plan will be paid only under this provision.

COVERED CHARGES FOR ORGAN TRANSPLANTS. Subject to the rules set forth in this organ transplant provision, the table below shows the circumstances in which we will pay for major medical benefit charges incurred for organ transplants.

Under certain circumstances, we will pay for charges incurred for organ transplants.

Situation	Coverage
1. The recipient is a participant under the Plan and receives the organ from a cadaver.	The recipient's expenses are covered charges.
2. The recipient is a participant under the Plan and receives the organ from a bank.	The recipient's expenses are covered charges.
3. The recipient and the donor are participants under the Plan.	The expenses of both are covered as two separate claims with separate deductibles.
4. The recipient is a participant under the Plan and the donor's expenses are not covered under any other plan.	The expenses of both are covered as one claim with one deductible and co-payment.
5. The recipient is a participant under the Plan and the donor's expenses are covered under another plan.	Only the recipient's expenses are covered charges.
6. The donor is a participant under the Plan but the recipient is not.	The expenses of neither are covered charges.

Subject to the list of Situations and Coverages given above, "covered charges" for organ transplants include charges for services and supplies that are listed in the covered charges provisions, or which are specifically identified below as covered under this Section, and which are Medically Necessary and appropriate to the transplant:

- Charges made for evaluation, screening and determination of a participant's candidacy for the organ transplant;
- Charges incurred for organ transplantation;
- Charges for organ procurement, to the extent permitted above; including in the case of organ procurement from a non-living donor, the costs involved in removing, preserving and transporting the organ, and in the case of procurement from a living donor, the costs of screening the potential donor, transporting the donor to and from the site of the transplant, removing the donated organ, and providing medical services to the donor for the donor's follow-up care; and
- Charges for the recipient's follow-up care, including immuno-suppressant therapy.

The percentage of covered charges we will pay under this organ transplant provision will be the percentage that would apply if the

charges were incurred with a member of the Plan's Preferred Provider Organization, Freedom Network Select. No payment will, however, be made under this organ transplant provision unless the projected charges for the organ transplant have been submitted to and approved before the organ transplant occurs by a case manager selected by the Plan Administrator.

We will also pay for charges for transportation to and from the site of the organ transplant procedure and charges for meals and lodging for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals, except that these expenses will be covered up to a maximum of $10,000 in connection with one transplant and will be subject to the following limitations:

We will only pay for reasonable and actual expenses, documented as required by the Plan Administrator. The amounts of the payments will in no event exceed the following limitation:

Category of Expenditure	Amount Per Day
Meals and tips for meals	$80.00
Beverages and snacks	$12.50

The individuals shall determine whether to travel to and from the site by car or plane. In addition to other expenses reasonably and actually incurred by the individuals, we will pay individuals who drive their car to and from the site of the organ transplant at the currently prevailing I.R.S. rate, the mileage to be determined by recourse to a standard road atlas. In the case of individuals who travel by plane, we will pay the individuals for their reasonable and actual plane fare (coach only). No more than the reasonable coach airfare rate will be paid to an individual who travels by car for the cost of travel.

We will also pay certain expenses related to the diagnosis and treatment of infertility, but will not pay for some of the more complicated treatments.

DIAGNOSIS AND TREATMENT OF INFERTILITY. We will pay for some expenses related to the diagnosis and treatment of infertility. In particular, infertility testing, laboratory tests and surgical procedures, and one cycle of drug treatment for infertility are covered. We will not, however, pay for some of the more complicated treatments and procedures such as artificial insemination and in vitro fertilization. Please check with the Plan Administrator for more specific details on the scope of this coverage.

We will pay for retail telehealth services provided through the Blue KC Virtual Care mobile application or website at 100%.

RETAIL TELEHEALTH SERVICES. We will pay 100% for retail telehealth services provided through the Blue KC Virtual Care mobile application or website. Doctors are available 24/7 for online office visits for common medical conditions such as colds, flu, fever, rash, abdominal pain, sinusitis, pinkeye, ear infection, and migraines.

The Major Medical Coverage will not pay for certain charges.

LIMITATIONS. We will not pay major medical benefits for services, supplies or treatment you incur on account of:

- services performed by or under the direction of a dentist, if the charges are not specifically included in the list of covered charges described on pages 28 through 31;
- services and supplies not specifically provided for in this Section of this booklet concerning Major Medical Coverage; or
- arch supports or corrective shoes.

We will pay for medical expenses for Preventive Health Services provided by a PPO Provider at 100% with no deductible.

PREVENTIVE HEALTH SERVICES.

Benefits. We will pay medical expenses for Preventive Health Services rendered by a Preferred Provider at 100%, with no deductible. If you obtain Preventive Health Services from other than a Preferred Provider that are otherwise covered charges under the Plan's Major Medical provisions, the co-payment percentage applicable to any resulting medical expenses will be 55%, and the expenses will be subject to applicable deductible amounts.

Office Visits. We may impose cost-sharing requirements for office visits that include the delivery of Preventive Health Services in certain instances. Here are the specifics:

- If a Preventive Health Services item or service is billed separately (or is tracked as individual encounter data separately) from an office visit, then we will impose cost-sharing requirements with respect to the office visit;
- If a Preventive Health Services item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then we will not impose cost-sharing requirements with respect to the office visit so long as the item or service was rendered by a Preferred Provider; and
- If a Preventive Health Services item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then we will impose cost-sharing requirements with respect to the office visit.

PRESCRIPTION DRUG BENEFITS

The Plan's prescription drug benefit is administered by OptumRx.

ADMINISTRATION. The Prescription Drug benefit is administered by OptumRx. OptumRx has a network of participating retail pharmacies through which you will be able to obtain discounted prescription drugs. Here are the particulars:

- You may order up to a 34-day supply of prescription medications routinely used for short term treatment and up to a 90-day supply of prescription medications routinely used for chronic conditions;

- When you purchase a drug or medicine that requires a Doctor's written prescription (or other item covered under the Prescription Drug benefit, as described below), and present your OptumRx card at a participating retail pharmacy, you will pay the greater of:

  - $5 or 20% of the discounted price that the pharmacy will charge for the generic drug or item,

  - $20 or 20% of the discounted price that the pharmacy will charge for a brand name drug or item for which a generic drug or item is not available, and

  - $35 ($70 for a 90-day supply) or 30% of the discounted price that the pharmacy will charge for a brand name drug or item specifically prescribed by your physician for which a generic drug or item is available.

    However, if you otherwise request a brand name drug when a generic equivalent is available, you will be responsible to pay (1) the co-payment amount for the brand name drug and (2) the difference between the cost of the brand name drug and the cost of the generic equivalent.

- We will pay the remainder of the discounted price for Employees and their Dependents. The pharmacy will bill the Plan directly for its portion of the charges. You will not be required to file a claim for such a payment.

- The Prescription Drug Benefit includes a step therapy program under which certain prescription drugs will be excluded from coverage, unless you first use a lower cost, equally potent alternative. When your Doctor prescribes a new medication targeted within the step therapy program, the Plan will require the use of a Step One drug. If the Step One drug proves ineffective, you are then eligible to obtain a Step Two drug as a covered benefit. The list of step therapy drugs is subject to

change by OptumRx. You may obtain a copy of the list of drugs subject to step therapy by contacting OptumRx at 1-844-265-1735.

- Each covered person must pay the annual deductible as set forth in the Prescription Drug benefit portion described in the Schedule of Benefits.

Here is how to obtain more information.

A list of OptumRx participating retail pharmacies is available to you online at optumrx.com/mycatamaranrx. You may also obtain a copy of the list, without charge, by contacting customer service between the hours of 8am and 9pm (cst), Monday through Friday and between the hours of 9am and 6pm (cst), Saturday, at 1-844-265-1735. A list of participating providers is also furnished automatically, without charge, as a separate document.

The Plan pays benefits for certain drugs prescribed by a Doctor. Covered drugs include...

COVERED DRUGS. The prescription Drug Benefit is available for drugs prescribed by a Doctor, except those excluded below. It is also available for:

- Insulin, syringes, and diabetic test supplies (e.g., strips and monitors), on an over-the-counter basis;
- Fluoride preparations for Dependent children 18 years old or younger;
- Smoking deterrent patches; and
- Some over-the-counter test supplies (check with the Plan Administrator for particulars).

If you are eligible for Medicare Part D benefits, refer to page 47 for a description of Medicare Part D benefits, and pages 48 and 49 for circumstances in which this Plan is primary to Medicare. You will find a list of the Plan's exclusions on pages 55 to 57, and of its provisions requiring coordination of benefits with other plans, and subrogation and reimbursement where others may be responsible for your expenses, on pages 75 to 77 and in the Appendix which begins on page 106.

Generally, you will not be required to pay more than a maximum amount of prescription drug charges during a year.

OUT-OF-POCKET MAXIMUM. The Prescription Drug Benefit Out-of-Pocket Maximum set forth in the Schedule of Benefits is the maximum amount of covered charges that you will be required to pay with respect to prescription drug claims incurred during a single calendar year. The Prescription Drug Out-of-Pocket Maximum does not include expenses for major medical claims, premiums, balance-billed charges, prescription drugs that are not covered by the Plan, or the amount you will pay (in addition to the regular co-payment amount) if you choose to purchase a brand name drug when a generic equivalent is available.

The Plan will not pay for some prescription drugs.

EXCLUDED DRUGS. The Plan will make no payment for:

- More than 60 tablets for treatment of erectile dysfunction per calendar year;
- Infertility treatment, except as described on page 36;
- Anabolic steroids;
- Vaccines, unless otherwise covered as a Preventive Health Service;
- Anti-obesity drugs, unless you are morbidly obese;
- Cosmetic drugs;
- Growth hormones;
- Blood sera;
- Retin-A, unless prescribed for the treatment of pre-cancerous lesions;
- Over-the-counter non-Federal Legend Drugs, unless you provide the Plan Administrator a statement from your Doctor that the drug is necessary for treatment of an injury or Sickness;
- PCSK9 inhibitors.

DENTAL BENEFITS

The Plan also provides certain dental benefits.

BENEFITS. We will pay the percentages shown in the Schedule of Benefits of charges that are reasonable and customary for covered dental services rendered by a legally qualified dentist. We will not pay more in any one calendar year than the maximum shown in that Schedule. If an adequate method or material could have been used which costs less than the method or material actually used, the dental expense benefits will be based on the method or material which costs less.

COVERED DENTAL SERVICES. Covered dental services are divided into Type I, Type II, and Type III procedures and include only the following services:

Type I Procedures.

Type I Procedures (Routine Restoration and Maintenance)

- Routine examinations, limited to two during any calendar year;
- Cleaning, including prophylaxis treatment (limited to two during any calendar year) and topical fluoride, for children under age 19, (limited to two treatments during any calendar year);
- Single tooth x-rays, bite-wing x-rays (limited to two during any calendar year), and full mouth x-rays (limited to one during any period of three calendar years) or panoramic-maxilla and mandible x-rays (limited to one during any period of three calendar years);
- Fixed and removable space maintainer (initial appliance only);
- Emergency palliative treatment for relief of pain;
- Regular cavity fillings, including amalgam, synthetic porcelain and plastic fillings; and
- Tooth extraction.

Type II Procedures.

Type II Procedures

- Oral surgery, including pre- and post-operative care;
- Endodontics, including pulpotomy, pulp capping, and root canal treatments;
- Periodontics, including examination, management of acute infection and oral lesions, gingival curettage, gingivectomy or gingivoplasty, osseous surgery, and mucogingivoplastic surgery;

- Anesthesia and its administration in connection with oral surgery, extractions or other covered dental services;
- Repair and recementing of inlays, onlays, crowns and bridges;
- Sealant application on posterior tooth for children under age 14;
- Pin retention; and
- Single crown and crown build-up.

Type III Procedures.

Type III Procedures

- Inlays and onlays;
- Full and partial dentures, including the replacement of dentures covered under this procedure, but only when Medically Necessary, and not more than once every five years;
- Fixed or removable bridge;
- Repair and adjustments to dentures, but only if performed more than six months after the installation of the denture; and
- Appliances used in the treatment of Temporomandibular Joint Syndrome (TMJ).

You will find a list of the Plan's exclusions on pages 55 to 57, and of its provisions requiring coordination of benefits with other plans, and subrogation and reimbursement where others may be responsible for your expenses, on pages 75 to 77 and in the Appendix which begins on page 106.

EXPENSES INCURRED. An expense for an appliance or modification of an appliance is considered incurred at the time the impression is made. For a crown, bridge or gold restoration an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply furnished.

The Trustees have entered into an agreement with a dental PPO.

DENTAL PREFERRED PROVIDER ORGANIZATION. The Trustees have entered into an agreement with a dental preferred provider program, Freedom Network Dental, maintained by Preferred Health Professionals, of Kansas City, Missouri. Dentists in the program have agreed to discount the cost of their services to participants in the Plan, resulting in savings to you and the Plan. The co-payment percentages are the same whether or not you use a provider who participates in the dental preferred provider program. For more information about the dental preferred provider program and to learn whether a dentist is a member of the preferred provider program, contact the Fund Office. A

list of participating providers is also furnished automatically, without charge, as a separate document.

Some dental expenses are not covered.

DENTAL BENEFIT EXCLUSIONS. We will not pay benefits under this Section for care or services:

- rendered solely for cosmetic purposes, unless the result of accidental bodily injury;
- paid for under any other provision of the Plan;
- not reasonably necessary for your dental care;
- any portion of charges for services greater than reasonable or customary charges;
- for orthodontia;
- for fluoride treatment for persons 19 years of age or older unless unusual circumstances warrant such treatment and, in the opinion of your dentist, such treatment is needed;
- for replacement of complete denture due to theft or loss of previous denture; or
- for replacement of a denture or prosthesis until you have had dental coverage under the Plan for at least one year.

VISION CARE BENEFITS

The Plan also provides vision care benefits, including certain charges for...

BENEFITS. We will pay for your covered vision care expenses, up to the maximums you will find in the Schedule of Benefits. Covered vision care expenses include the following:

...vision exams...

- **Vision Examination**. The cost of an examination performed by a licensed optometrist or ophthalmologist, but limited to one such examination in each calendar year;

...lenses...

- **Lenses.** The cost of prescribed lenses, but limited to only one prescription for lenses in each calendar year;

...frames...

- **Frames.** The cost of frames, but limited to one pair of frames in any two consecutive calendar years; and

...and contact lenses.

- **Contact Lenses**. The cost of contact lenses, but only:
  - following cataract surgery;
  - where visual acuity cannot be corrected to 20/70 in the better eye except by the use of contact lenses.

  The maximum we will pay is $55.00 for a single contact lens and $110 for a pair. We will pay for replacement of contact lenses only if there have been at least 12 months since the last time you obtained contact lenses covered under this provision.

  If you choose contact lenses for cosmetic purposes instead of glasses available under this provision, an allowance of $80.00 will be made for the contact lenses in addition to the examination fee. We will make this allowance available only if there have been at least 12 months since the last time you obtained lenses of any kind under this Vision benefit provision.

Certain limits apply to the amount and type of vision care expenses for which the Plan will pay.

LIMITATIONS. We will not pay benefits under this Vision benefit provision for:

- Any eye examination required by an Employer as a condition of employment;
- Extra charges for glasses with tinted lenses, unless prescribed by an optometrist or ophthalmologist as Medically Necessary;
- Sunglasses;

- Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonia lenses and tonography;

- Vision examinations rendered and lenses or frames ordered before the person became eligible for benefits under this provision; or

- Lenses or frames ordered while covered for Vision Care benefits, but delivered more than 60 days after termination of such coverage.

You will find a list of the Plan's exclusions on pages 55 to 57, and of its provisions requiring coordination of benefits with other plans, and subrogation and reimbursement where others may be responsible for your expenses, on pages 75 to 77 and in the Appendix which begins on page 106.

OTHER BENEFITS

The Plan also provides special benefits, such as benefits to supplement Medicare...

BENEFITS TO SUPPLEMENT MEDICARE. (Refer to pages 48 and 49 for circumstances in which this Plan is primary to Medicare.)

Part A Benefits. If:

- you are eligible for Medicare Part A benefits (whether or not you enroll in or apply for such benefits), then
- we will treat you as if you are covered by Medicare Part A benefits in determining your benefits under this Plan.

If you are covered by Medicare Part A benefits, Medicare pays for 100% of Hospital costs after the inpatient Hospital deductible. We will pay the first $696 of the inpatient Hospital deductible.

Part B Benefits. If:

- you are eligible for Supplementary Part B Medicare benefits (whether or not you enroll in or apply for such benefits), then
- we will treat you as if you are covered by Medicare Part B benefits in determining your benefits under this Plan.

If you are covered by Medicare Part B benefits, Medicare pays for 80% of reasonable costs or charges for expenses covered by Medicare, after an annual deductible. We will pay for the remaining 20% of such reasonable costs or charges after the deductible. We will not pay for the deductible.

EXAMPLE

Here is an example. Part A of Medicare pays for 100% of Hospital costs after you satisfy the Part A deductible. Therefore, if you are eligible to receive benefits under Medicare, this Plan will pay the first $696 of the Part A deductible. Part B of Medicare pays for 80% of reasonable costs or charges for covered expenses after you satisfy a smaller Part B annual deductible. This Plan will pay for the remaining 20% of reasonable and customary expenses *after* you pay the Part B deductible. The Plan will *not* pay the Part B deductible.

Part C Benefits. If:

- you are covered by Medicare Part C benefits,
- then we will pay the reasonable costs and charges not covered by Medicare Part C benefits for treatment expenses that are:

- otherwise covered under the Plan's benefit provisions;
- not otherwise excluded under the Plan's exclusions described on pages 55 through 57; and
- otherwise covered, in whole or in part, under either Medicare Part A or Part B, or both.

In no case will the Plan's payment under Medicare Part C exceed amounts that would otherwise be payable under the provisions above on Part A Benefits and Part B Benefits.

Part D Benefits. If:

- you are eligible for Medicare Part D benefits (whether or not you enroll in or apply for such benefits), unless you are eligible for Medicare Part D benefits solely because you are disabled, then
- you will not have coverage under the Plan's Prescription Drug Benefit.

Note that if you do not timely enroll for Medicare prescription drug coverage, you may have to pay a higher premium if you enroll later.

Making sure you are covered by Medicare is your responsibility.

Making sure you are covered under the various Parts of Medicare is your responsibility. You should contact the Social Security Administration for answers to any questions you may have about enrollment or eligibility for Medicare coverage.

You will find a list of the Plan's exclusions on pages 55 to 57, and of its provisions requiring coordination of benefits with other plans, and subrogation and reimbursement where others may be responsible for your expenses, on pages 75 to 77 and in the Appendix which begins on page 106.

No Payment by Medicare. There will be circumstances in which Medicare will not pay the Part A, Part B, or Part C benefits described above, even though you are covered by Medicare. Where that is the case we will not increase our payment to cover the shortfall caused by Medicare's lack of payment or reduced payment. As a result, whatever Medicare pays for Hospital costs, we will pay no more than the first $696 of expenses you incur because you are Hospitalized. Similarly, if for any reason Medicare pays less than the amounts described above for Part B or Part C benefits, we will pay no more than 20 percent of the reasonable and customary expenses after the Part B deductible.

For instance, federal law prohibits the Veterans Administration from billing Medicare, so if you received care in a Veterans Administration Hospital, Medicare will pay nothing for the services you receive. In that case our payments will be limited to the amounts described above; we will not make-up the amounts Medicare didn't pay. In addition, unless

you are eligible for Medicare benefits solely because you are disabled, we will make no payment under this Plan for any expense that is not covered, at least in part, under Medicare Part A or Part B.

This Plan is primary to Medicare in certain circumstances.

Circumstances in Which This Plan is Primary to Medicare; Medicare Enrollment. The provisions above concerning Part A Benefits, Part B Benefits, Part C Benefits, and Part D Benefits will not apply if you are:

- an Employee of an Employer who has 20 or more Employees for each working day in each of 20 or more calendar weeks in the calendar year in which the expense is incurred or the preceding calendar year, are age 65 or older, and elected coverage under this Plan;
- a Spouse age 65 or older of an Employee of such an Employer and you have elected coverage under this Plan;
- eligible for Medicare Part A coverage solely because of end-stage renal disease, but only for the thirty-month period beginning with your Medicare eligibility; or
- eligible for Medicare Part A coverage solely as a result of a disability (within the meaning of the Social Security Act) other than end-stage renal disease under 42 U.S.C. § 426-1, and you are an Employee, or an Employer, or you are associated with an Employer in a business relationship, or you are a member of the family of any of them.

In any case, in determining your rights under Medicare coordination rules, applicable Medicare secondary payment requirements of federal law shall govern.

NOTE: Coverage under this Plan is available to Employees age 65 or older and to Spouses of Employees age 65 or older under the same conditions as coverage is available to Employees and their Spouses under age 65. Nonetheless, persons over age 65 are entitled to select primary coverage under Medicare. To do so, they must decline all coverage under this Plan.

If you wish to do so, you may elect--once you become eligible for Medicare--to decline coverage under the Plan. Call the Plan Administrator for more information. An Employee who declines coverage will still be eligible for:

- death benefits,
- weekly disability benefits, and

- accidental death and dismemberment coverage on the same terms as before.

To become covered again under the Plan after declining coverage, you must file a request for reinstatement in the Plan with the Plan Administrator.

In any case, you need a Medicare card in order to submit claims for Part A coverage. To get one, enroll in Medicare at your local Social Security office. It is your responsibility to apply for Medicare coverage and pay your Part B and D premiums, if you wish Part B or D coverage. If you do not apply for coverage or allow your coverage to lapse, you may suffer a gap in Medicare coverage. If you do not timely enroll for Medicare Part D (prescription drug coverage), you may have to pay a higher premium if you enroll later. There may be other penalties and disadvantages of not maintaining Medicare coverage. Check with your local Social Security office if you have any questions.

This Plan also provides hearing aid benefits.

HEARING AID BENEFITS. Only active Employees and their Dependents are eligible for Hearing Aid benefits. We will pay for the cost of a hearing aid for each ear provided it is recommended by a Doctor up to the maximum (for each hearing aid) you will find the Schedule of Benefits, but only if at least 60 months have elapsed since the last time you incurred any charges payable under this provision.

Eligible Employees are eligible for weekly disability benefits.

WEEKLY DISABILITY BENEFITS. Only active Employees are eligible for weekly disability benefits. Those making contributions on their own behalf, or those receiving or who have applied to receive a disability pension from the Pension Plan, are not eligible. If:

- you become totally disabled because of an injury or Sickness that did not arise from or in connection with your occupation, and
- remain under the care of a Doctor, then
- you will receive the weekly disability benefit set out in the Schedule of Benefits.

You will not receive a weekly disability benefit for any period in which you are disabled because of alcoholism or drug abuse.

Duration of Benefits. These benefits will be payable to you beginning on:

- the ***first*** day of disability, if it is due to an ***accident,*** or
- the ***eighth*** day of disability, if it is due to a ***Sickness*** (however, if you are disabled because of Sickness for more than 30 days,

you will receive a weekly disability benefit for the first seven days paid retroactively).

No disability, whether due to accident or Sickness, will be considered as beginning more than three days before the day you first visit a Doctor. These benefits will end when the total disability ends or when you have been continuously and totally disabled for 26 weeks, whichever happens first. A new period of disability will not occur unless you were re-employed for two full weeks.

An Eligible Employee must be "disabled" before we will pay weekly disability benefits. Here's how we define "disabled."

"Disabled." You will be considered disabled during any period in which, as a result of illness or injury, you are unable to perform bargaining unit work and are not performing any other work for wage or profit. Disability because of pregnancy, childbirth, miscarriage or abortion is determined on the same basis as for any illness.

The Plan will pay up to $75 for asbestosis screening.

ASBESTOSIS SCREENING AND HEPATITIS B VACCINATIONS.

Asbestos Screening. We will pay for asbestosis screening for you and your Spouse if you have twenty years of service in a bargaining unit represented by Plumbers Local Union No. 8. The asbestosis screening shall include an X-ray and spirometry. We will pay for such screening only once for each person. The maximum we will pay for asbestosis screening is $75.00 per person.

Under certain circumstances, the Plan will reimburse you for the cost of Hepatitis B vaccinations.

Hepatitis B Vaccinations. If the following conditions are met, we will reimburse you for the cost of Hepatitis B vaccinations:

- You receive the vaccinations from CorporateCare Occupational Medicine, either at one of its offices in the Kansas City, area or as required at a job site, Employer's office, or the UA Training Center; and
- You complete the series of three Hepatitis vaccinations in the course of an eight month period.

In addition, we will reimburse you for the cost of a post-vaccination Hepatitis B titer if:

- The test is administered by CorporateCare Occupational Medicine, either at one of its offices in the Kansas City area or as required at a job site, Employer's office, or the UA Training Center; and
- The test is administered within 12 months after you receive the last vaccination.

The Plan pays a death benefit to your surviving beneficiary, if certain conditions are met.

DEATH BENEFIT. In the event of death of an active, retired or disabled Employee from any cause, we will pay a death benefit to the named beneficiary. The total amount of the death benefit is $10,000 if:

- the decedent was covered by this Plan as an Employee at the time of his death, or
- was under age 65 at the time of his death, ***and*** retired because of total and permanent disability under the Pension Plan before reaching age 60.

Otherwise, the total amount of the death benefit is $1,000. You are covered under this provision while you are covered under the Plan and for 31 days after that.

Beneficiary. The beneficiary will be the party or parties designated on the Plan's records in accordance with your election. You may change the beneficiary, without consent of any previously designated beneficiary, by a written request upon a form we provide. The change will not take effect until we receive the request for the change at the Plan's office. A trust may not be designated as a beneficiary.

If:

- any beneficiary dies before you, the interest of the beneficiary will automatically terminate;
- there is no beneficiary designated by you or living at your death, we will make a single lump sum payment to the first of the following classes in which there is at least one living person when you die:
  - your widow or widower,
  - your surviving children,
  - your surviving parents,
  - your surviving brothers and sisters, or
  - your executors or administrators.

Burial Expense. In case of your death, we may pay up to $500 of the Death benefit to the beneficiary designated by you, or to your executor or administrator, your Spouse, or any relative by blood or marriage, or to any other person we feel is equitably entitled to payment because of having incurred the expense of your burial. Production of a receipt signed by any of these persons will be conclusive evidence that all claims under this provision, to the extent of the amount showing on the

receipt, have been paid. A trust may not be designated as a beneficiary.

Limitations. Benefits are not payable under this provision on account of death:

- due to war or any act of war;
- occurring while you are engaged in service with the Armed Forces of any nation or state; or

occurring as a result of your having engaged in a criminal act.

The Plan pays Accidental Death and Dismemberment benefits in the event of your accidental death or serious injury.

ACCIDENTAL DEATH AND DISMEMBERMENT. The benefits under this provision will be paid in addition to other benefits payable under this Plan. Benefits are payable if as a result of an accident, an Employee:

- sustains bodily injuries caused directly and exclusively by external, violent and purely accidental means;
- sustains the loss of one or both limbs, the loss of sight in one or both eyes, or the loss of life;
- sustains the loss within 90 days after the injuries occur; and
- sustains the loss as a result of the injuries directly and independently of all other causes.

The benefit is payable whether or not the accident occurs during the course of your employment.

Schedule of Losses.

Life	$5,000
Two Hands	$5,000
Two Feet	$5,000
Sight of Two Eyes	$5,000
One Hand and One Foot	$5,000
One Hand and Sight of One Eye	$5,000
One Foot and Sight of One Eye	$5,000
One Hand or One Foot	$2,500
Sight of One Eye	$2,500

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the entire irrecoverable loss of sight. If more than one of the losses set forth above is suffered as the result of any one accident, payment will be made only for the one loss for which the largest amount is payable.

If you sustain a loss, as described above, then for any *subsequent* loss benefits are again payable according to the schedule set forth above for such subsequent loss.

Limitations. Benefits are not payable under this provision for any loss:

- which occurs while you are engaged in service with the Armed Forces of any nation or state, or
- for any loss resulting from or caused directly or indirectly, in whole or in part, by:
  - bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyrogenic organisms which occur with and through an accidental cut or wound), or disease or illness of any kind;
  - intentional self-destruction or any intentional self-inflicted injury, while sane or insane;
  - war or any act of war; or
  - your having engaged in a criminal act.

You must designate the beneficiary to whom we'll pay benefits in the event of your death.

Beneficiary. Your beneficiary will be the person(s) designated on the Plan's records in accordance with your election. You may change your beneficiary, without the consent of any previously designated beneficiary, in writing upon a form we provide. The change will not take effect until we receive the request for the change at the Plan's office. A trust may not be designated as a beneficiary.

If any beneficiary dies before you, the interest of the beneficiary will automatically terminate. If there is no beneficiary designated by you or living at your death, we will make a single sum payment to the first of the following classes in which there is at least one living person when you die:

- your Spouse,
- your children,
- your parents,
- your surviving brothers and sisters, or
- your executors or administrators.

EMPLOYEE ASSISTANCE PROGRAM.

Benefits. The Employee Assistance Program provides assistance with personal issues, including stress management, family and marriage concerns, grief and loss, work-related difficulties, substance abuse problems, and financial issues, for Employees and their Spouses and dependent children through short-term counseling, referral, and follow-up services with Saint Luke's Hospital of Kansas City. We will pay for up to five counseling sessions through the Saint Luke's Employee Assistance Program. Substance abuse benefits provided through the Employee Assistance Program are separate from the alcohol and drug abuse benefits provided for in the Section of this booklet concerning Major Medical Coverage.

Eligibility For Benefits. All Employees and their Spouses and dependent children will be eligible for the benefits provided under the Employee Assistance Program.

ONSITE HEALTH SCREENINGS.

Benefits. From time-to-time, the Plan may provide certain onsite health screenings through a preferred provider vendor. Benefits may include services such as biometric screenings, bloodwork, and ultrasound testing. The Plan will pay 100% of the cost of any such services.

EXCLUSIONS

The Plan does not cover certain procedures, and treatment of certain injuries or illnesses. These include certain expenses related to...

GENERAL EXCLUSIONS. In spite of other provisions of this booklet which may indicate or imply to the contrary, no payment shall be made under this Plan for any expense you incur:

- for any injury or Sickness arising from or in connection with your occupation;
- for Hospitalization or medical or surgical treatment provided without cost by or paid for by any governmental agency;

…your occupation, payments by the government, war, military service…

- because of war or any act of war;
- except as provided in the Qualified Uniformed Service provisions that begin on page 19, while engaged in service with the armed forces of any nation or state;

...treatment of injuries incurred during commission of a felony...

- as a result of having engaged in a felony;
- which neither you nor your Sponsor are required to pay;

...routine physical exams and immunizations, with limited exceptions...

- for routine physical or screening examinations or for immunizations except, we will pay for: (1) charges for routine gynecological examinations (as provided on page 29), (2) charges for mammograms ordered by a physician (as provided on page 29), (3) charges for prostate antigen testing (as provided on page 29), and (4) charges for Preventive Health Services (as provided on page 37), if payment would be made under the Plan but for the provisions of this Section;

...most cosmetic surgery...

- for cosmetic surgery, except we will pay for treatment which was necessary as the result of a birth defect or an accident, and we will pay for reconstructive surgery following a mastectomy, including reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas;

…Medicare…

- which are paid or payable under Medicare, except as provided on pages 46 through 49;

...treatments and supplies which are not Medically Necessary, blood donations, music therapy, or remedial reading...

- for services and supplies that are not Medically Necessary, whether or not recommended by a Doctor;
- for blood donations;
- for music therapy or remedial reading;

…marital counseling…	• for marital counseling;
…some transportation…	• for transportation, except local ambulance service;
..illegal or Experimental/ Investigative procedures...	• for any procedure or course of treatment which is prohibited by applicable law or which is Experimental/Investigative;
…unreasonable fees…	• for any amount that is greater than the Allowable Charge;
...a time you are not covered by this Plan...	• for any expense that is not incurred while you are covered under this Plan, unless a Plan provision specifically provides otherwise (for this purpose, an expense is incurred at the time the service or supply is actually provided);
…(except as provided) alcohol and drug abuse, mental and nervous disorders, and chiropractors…	• for the treatment of alcohol and drug abuse, except as provided on page 32; • for the treatment of any nervous or mental disorder, except as provided on pages 32 and 33; • for any expense incurred or treatment rendered by or at the direction of a chiropractor, except as provided on page 29;
…ADD…	• for treatment of Attention Deficit Hyperactivity Disorder (ADHD), sometimes referred to as Attention Deficit Disorder (ADD);
…more than five emergency room visits in a year, and	• for treatment in an emergency room once you have six or more emergency room visits in the course of a calendar year;
…certain non-PPO ambulatory surgical centers.	• for services rendered or supplies provided within a Preferred Provider Operating Area by an ambulatory surgical center that is not a Preferred Provider; provided, however, that such services or supplies shall be covered at the non-PPO rate of 55% if the ambulatory surgical center is part of the BCBSKC Preferred-Care network; • for inpatient services rendered by a Hospital or Treatment Center that is not a Preferred Provider except, we will pay: (1) for medical expenses you incur for the treatment of an emergency medical condition from a non-Preferred Provider at the co-payment percentage that would otherwise apply to PPO Providers, but only until you can be transferred to a PPO Provider without risk to your life or health; and (2) the co-payment percentage that would otherwise apply to PPO Providers if there is no PPO Provider capable of treating a particular medical condition; or

- for any injury sustained while you are engaged in the Illegal Use of alcohol or any controlled substance, drug, hallucinogen or narcotic (whether operating a motor vehicle or another illegal act). "Illegal Use" means any activity that is prohibited from being conducted while: (1) the blood alcohol content; (2) the results of other means of testing blood alcohol level; or (3) the results of other means of testing other substances meets or exceeds the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

As provided in the Health Insurance Portability and Accountability Act of 1996, no eligibility requirement of the Plan shall be given any effect to the extent that it discriminates on the basis of a health factor.

There are special exclusions which apply to persons eligible for Medicare.

EXCLUSIONS REGARDING MEDICARE. Except as provided on pages 46 and 47, no payment will be made for any of the following types of expenses, described on the pages referenced below, incurred by a person eligible for Medicare:

- Pages 17 through 18, providing extended benefits for disability;
- Pages 26 through 37, regarding major medical benefits; or
- Pages 38 through 40, regarding prescription drug expenses.

GENERAL PROVISIONS

Here's some general information you should know about the Plan.

GOVERNING LAW. The Plan is established in the State of Missouri. To the extent federal law does not apply, any questions arising under the Plan shall be determined under the laws of the State of Missouri.

We have the power to construe and interpret the Plan, and our interpretations are binding.

INTERPRETATION. We have the power to construe the Plan and to determine all questions that arise under it. Such power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Plan document. Further, to the extent that any Plan benefit is subject to a determination of medical necessity, reasonableness or the like, we will make that factual determination. Our interpretations and determinations are binding on all Employees, Retired Employees, Dependents, and their beneficiaries, and are intended to be subject to the most deferential standard of judicial review.

Generally, you cannot assign your benefits under this Plan, although under certain circumstances we may pay your health care providers directly.

ALIENATION AND ASSIGNMENT. No benefits under this Plan may be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations, except that:

- You may assign benefits to a PPO Provider of medical services or supplies for which benefits will be paid by us, and
- We may, where we deem it appropriate, direct that benefits under this Plan be paid directly to the provider of the benefits or to both you and the provider of benefits in whatever manner we authorize.

If a person who is entitled to receive a payment under the plan is, in our opinion, incapable of giving a valid receipt for the payment and if no guardian has been appointed for that person, we may make the payment to the person or persons who in our opinion have assumed the obligations of caring for the person on whose behalf the payment is made.

Special Medicaid Rule. Notwithstanding the foregoing, this Plan will honor any assignment of rights made by you or on your behalf as required by Medicaid, that is, a State plan for medical assistance approved under Title XIX of the Social Security Act. In addition, to the extent that Medicaid makes payments which this Plan has a legal liability to make, this Plan will reimburse Medicaid for those payments, but only to the extent it is required to do so by State statute.

We have the power to amend and terminate the Plan.

TERMINATION AND AMENDMENT. We have the power to terminate this Plan at any time or to amend and modify it from time to time as we deem proper, provided that such action:

- shall comply with the purposes of the Trust, and

- shall not violate any provision of a Collective Bargaining Agreement then in effect between the Union and any one or more of the Employers.

Any amendment or modification will be in writing and as formal as the Plan.

The Plumbers Local No. 8 Health and Welfare Trust Fund may be terminated at any time by written action of the Board of Trustees, but only with the consent of the Mechanical Contractors Association of Kansas City and Plumbers Local No. 8. In the event that the obligation of Employers to make contributions to the Trust Fund terminates, or on any liquidation of the Health and Welfare Fund for any reason, Trustees are to continue to apply the Fund to the purposes specified in the Trust Agreement. On disbursement of the entire assets of the Fund, the Trust Fund will terminate.

General information about how the Plan is maintained and funded.

GENERAL INFORMATION. The Plan is a self-administered group health plan:

- Maintained for the exclusive benefit of Eligible Employees and their Dependents; each of the Plan's terms, including those relating to coverage and benefits, is legally enforceable by you;

- Maintained in accordance with the Plumbers Local No. 8 Collective Bargaining Agreement;

- Funded through Employers' contributions determined through collective bargaining, except that self-payment by Employees to maintain their coverage is permitted in some circumstances. The bargaining agreements require contributions to be made at specified rates for each hour worked in covered employment. Self-payment amounts are determined by the Board of Trustees. The funds are held in trust by the Fund's custodian, BMO Global Asset Management, 3993 Howard Hughes Parkway, Suite 280, Las Vegas, Nevada 89169, until they are dispersed. The Trust is known as the Plumbers Local No. 8 Health and Welfare Fund.

TRUSTEES AND PLAN ADMINISTRATOR. The Plan's Trustees are:

The Plan has eight Trustees, four representing the Union, and four representing the Employers.

Mr. Matthew D. Harris
Union Trustee
Plumbers Local No. 8
5950 Manchester Trafficway
Suite 2
Kansas City, Missouri 64130

Mr. Kollin Knox
Employer Trustee
P1 Group, Inc.
13605 W. 26th Terrace
Lenexa, Kansas 66215

Mr. Craig L. Mullins
Union Trustee
Plumbers Local No. 8
5950 Manchester Trafficway
Suite 2
Kansas City, Missouri 64130

Mr. Bob Looman
Employer Trustee
Mechanical Contractors Association
10955 Lowell Avenue, Suite 1050
Overland Park, Kansas 66210

Mr. Charles Tarpley
Union Trustee
Plumbers Local No. 8
5950 Manchester Trafficway
Suite 2
Kansas City, Missouri 64130

Mr. Louis Saladino
Employer Trustee
Saladino Plumbing and Heating
2210 Television Place
Kansas City, Missouri 64126

Mr. Charley Wittfield
Union Trustee
Plumbers Local No. 8
5950 Manchester Trafficway
Suite 2
Kansas City, Missouri 64130

Mr. Greg Stanger
Employer Trustee
Stanger Industries
4911 Elmwood Avenue
Kansas City, Missouri 64130

You may write to the Trustees at the address given in the following item.

The Plan Administrator may be reached at the Fund Office.

The Plan Administrator is:

Ms. Danielle Wiley
5950 Manchester Trafficway
Suite 1
Kansas City, Missouri 64130
Telephone Number: (816) 361-0666

The Plan is administered by employees of the Health and Welfare Fund.

The Plan Year runs from June 1 to May 31.

Plan records are maintained in accordance with a June 1 to May 31 fiscal year.

Plan Numbers.

The Plan's tax identification number is 44-0582944, and the Plan Number is 501.

You may obtain information on bargaining agreements and contributing Employers.

COLLECTIVE BARGAINING AGREEMENTS. The Plan is maintained pursuant to Collective Bargaining Agreements with Plumbers Local No. 8. Copies of the Collective Bargaining Agreements are available, at no charge, upon written request to the Plan Administrator, and are available for examination at the Fund Office. You may request information as to whether a particular Employer is required to contribute to the Plan, and, if so, that Employer's address. The complete list of contributing Employers is also available to you, at no charge, upon written request to the Plan Administrator, and is available for examination at the Fund Office. Both Collective Bargaining Agreements and the complete list of contributing Employers will, with prior notice to the Plan Administrator, be made available to you for

examination at the principal office of the Union and at each contributing Employer establishment where at least 50 participants customarily work.

The Plan has an agent for service of legal process.

AGENT FOR SERVICE OF PROCESS. The person designated as agent for service of process for the Plan is the Plan Administrator, Danielle Wiley, at the address provided on page 61. Service of legal process may also be made upon a Plan Trustee.

GENDER AND NUMBER. In the construction of the Plan the masculine shall include the feminine and the singular the plural in all cases where those meanings would be appropriate.

PLAN NOT IN PLACE OF WORKMEN'S COMPENSATION. The Plan is not in place of and does not affect any requirement for coverage by Workmen's Compensation insurance.

EFFECTIVE DATE. The effective date of the Plan was January 1, 1975, except that the Major Medical, Death benefit and Accidental Death and Dismemberment benefits were effective June 1, 1975. The Plan is restated effective June 1, 2011.

PARTICIPANT'S RIGHTS

Under federal law you have rights to receive information about the Plan.

YOUR RIGHTS TO INFORMATION. The Employee Retirement Income Security Act ("ERISA") provides that all Plan participants are entitled to:

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

- Obtain, upon written request to the Plan's Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies;

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

You have the right to continue group health plan coverage.

- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage; and

- Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Plan fiduciaries must act prudently.

DUTIES OF PLAN FIDUCIARIES. In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for operation of the 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, our 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.

YOUR RIGHTS REGARDING CLAIM PROCESSING. If your claim for a 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.

You can enforce your rights under ERISA.

ENFORCING YOUR RIGHTS. Under ERISA, there are steps you can take to enforce the above rights. For instance, if:

- You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan's Administrator to provide the materials

and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator;

- You have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court;

- You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court (refer to Section 12 of the Claims and Appeals Procedures Appendix for a statement of the requirement that you may not bring a lawsuit against the Plan unless you fully pursue your right to appeal, as explained in that Appendix); or

- The Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the 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.

Under ERISA you may get help with your questions.

ASSISTANCE WITH YOUR QUESTIONS. If you have any questions about your Plan, you should contact the Plan's Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan's Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

The Plan and this booklet include many defined terms. The following terms have the meanings described to the right...

GENERALLY. The Plan and this booklet contain many defined terms. It's important that you understand how these terms will be used and applied. Where there is or may be an ambiguity, we have the discretion to construe and interpret any terms used in the Plan or this booklet. Remember, too, that the terms of the Plan control over anything in this booklet to the contrary.

Where the following words and phrases appear in this booklet, whether or not they are capitalized, they shall have the respective meanings set forth below, unless their context clearly indicates to the contrary:

Affordable Care Act… means the federal health care reform legislation enacted in March 2010.

Allowable Charge… means the dollar amount upon which benefits will be determined. Any amounts for covered charges (other than co-payments) you are required to pay will be based on the Allowable Charge. Benefit limits, if any, will also be based on this Allowable Charge. The Allowable Charge may vary depending on whether or not the provider is a PPO Provider and the terms of that provider's contract with BCBSKC.

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

- For Hospitals, other institutional health care facilities, Doctors or suppliers of medical goods and services which are Preferred Providers, the Allowable Charge is the lesser of:
  - the amount the provider has agreed to accept as payment in full as of the date of service; or
  - the provider's billed charges.
- For Hospitals, other institutional health care facilities, Doctors or suppliers of medical goods and services which are non-Preferred Providers inside the BCBSKC Operating Area, the Allowable Charge is the lesser of:
  - the amount the provider has agreed to accept as payment in full as of the date of service; or
  - BCBSKC's participating fee schedule amount for the same services or supplies for such provider-type, if any; or
  - the provider's billed charges.

- For Hospitals, other institutional health care facilities, Doctors or suppliers of medical goods and services which are non-Preferred Providers outside the BCBSKC Operating Area, the Allowable Charge is the lesser of:

  - the amount that the local Blue Cross and/or Blue Shield plan ("Host Blue") passes on if the claim is submitted to BCBSKC through the BlueCard PPO Program for Doctors or suppliers of medical goods and services; or

  - the amount that is based on the nationally recognized fee schedule to which BCBSKC currently subscribes if the claim is not submitted to BCBSKC through the BlueCard PPO Program; or

  - the amount the provider has agreed to accept as payment in full at the time of claim payment; or

  - the provider's billed charges.

- For BlueCard PPO Program Providers outside the BCBSKC Operating Area –

  When you obtain covered services outside of the BCBSKC Operating Area through the BlueCard PPO Program, the amount you pay for covered services is calculated on the lesser of:

  - the provider's billed charges, or

  - the negotiated price that the Host Blue passes on to BCBSKC.

  Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect average expected savings with your health care provider or with a specified group of providers. The price that reflects the average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

  Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered charges that does not reflect the entire savings realized, or expected to

be realized, on a particular claim or to add a surcharge. Should any state statutes mandate that your liability calculation method differ from the usual BlueCard PPO Program method or require a surcharge, BCBSKC would then calculate your liability for any covered charge in accordance with the applicable state statute in effect at the time you received your care.

Collective Bargaining Agreement…

means the Agreement and Contract By and Between Members of Mechanical Contractors Association and Plumbers Local Union No. 8.

Credited Hour...

An Employee will have a Credited Hour for each hour he performs bargaining unit work for an Employer for which contributions to this Fund are required by the Collective Bargaining Agreement between the Employer and the Union, each hour for which he is paid for attending meetings of the Trustees of this Plan or of the Plumbers Local No. 8 Pension Plan, each hour of work as an Employee of the Fund, and each hour of work as an Employee of the Union for which contributions to this Fund are required. If an Employee has any option as to whether his Employer will make contributions on his behalf to the Fund, he will not have a One-Month or Six-Month Eligibility Period unless he elects to have the Employer make contributions to the Fund for all of the hours he works during the one-month or six-month period. Only hours for which an Employer is required to contribute at or above the rate specified by the Trustees for Plan B (but less than the contribution rate required for Plan A) shall be Credited Hours for purposes of the Plan.

Dependent...

means any person who is:

- an Eligible Child, or
- the Spouse (excluding common law Spouse), unless legally separated,

of an Employee or Retired Employee. You should notify the Plan Office promptly when a person becomes or ceases to be a Dependent, whether because of marriage, divorce, the birth of a child, or for some other reason.

Disabled Child...

means any child who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months, provided that the physical or mental impairment began before he reached age 26.

Doctor...

means an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery.

Eligible Child...

means any person:

- who is the natural, adopted, or stepchild of an Employee or a Retired Employee; and
- who:
  - has not reached age 26; or
  - is a Disabled Child.

We will consider a child to be adopted only when he or she is adopted or placed for adoption, and only if the adoption or placement occurs before the child reaches his or her 18th birthday. A child is placed for adoption when an Employee or Retired Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption. The child's placement with an Employee or Retired Employee terminates upon the termination of such legal obligation.

In addition, under federal law, a qualified medical child support order may require a child of an Employee or Retired Employee to be covered under this Plan, even if the child is not an Eligible Child. See page 19 for a discussion of the phrase "qualified medical child support order."

Emergency Medical Condition

means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) causing serious impairment to bodily functions; or (iii) causing serious dysfunction of any bodily organ or part.

Employee...

means any person who is (1) employed by an Employer and a member of a collective bargaining unit covered by the Collective Bargaining Agreement between the Employer and the Union, or covered by a participation agreement between the Employer and the Fund, (2) an employee of the Trust Fund established by the Trust, or (3) an employee of the Union covered by a participation agreement with the Fund. A person who is a member of such a bargaining unit is not an "Employee" in a calendar month if, during that month, he:

- owns a ten percent or greater interest in the corporation that is his Employer, unless

- all Employees of the Employer are members of a collective bargaining unit covered by the Collective Bargaining Agreement between the Employer and the Union; and

- the person works with tools of the trade for at least half of the hours he works for the Employer;

- owns no interest in the corporation that is his Employer and holds an active Master Plumbers License within the Union's jurisdiction;

- is a sole proprietor; or

- is a partner who has a ten percent or greater interest in his Employer.

Employer... means any employer which is a party to the Collective Bargaining Agreement with the Union and which has agreed to make contributions to the Welfare Fund established by the Trust, and the Union and the Fund with respect to their own Employees.

Essential Health Benefits… The health benefits that are comprised of general categories and covered items/services within those categories, as defined by Section 1302(b) of the Affordable Care Act and subsequent official guidance. Essential Health Benefits include the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/ Investigative… means the criteria that BCBSKC will use to determine whether drugs, devices and medical treatment or procedures and Related Services and Supplies are Experimental or Investigative.

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

- 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

- Reliable evidence shows that the drug, device or medical treatment or procedure:

    - is provided as part of a Phase I or Phase II clinical trial, as the Experimental or research arm of a Phase III

clinical trial, or in any other manner that is intended to evaluate the maximum tolerated dose, safety, toxicity, or efficacy as its objective;

- is provided pursuant to a written protocol or other document that lists an evaluation of its safety, toxicity, or efficacy as its objective; or

- is Experimental/Investigative per the informed consent document utilized with the drug, device or medical treatment; or

- The national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time) has determined the device or medical treatment or procedure ("technology") is investigational based on the following criteria:

  - Final approval from the appropriate governmental regulatory bodies has not been received;

  - Scientific evidence does not permit conclusions concerning the effect of the technology on health outcomes;

  - The technology does not improve the net health outcome;

  - The technology is not as beneficial as established alternatives; or

  - The improvement is not attainable outside the investigational settings; or

- BCBSKC's local medical policy committee, utilizing additional authoritative sources of information and expertise, has determined that the technology does not meet the criteria listed in Subparagraph (c), or there is not sufficient evidence based peer reviewed studies published in medical literature to establish the safety and efficacy of the technology.

"Related Services and Supplies" for the purposes of this definition shall mean any service or supply that BCBSKC determines is primarily related to the application or usage of a drug, device, medical treatment or procedure that is Experimental or Investigative.

Home Health Agency... means an agency or organization federally certified as a home health agency, and primarily engaged as such. It must be duly licensed, if licensing is required by the appropriate licensing authority, to provide nursing and other therapeutic services. In addition, to be a Home Health Agency, the agency or organization must provide for full-time

supervision of its services by a Doctor or by a Registered Graduate Nurse.

Hospital... means:

- an institution constituted, licensed, and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises the facilities necessary to provide for the diagnosis and medical and surgical treatment of injury or Sickness, and which provides such treatment for compensation, by or under the supervision of Doctors on an inpatient basis with continuous 24-hour nursing service by Registered Graduate Nurses, or

- an institution which qualifies as a Hospital, a psychiatric Hospital, a tuberculosis Hospital, or a provider of services under Medicare, and which is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals.

The term "Hospital" will not include an institution which is, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospitalized... You will be considered ***Hospitalized*** if you are a registered bed patient in a Hospital upon the recommendation of a Doctor, a patient in a Hospital because of a surgical operation or a patient receiving emergency treatment or care in a Hospital for an injury within 72 hours after the injury is received.

Independent Review Organization ("IRO")… means an entity that conducts independent external reviews of adverse benefit determinations.

Married… means only two individuals joined in a legal union that is recognized as a marriage under applicable law.

Medically Necessary… means services and supplies which are determined by the Plan in the Plan's discretion to be essential to the health of a participant and are:

- appropriate and necessary for the symptoms, diagnosis or treatment of a medical or surgical condition;

- consistent with acceptable medical practice according to the national Blue Cross and Blue Shield Association's uniform medical policy (as amended from time to time);

- not primarily for the convenience of the participant, nor the participant's family, Doctor or another provider;

- consistent with the attainment of reasonably achievable outcomes; and

	• reasonably calculated to result in the improvement of the participant's physiological and psychological functioning.
Medicare...	means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.
One-Month Coverage Period...	is a calendar month in which an Employer is covered under the Plan by virtue of the operation of its One-Month Coverage Period rules, as set forth on pages 4 and 5.
One-Month Eligibility Period...	is a calendar month in which an Employee who meets the requirements for participating in the One-Month Coverage provisions of the Plan, as described on pages 4 and 5, has at least 100 Credited Hours.
Pension Plan...	means Plumbers Local No. 8 Pension Plan as from time to time amended.
Plan...	means the Plumbers Local No. 8 Health and Welfare Plan as established and maintained by the Board of Trustees, their predecessors and successors, which is summarized in this booklet.
Plan Administrator...	means that person designated in writing by us as the Plan Administrator with the duty of processing claims, and such other duties as we may from time to time direct.
Preferred Provider or PPO Provider…	means a Hospital, Doctor or other provider of medical services and supplies participating under a contract with BCBSKC through the Preferred-Care Blue network as named in the provider directory. Preferred Provider also includes providers outside the BCBSKC service area who participate in other designated Blue Cross and/or Blue Shield Plan networks in the national BlueCard PPO program. Call the toll free number on your identification card for a list of Preferred Providers participating in the BlueCard PPO Program. Such Preferred Provider will bill BCBSKC directly for covered charges you incur and will not bill you for any charges above the amount agreed upon by BCBSKC and the provider except for any copayments, coinsurance, and/or deductible amounts for which you are responsible.
Preventive Health Services…	means: • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; • Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

- With respect to women, to the extent not described in the first bullet point above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Registered Dietician... means a professional dietitian who has the right to use the title "Registered Dietitian" and the abbreviation "R.D."

Registered Graduate Nurse... means a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N."

Retired Employee... means any former Employee who is receiving a normal or early retirement pension from the Pension Plan, who is Totally and Permanently Disabled, or who is a former tradesman (or any other job classification for which an Employer has agreed to make contributions to this Plan) who has at least five Years of Service. For this purpose, a tradesman (or other job classification) has a Year of Service for a calendar year if:

- he worked in one or more bargaining units represented by the Union during the year, and

- he would, had he been eligible to participate in the Pension Plan, have earned (and retained under the Pension Plan's Rule of Parity) a Year of Service for Vesting for that year.

A former Employee who is Totally and Permanently Disabled is sometimes referred to in the Plan as a disabled Employee. Refer to pages 14 through 17 for other rules on retiree's coverage, and to pages 17 through 18 for rules on coverage of Disabled Employees.

Room and Board... includes all charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Sickness... means physical sickness, mental illness, or functional nervous disorder.

Six-Month Coverage Period... is any six-month period extending from February 1 through July 31 or August 1 through January 31 that, for an Employee, next follows a Six-Month Eligibility Period. A Six-Month Coverage Period next follows a Six-Month Eligibility Period only if it is the one beginning one month after the end of the Six-Month Eligibility Period. So the Six-Month Coverage Period that next follows the Six-Month Eligibility Period that extends from January 1, 2021 through June 30, 2021 is the one that begins August 1, 2021.

Six-Month Eligibility Period... is a six-month period beginning January 1 or July 1 of any calendar year in which:

- an Employee has at least 600 Credited Hours for one or more Employers; or
- an Employee has at least the number of Credited Hours (not to exceed 600) specified by us for a six-month period.

An Employee's hours will be credited to the calendar month for which they are reported on the Employee's Employer's monthly fringe benefit reports, even if they were in fact worked in the preceding or following calendar year.

An apprentice who is an Employee shall be deemed to have a Six-Month Eligibility Period for the six-month period immediately preceding the first February 1 or August 1 occurring after he becomes an active participant in the apprenticeship training program sponsored by the Plumbers Local No. 8 Joint Apprenticeship Committee, regardless of the number of hours credited to him in such six-month period. Pursuant to this rule, and as described in the Six-Month Coverage Period provisions on pages 5 and 6, coverage of an apprentice who is an Employee may begin on the February 1 or August 1 first following his commencement of active participation in the apprenticeship training program.

Sponsor... means an Employee or Retired Employee who has one or more Dependents.

Spouse… means only a person to whom you are legally married under applicable law.

Totally and Permanently Disabled... You will be considered ***Totally and Permanently Disabled*** during any period of total and permanent disability for which you are receiving a disability pension from the Pension Plan or on account of which you have received a lump-sum disability benefit from the Pension Plan.

A period of total and permanent disability is any period during which you are, as a result of injury or Sickness, totally unable to engage in any occupation for remuneration profit, ***but only*** if this total disability will continue for the rest of your life.

Disability does not include any injury or Sickness which:

- arose as a result of your having engaged in a criminal act, or
- is the result of service in the armed forces of any country.

	We may accept or require the determination of the Board administering the Pension Plan as sole proof of the existence and duration of total and permanent disability.
Treatment Center...	means, for purposes of the provisions concerning the treatment of nervous or mental disorders, alcoholism, and drug abuse, a facility offering a treatment program certified by the Missouri Department of Mental Health, the Kansas Department of Social and Rehabilitative Services, or like agency of another state.
Union...	means Plumbers Local No. 8, United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada.
We..	means the Board of Trustees, Plumbers Local No. 8 Health and Welfare Fund, constituted under Section 5 of the Agreement and Declaration of Trust made August 6, 1954, as restated effective June 1, 2005, and as from time to time amended, between Plumbers Local No. 8, United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada and Mechanical Contractors Association of Kansas City.
You...	means any person who is: • an Employee, • a Retired Employee, or • a Dependent, as the context indicates.

COORDINATION OF BENEFITS, SUBROGATION, REIMBURSEMENT, AND SET-OFF

The Plan is designed to help you meet the cost of injury and illness, but has rules which ensure that your benefits are not greater than your medical expenses.

INTRODUCTION. This Plan is designed to help you meet the cost of injury and illness. It is not intended to provide you with benefits greater than your medical expenses. Therefore, if you are entitled to payment of any of your medical expenses by any other person or any other plan, including your insurance company as well as the insurance company of anyone responsible for your injury or illness, this Plan will take such payments into account so that you are not paid twice for your medical expenses. (However, this Plan will not take into account payments by any individual or family insurance policy which provides only medical benefits.)

For example, if you are injured in an automobile accident, this Plan may reduce its benefits by amounts payable under your automobile insurance policy as well as any amounts payable under the automobile insurance policy of anyone who may be liable for your injuries, and we may seek reimbursement of any excess payments. And if this Plan chooses, it may bring suit directly against anyone who may be liable for your injuries. These options are called "coordination of benefits," "subrogation," "reimbursement," and "set-off."

The Plan will coordinate benefits with other plans under which you have coverage.

COORDINATION OF BENEFITS. "Coordination of benefits" ensures that two plans, including insurance policies, cannot pay for the same medical expenses. When you are covered by more than one plan, one plan is called the primary plan. That plan pays first and ignores benefits payable under other plans when determining benefits. Any other plan is called a secondary plan, which pays benefits after the primary plan. A secondary plan reduces its benefits by those payable under other plans and may limit the benefits it pays. Note that these coordination rules do not apply to individual or family insurance policies that provide only medical benefits. Special rules apply if you are covered by this Plan as an Employee and your Spouse also is covered as an Employee.

Subrogation entitles the Plan to share in an award against or settlement by any plan or person who is liable for your injury or illness.

SUBROGATION, REIMBURSEMENT, AND SET-OFF. This Plan is "equitably subrogated" to any claim you may have against any other person or plan (except any individual or family policy which provides only medical benefits) for the payment of medical expenses reimbursed by this Plan. Subrogation entitles this Plan to sue any plan or person liable for an injury or illness for which this Plan has paid benefits.

In the event this Plan pays benefits for treatment of an injury or illness for which another person or plan is or may be liable, and such other person or plan makes payment in connection with this injury or illness (regardless of how the payment is characterized) to you, a relative, a trust under which you or a relative are a beneficiary, or to any other party on your behalf or for your benefit, this Plan has an equitable right to reimbursement in an amount equal to the payment made to you or on your behalf, or the benefits paid by this Plan, whichever is less. You agree that an equitable lien attaches to any amounts recovered in connection with an injury or illness for which the Plan has paid benefits, up to the amount of the Plan's right to reimbursement. You or other parties possessing such funds will hold them in constructive trust for

the benefit of the Plan and must reimburse the Plan, out of the recovery, for all benefits it has paid.

In order to receive benefits to which the Plan's coordination or subrogation rules might apply, you must provide some information and execute documents as requested by the Plan.

DUTY OF COOPERATION; RIGHT TO OBTAIN AND RELEASE INFORMATION. You and your covered Dependents have a duty to cooperate with this Plan. This duty is a condition of coverage to which you and/or your covered Dependents might otherwise be entitled. It includes, without limitation, the following specific obligations:

- You must, at the request of the Plan Administrator or its designee, take any action, give information and assistance, and execute any documents required by this Plan to enforce its rights under this Section; and
- You must notify the Plan Administrator before you or any other person receive any funds, through settlement or otherwise, that are subject to the Plan's subrogation and reimbursement rights under this Section.

In addition, the Plan Administrator or its designee, without the consent of or notice to any person, may release to or obtain from any person any information, with respect to any person, that the Plan Administrator or its designee deems necessary to implement this Section.

EXAMPLE

Alan Ransom is an Eligible Employee and is injured in an automobile accident. This Plan will take into account benefits payable under his automobile insurance policy as well as any benefits payable under the automobile insurance policy of anyone who may be liable for his injuries. And if this Plan chooses, it may bring suit directly against anyone who may be liable for his injuries. If this Plan pays his medical expenses and then he becomes entitled to receive compensation for his injuries from an insurance company, this Plan will demand that the insurance company first pay the Plan up to the amount of benefits the Plan paid for treatment of those injuries, plus the fees the Plan paid for treatment of those injuries, plus the fees the Plan paid to its managed care network with respect to his claim.

EMPLOYEE AND SPOUSE BOTH COVERED AS EMPLOYEES BY THIS FUND.

If you are covered by this Plan as an Employee and your Spouse also is covered as an Employee, any claim you have will be coordinated. You will be paid the full benefits normally due you as an Employee. Your claim will then be processed as a Dependent claim of your Spouse. The payment resulting from this second processing will be coordinated with the payment made to you as an Employee.

If an Employee and Spouse are both covered by this Plan as Employees and their Eligible Children have claims, benefits payable for the children will be coordinated. The Eligible Child's claim will be processed and paid first as a Dependent claim of the Employee whose date of birth, excluding year of birth, occurs earlier in a calendar year. Benefits normally payable by the Plan will be paid on the Dependent claim of such Employee. The claim will then be processed and paid as

a Dependent claim of the Employee whose date of birth, excluding year of birth, occurs later in a calendar year, and benefits payable will be coordinated with the claim submitted by the other Employee.

The application of the Coordination of Benefits provision when both an Employee and Spouse are covered as members of the Fund will, in many cases, bring the total reimbursement for the family up to 100%.

DEPENDENT SPOUSES ELIGIBLE FOR OTHER HEALTH COVERAGE. In general, if your Spouse works and is eligible for medical and prescription drug coverage through his or her employer, then your Spouse is required to enroll in his or her employer's health plan, unless he or she qualifies for one of the exceptions described below. If your Spouse fails to enroll in his or her employer's plan, this Plan will pay only 20% of his or her covered medical and prescription drug expenses.

If your Spouse has already declined his or her employer's plan at the time you become eligible, the penalty reduction will not apply to his or her claims as long as he or she opts into his or her employer's plan during the next open enrollment period. The Fund has the right to request written verification from your Spouse's employer to determine his or her eligibility for coverage under his or her employer's plan.

This requirement does not mean that your Spouse cannot also be enrolled for coverage under this Plan. However, your Spouse's employer's plan will be primary for him or her and this Plan will be secondary, as explained in the part of this Section dealing with coordination of benefits.

Exception for Spouses in Part-Time Employment. The requirement described above does not apply to your Spouse if he or she works fewer than 30 hours per week, unless medical and prescription drug coverage under his or her employer's plan is provided to your Spouse free of charge.

Exception for Higher-Cost Coverage. If your Spouse works 30 or more hours per week, and his or her rate for employee-only medical and prescription drug coverage under his or her employer's plan is greater than the applicable rate for individual continuation coverage under this Plan (see page 84 for the COBRA rate for single coverage), then the requirement described above does not apply to him or her.

These rules are set out in more detail in the Coordination, Subrogation, and Reimbursement Appendix.

The Coordination, Subrogation, and Reimbursement Appendix contains a detailed discussion of these important rules regarding coordination of benefits and subrogation.

COBRA COVERAGE APPENDIX

COBRA provides coverage continuation rights in several circumstances.

This Appendix contains important information about your right to COBRA coverage, which is a temporary extension of coverage under the Plan. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This Appendix generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

You must first experience a "qualifying event."

QUALIFIED BENEFICIARIES AND QUALIFYING EVENTS. COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this Appendix. COBRA coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Employees, Spouses of Employees, and Dependent children of Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage. An individual is also eligible to elect COBRA coverage if:

- he or she is a child born to, adopted by, or placed for adoption with an Employee or former Employee while the Employee or former Employee is receiving COBRA coverage; or

- his or her coverage under the Plan is reduced or eliminated in anticipation of a qualifying event.

In the case of the first bullet point, above, so long as proper notice of the birth or adoption is provided to the Plan Administrator, an Employee or former Employee will be allowed to add any newborn or newly adopted child to that individual's COBRA coverage immediately upon the child's birth or adoption. Moreover, such children will enjoy an independent right to maintain their COBRA coverage in the event the Employee or former Employee drops his or her own COBRA coverage before the end of the maximum coverage period.

In the case of the second bullet point, above, a person whose coverage under the Plan is reduced or eliminated in anticipation of a qualifying event becomes eligible to elect COBRA coverage upon the occurrence of the qualifying event.

An individual is not eligible to elect COBRA coverage, if on the day before the qualifying event the individual is covered under the Plan by reason of another person's election of COBRA coverage, and the individual is not already eligible under the provisions of this subsection.

If multiple individuals are eligible to elect COBRA coverage due to the same qualifying event, each individual has a separate right to elect COBRA coverage.

An **Eligible Employee** will become a qualified beneficiary if he or she would lose coverage because either of the following qualifying events occur:

- The termination of an Eligible Employee's employment; or
- A reduction in an Eligible Employee's work hours below the minimum needed to maintain his or his Dependent's eligibility under the Plan.

A **Dependent Spouse** of an Eligible Employee or Retired Employee will become a qualified beneficiary if he or she would lose coverage under the Plan because any of the following qualifying events occur:

- The death of an Eligible Employee or Retired Employee;
- The termination of an Eligible Employee's employment;
- A reduction in an Eligible Employee's work hours below the minimum needed to maintain his or his Dependent's eligibility under the Plan; or
- The divorce or legal separation of an Eligible Employee or Retired Employee.

A **Dependent child** of an Eligible Employee or Retired Employee will become a qualified beneficiary if he or she would lose coverage under the Plan because any of the following events occur:

- The death of the Eligible Employee or Retired Employee;
- The termination of an Eligible Employee's employment;
- A reduction in an Eligible Employee's work hours below the minimum needed to maintain his or his Dependent's eligibility under the Plan;
- The divorce or legal separation of an Eligible Employee or Retired Employee; or
- A child's ceasing to qualify as an Eligible Child under the Plan.

In addition, when an Employee fails to return to work for his or her Employer at the conclusion of a period of leave authorized under the Family and Medical Leave Act, a "qualifying event" occurs on the last day of the FMLA leave.

Children born or adopted during a former Employee's COBRA coverage are eligible for COBRA coverage upon proper notice.

COBRA COVERAGE OF NEWBORN AND NEWLY ADOPTED CHILDREN. A child born to, adopted by, or placed for adoption with a former Employee while the former Employee has COBRA coverage will be allowed to enroll for COBRA coverage as well. So long as the former Employee notifies the Fund Office within 60 days of the birth, adoption, or placement, the Employee will be allowed to add the new child to the Employee's COBRA coverage immediately upon the child's birth or adoption.

COBRA coverage normally continues for 18 to 36 months.

TERM OF COBRA COVERAGE. COBRA coverage does not continue indefinitely. How long it lasts depends on the type of "qualifying event," and when it occurs.

If coverage would be lost due to	COBRA coverage may extend for up to
Termination of an Employee's employment or reduction in hours	18 months

NOTE: This 18-month period is extended to 30 months for Employees who are working in a bargaining unit represented by the Union, or are ready, willing and available for such work.

If coverage would be lost due to	COBRA coverage may extend for up to
Employee's or Retiree's death, Medicare entitlement, or divorce or legal separation; or a child's ceasing to satisfy the definition of Eligible Child	36 months
Termination of an Employee's employment or reduction in hours, and the person eligible for COBRA coverage was disabled (as described below) on such date or within the first 60 days of his COBRA coverage	29 months

A special rule applies if an Employee becomes entitled to Medicare within 18 months prior to the termination of employment or reduction in work hours below the minimum needed to maintain his or her Dependent's eligibility under the Plan. In such a case, the Employee's subsequent termination of employment will entitle his Dependents to continuation coverage that extends until the later of (a) 18 months after the Employee's termination of employment or reduction in work hours,

or (b) 36 months after the Employee's Medicare entitlement. In no case will any cumulative period of continuation coverage extend beyond 36 months.

Special rules apply in the case of successive qualifying events.

SUCCESSIVE QUALIFYING EVENTS.

If

- your Dependents elect COBRA coverage following your termination of employment or reduction in work hours,

and

- another qualifying event occurs during that continuation period,

a special rule applies. Those Dependents may elect to continue their coverage for up to **36 months**, rather than only 18 months. This 36-month period will be determined by adding an additional 18 months to the original 18-month coverage period. Should this situation arise, Dependents will be given another opportunity to elect or decline continued coverage for the remainder of the 36-month period. A qualified beneficiary (or his or her representative) must notify the Plan Administrator within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator, Plumbers Local No. 8 Health and Welfare Fund, 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130.

Social Security Disability may also extend COBRA continuation coverage.

SOCIAL SECURITY DISABILITY. A special rule applies if an Employee or his Dependent is determined to have been disabled. The disability has to have started at some time before the 60th day of COBRA coverage attributable to an Employee's termination of employment or reduction in hours and must last at least until the end of the 18-month period of continuation coverage. Subject to the conditions described in this and the following paragraph, such a disabled individual (and all other members of that individual's family who are receiving continuation coverage due to the same qualifying event) may purchase up to 11 more months of coverage — for a total of 29 months.

The cost of such coverage may be higher, however, during these last 11 months than during the initial 18 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual's initial 18 months of continuation coverage. One of the persons eligible for this extension must then notify the Plan Administrator of the Social Security Administration's disability determination within 60 days after the later of (a) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event, or (b) the date the disability determination is issued (and within the individual's first 18 months of continuation coverage). This notice must be sent to the Plan Administrator, Plumbers

Local No. 8 Health and Welfare Fund, 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130.

If the Social Security Administration later determines that an individual described in the preceding paragraph is no longer disabled, that individual must notify the Plan Administrator within 30 days after the date of that second determination. This notice must be sent to the Plan Administrator, Plumbers Local No. 8 Health and Welfare Fund, 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130. The individual's right to the 11-month extension of continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued.

Eligibility might depend on giving notice to the Fund Office.

DUTY TO NOTIFY THE FUND OFFICE REGARDING QUALIFYING EVENTS. In some cases, the Plan's obligation to offer COBRA coverage is contingent upon the Fund Office's receipt of notice of the qualifying event within a given period of time.

If the Qualifying Event is:	Then the Office must get notice:
Divorce or legal separation, a child ceasing to meet the definition of Eligible Child, or the birth, adoption or placement for adoption of a former Employee's new child	From the qualified beneficiary within 60 days after the qualifying event
An Eligible Employee's or Retired Employee's death or an Eligible Employee's termination of employment, or reduction in hours	From the Employer within 30 days after the qualifying event

This notice must be sent to the Plan Administrator, Plumbers Local No. 8 Health and Welfare Fund, 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130. If such notice is not timely received, these COBRA coverage provisions will not apply.

You pay for COBRA coverage.

COST OF COBRA COVERAGE. The monthly charge for continued health coverage, or health plus dental and vision coverage, will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. In their discretion, however, the Trustees may require smaller monthly payments by former Employees who are actively seeking work in a bargaining unit represented by the Union.

We may subsidize your cost of COBRA coverage in some cases.

In the event an Employee in this situation is eligible for continued coverage because he cannot meet the 600-hour requirement described on page 6 of this booklet, and does not have sufficient hours in his hour bank to maintain coverage under the rules described on that page 6, the rules under the heading "Subsidized Self-Payments to Maintain

Coverage" on pages 86 through 88 will apply to determine the applicable subsidized rate for that Employee. The special subsidized rates will not apply to Employees who are continuing coverage up to an additional 12 months, as provided in the special Note under "Term of COBRA Coverage on pages 80 and 81.

You may purchase health, or health plus dental and vision coverage.

BENEFITS SUBJECT TO CONTINUATION. The health coverage or health plus dental and vision coverage that you and your Dependents are entitled to continue will be the same as that provided to similarly situated people. For example, if you are a former Eligible Employee, the coverage will be the same as that offered to Eligible Employees. If you are a Retired Employee, the coverage will be the same as that offered to Retired Employees who are not on COBRA coverage.

Except as provided elsewhere in the Plan, the Plan's death benefit, accidental death and dismemberment benefit, and weekly disability benefits are not available under these COBRA rules. Retired Employees and their Dependents are not entitled to continuation of the Plan's death benefit.

How you elect COBRA coverage.

ELECTING COBRA COVERAGE. When the Fund Office is timely notified of a qualifying event:

- the Fund Office will send the individual eligible for COBRA coverage an application for COBRA coverage within **30 days** after the Fund Office's receipt of the notice.

If that individual wishes to purchase COBRA coverage, he or she must;

- complete the application and return it within **60 days** from the ***later of:*** (a) the date it is sent to him, or (b) the date his coverage would otherwise terminate.

Special COBRA rights, including a second opportunity to elect COBRA apply to Employees who have been terminated or experienced a reduction of hours and who qualify for trade adjustment assistance under the Trade Act of 1974. An Employee who believes he or she might qualify for assistance under the Trade Act of 1974 should contact the Plan Administrator.

How and when you pay for COBRA coverage.

PAYING FOR COBRA COVERAGE. If you elect continued coverage, you must make payment for the period from the date coverage would otherwise terminate. If you wait the full 60 days to make the election, you still must pay for the coverage provided between the date the coverage would otherwise have terminated, and the date of your election, **even if you have no claims in that period.**

Payments for	Must be Made
The period of coverage between the date coverage would otherwise have been lost, and the date of the election	Within 45 days after the date the election is made
Payments for	Must be Made
Subsequent months of coverage	By the 1st day of the month for which coverage is to be provided, subject to a 30-day grace period

If an Employee, former Employee, or covered Dependent makes payment for COBRA coverage of an amount that is less than the amount due for that month's premium due but greater than ninety percent (90%) of the amount of the premium due, the Plan will notify the individual of the deficiency. To maintain coverage the individual must pay that deficiency within 30 days of the date the Plan notifies the individual of it.

As of August 1, 2021, the single and family rates for medical, dental, and vision coverage were $585 and $1,466.

Special rules apply in the case of Disabled Employees.

DISABLED EMPLOYEES.

If

an Employee's qualifying event results from a disability for which the Employee is entitled to disability coverage under the rules described on pages 16 through 18 of this booklet.

then

the period of continuation coverage to which the Employee is entitled under this provision shall be measured from the date the Employee's disability coverage under the rules with the caption "Continuing Coverage While Totally Disabled" on pages 17 through 18 begins, *not from the date it ends.*

The result will be that so long as the disability continues, the 29 months of disability coverage provided under the rules on pages 17 through 18 will replace the continuation coverage provided under this provision.

EXAMPLE

Jason Jennings, an Employee, would lose coverage under this Plan on August 1, 2021, due to a reduction in hours resulting from a disability for which he is entitled to a disability pension from the Pension Plan. His coverage under the rules on pages 17 through 18 would continue for at least 29 months after that August 1, provided he remained Disabled and coverage is not otherwise terminated under the rules on those pages. Assume that coverage under the rules on those pages ends 29 months later, on December 31, 2023. Unless

Jason is entitled to and does make payments for Retired Employee coverage, his continued coverage under this Plan would then terminate; he would not be entitled to any additional COBRA coverage under this provision.

COBRA coverage terminates early in certain cases.

TERMINATION OF COBRA COVERAGE. COBRA coverage is subject to automatic termination upon the occurrence of any of the following events:

- If a required payment is not made before the end of the 30-day grace period as described above;
- If an individual becomes covered under another employer group health plan (as an Employee or otherwise);
- If after an individual elects COBRA coverage he or she becomes entitled to Medicare benefits;
- If the last Employer to contribute to the Plan on behalf of the individual ceases to be required to contribute to the Plan and either:
  - makes group health plan coverage available to a class of its employees formerly covered under the Plan; or
  - starts to contribute to another multiemployer plan that is a group health plan with respect to a class of its employees formerly covered under the Plan.

  For purposes of this rule:
  - the last Employer to contribute on behalf of a Retiree is the last Employer to have employed the Retiree and to have been obligated to make contributions on his behalf; and
  - the last Employer to contribute on behalf of a Dependent is the last Employer to have employed and to have been obligated to make contributions on behalf of the Employee whose participation in the Plan permitted the Dependent to be covered; or
- If coverage has been extended for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

In some cases we'll subsidize your COBRA premium.

SUBSIDIZED SELF-PAYMENTS TO MAINTAIN COVERAGE.

The rules which follow provide *subsidized* monthly COBRA rates which may enable you to continue your coverage in the event you:

- were working or seeking work in a bargaining unit, and
- cannot meet the 600 hour requirement described on page 6 of this booklet.

NOTE: If the sum of the number of hours you worked during the relevant six-month period beginning January 1 or July 1 and the number of hours you have left in your hour bank equals or exceeds 600 hours, you will not need to take advantage of this provision.

You must be working or seeking work in a bargaining unit represented by the Union, or doing both of these things, for these subsidies to apply to you.

Requirements. You may take advantage of this subsided self-payment rate for coverage during a calendar month only if, throughout that month:

- you are working in a bargaining unit represented by the Union;
- you are seeking such work; or
- you have some combination of these two.

Except for the subsidized rates, each of the rules on continuation of coverage under COBRA described in this Appendix will apply.

Generally, a subsidized rate will apply to you for a Six-Month Coverage Period.

Duration of Subsidized Rate. A particular subsidized rate will continue in effect for you for a Six-Month Coverage Period, assuming you meet the other requirements of these special rules concerning subsidized COBRA rates.

The amount you pay depends on the hours in your hour bank and the hours you worked during the immediately preceding six-month period.

Your Hours Worked and Hour Bank Balance. To determine the amount of your self-payment rate under this Section, we will take into account the hours remaining in your hour bank and the hours you actually worked during the immediately preceding six-month period beginning January 1 or July 1. For example, if you have 200 hours remaining in your hour bank and you worked for 200 hours during that six-month period, the entire 200 hours would be withdrawn from the hour bank so that the total number of hours that will be taken into account on your behalf for that six-month period would be 400, the sum of your hour bank balance and hours you worked during the six-month period.

Here's how we calculate your COBRA subsidy.

Computing the Monthly Self-Payment Rate. If the sum of:

- the hours you worked in the preceding six-month period beginning January 1 or July 1, and
- the hours in your hour bank

is insufficient to meet the 600 hour prerequisite for a six-month period beginning January 1 or July 1, the self-payment you may make to continue coverage will be computed as follows.

First, we take the *difference* between that sum, and the 600 hours you would need for a six-month period beginning January 1 or July 1, and make it the *numerator* of a fraction, the denominator for which is 600.

Then, we multiply that fraction by the actual cost to the Plan for family or single coverage, whichever is relevant, to determine your contribution rate.

Thus, the greater sum of your hours worked and your hour bank balance, the larger our subsidy, and the smaller payment you must make. In no event, however, will any monthly payment determined under this method be greater than 50% of the otherwise applicable COBRA rate.

Special rules apply if a subsidized rate must be determined for successive Six-Month Coverage Periods.

Successive Six-Month Coverage Periods. If, after completing one Six-Month Coverage Period during which the special subsidized COBRA rate applied to you, you again meet the requirements for application of this special subsidy rule, you may again take advantage of a subsidized COBRA rate. The new rate which will apply to this, and to any subsequent Six-Month Coverage Period in which you qualify, will be recalculated under the formula described above at the beginning of each successive Six-Month Coverage Period.

Here's an example of how these rules work:

EXAMPLE

Continuing the example given above, if the hours you worked during the preceding six-month period beginning January 1 or July 1 and your hour bank balance total 400, you are 200 hours short of the 600 hour requirement. The numerator of the fraction, therefore, will be 200; the denominator will be 600 for a multiplier of one-third.

If the cost to the Plan were $1,195 per month for family coverage, the multiplier of one-third would be applied to the cost of $1,195, to equal a subsidized monthly COBRA rate of $398.33. Accordingly, you will pay $398.33 a month to maintain coverage for you and your family, for the next Six-Month Coverage Period beginning August 1 or February 1.

If you have another six-month period beginning January 1 or July 1 during which you worked 450 hours, and you remain entitled to COBRA continuation coverage, you will qualify for another six months of coverage with a subsidized COBRA rate. You will be 150 hours short of the 600 hour requirement (note that you will have no hour bank balance because all of your hours would have been withdrawn during the last six-month period beginning January 1 or July 1.) The numerator of the fraction will therefore be 150. The denominator is always 600, for a multiplier of one-fourth. You would thus pay one-fourth of the applicable family rate to maintain coverage for the next Six-Month Coverage Period.

Please feel free to call the Plan Administrator to determine the subsidized COBRA rate which would apply in your situation.

QUESTIONS. COBRA coverage is administered by the Plan Administrator. If you have any questions about COBRA coverage, please contact the Plan Administrator at 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130, (816) 361-0666, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

CLAIMS AND APPEALS PROCEDURES APPENDIX

This chart gives You an outline of some of the key points of the Plan's claims and appeals procedure. A copy of the complete procedure is detailed below.

Claims Procedures			
	Where to File Claims	**Filing Deadlines**	**Notification of Benefit Determination**
Urgent Care Claim*	Plumbers Local No. 8 Health and Welfare Fund 5950 Manchester Trafficway, Suite 1 Kansas City, MO 64130 (816) 361-0666	Before expense is incurred	Generally, not later than 72 hours after receipt of the claim
Pre-Service Claim*			Not later than 15 days after receipt of the claim (may be extended an additional 15 days)
Post-Service Claim		Within one year of the later of the date the expense was incurred or the date you were discharged from the Hospital	Not later than 30 days after receipt of the claim (may be extended an additional 15 days)
Disability Claim			Not later than 45 days after receipt of the claims (may be extended an additional 60 days)
Appeals Procedures			
	Where to File Internal Appeals	**Filing Deadlines**	**Notification of Internal Appeal Determination**
Urgent Care Internal Appeal*	Plumbers Local No. 8 Health and Welfare Fund 5950 Manchester Trafficway, Suite 1 Kansas City, MO 64130 (816) 361-0666	Before expense is incurred	Not later than 72 hours after receipt of the appeal
Pre-Service Internal Appeal*			Not later than 30 days after receipt of the appeal
Post-Service Internal Appeal		Within 180 days following receipt by you of an adverse benefit determination	Not later than five days after the 1st Trustee meeting following receipt of the appeal (may be extended to five days after the 3rd Trustee meeting)
	Where to File External Appeals	**Filing Deadlines**	**Notification of External Appeal Determination**
External Appeals** (For decisions involving medical judgment or rescission of coverage only)	Plumbers Local No. 8 Health and Welfare Fund 5950 Manchester Trafficway, Suite 1 Kansas City, MO 64130 (816) 361-0666	Within 4 months from the date of receipt of the denial notice	Within 45 days after the IRO receives the external review request

* Urgent care and pre-service claims only involve expenses for which the Plan requires approval before the expenses are incurred.

** See Section 23 of this Appendix for the circumstances under which you may request an expedited external review.

The Plan Administrator decides claims.

1. Deciding the Claim. A claim is a request for a plan benefit made by a client consisting of a fully completed claim form provided by the Plan Administrator or her designee and appropriate documentation of an incurred expense, or, in the case of an urgent care claim, either orally or on such a form. A claimant is a person who participates or claims to participate in the Plan, or a PPO Provider if (i) a participant assigned his or her appeal rights in writing to the PPO Provider, or (ii) the Plan provided a voluntary predetermination approval of a service based on medical necessity, but denied the claim for benefits post-service. For such a form to be considered, the claimant must mail or deliver it annually, completed and executed, to the Plan Administrator at the following address:

Plumbers Local No. 8 Health and Welfare Fund
5950 Manchester Trafficway, Suite 1
Kansas City, MO 64130

Urgent care claims can be phoned in.

For an urgent care claim to be considered, it must be communicated to the Plan Administrator, using the following phone number:

(816) 361-0666

The Plan Administrator shall decide the claim. In the case of a claim for disability benefits, the Plan Administrator will take additional steps to ensure the independence and impartiality of the persons involved in deciding the claimant's claim or appeal. None of the following constitutes a claim:

(a) The presentation of a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the Plan;

(b) A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan; or

(c) Interactions between participants and Preferred Providers under arrangements by which the providers provide services or products at a predetermined cost to participants and with respect to which the providers exercise no discretion on behalf of the Plan.

Generally the Plan Administrator will decide an urgent care claim within 72 hours.

2. Urgent Care Claims. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Post-service claims are not claims involving urgent care.

Except as provided below in this Section 2 of this Appendix, whether a claim is a "claim involving urgent care" within the meaning of this Section is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care," within the meaning of this Section, shall be treated as a "claim involving urgent care" for purposes of this Section. The nature of a claim or a request for review of an adverse benefit determination shall be judged as of the time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and the request for review was filed, the claim no longer involves urgent care. The Plan Administrator may request specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim. A post-service claim never constitutes a claim involving urgent care. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this Section shall be made in accordance with the provisions of Section 9 of this Appendix. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

In most cases, the Plan Administrator will decide pre-service claims within 15 days.

3. Pre-Service Claims. The term "pre-service claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining medical care. In the case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a

reasonable period of time appropriate to medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this Section shall be made in accordance with Section 9 of this Appendix.

If you fail to follow the Plan's pre-service claim procedures you will be notified as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure.

4. Failure to Follow Pre-Service Claim Procedures. In the case of a failure by a claimant to follow the Plan's procedures for filing a pre-service claim, within the meaning of Section 3 of this Appendix, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant. This Section shall apply only in the case of a failure that:

(a) Is a communication by a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(b) Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

These procedures apply to a reduction or termination of an ongoing course of treatment approved by the Plan.

5. Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with the provisions of Section 9 of this Appendix, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Moreover, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such

claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance with the provisions of Section 9 of this Appendix, and the appeal shall be governed by Sections 14, 15 or 16 of this Appendix, as appropriate.

The Plan Administrator will typically notify you of an adverse decision in the case of a post-service claim not later than 30 days after receipt of the claim.

6. Post-Service Claims. The term "post-service claim" means any claim for a benefit under the Plan that is not a pre-service claim, as provided in Section 3 of this Appendix. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Section 9 of this Appendix, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary, due to a failure of a claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Generally, you will be notified of the Plan Administrator's adverse decision in the case of a disability claim not later than 45 days after receipt of the claim.

7. Disability Claims.

(a) In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant, as provided in Section 9 of this Appendix, of the Plan Administrator's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan Administrator. This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that

prevent the decision on the claim, and the additional information needed to resolve those issues. The claimant should be afforded at least 45 days within which to provide the specified information.

(b) If the Plan Administrator does not strictly adhere to the Plan's claims and appeal procedures, the claimant will be "deemed" to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan Administrator asserts that it has "substantially complied" with those procedures, and the claimant will be able to initiate any available external review process or remedies available under ERISA or under state law, unless the violation was all of the following:

(i) De minimis (i.e., a minor violation);

(ii) Non-prejudicial (i.e., the violation does not cause, and is not likely to cause, harm or prejudice to the claimant);

(iii) Attributable to a good cause or matters beyond the Plan's control;

(iv) In the context of an ongoing good-faith exchange of information between the claimant and the Plan; and

(v) Not reflective of a pattern or practice of non-compliance by the Plan.

In addition, the claimant may request a written explanation of the Plan's basis for asserting that it meets this standard. The Plan must provide the explanation within 10 days of the claimant's request. If the court rejects the claimant's request for immediate review on the basis that the Plan met this standard, the Plan shall consider the claim as re-submitted upon the Plan receiving notice of such rejection and shall notify the claimant of the re-submission.

Filing a claim generally triggers the running of periods of time under these procedures.

8. Calculating Time Periods for Claims. For purpose of Sections 2 through 7 of this Appendix, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures set forth in Section 1 of this Appendix, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended as permitted by Sections 3, 6, 7 of this Appendix due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

The Plan Administrator will provide you with written or electronic notification of any adverse benefit determination.

9. Notification of the Decision. The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulations issued by the Department of Labor under ERISA. The notification shall set forth, in a culturally and linguistically appropriate manner, and in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the claim involved (including the date of service, health care provider, claim amount (if applicable), and a statement describing the availability upon request of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);

(b) The specific reason or reasons for the adverse determination, including a description of the Plan's standard, if any, that was used in denying the claim;

(c) Reference to the specific plan provisions on which the determination is based;

(d) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(e) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including information regarding how to initiate an appeal; and including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination of appeal;

(f) Information about the availability of, and contact information for, any office of health insurance consumer assistance established under applicable law to assist individuals with the internal claims and appeals and external review process;

(g) In the case of an adverse benefit determination with respect to a claim involving health benefits,

(i) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or

(ii) If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(i) In the case of notification of an adverse determination for disability claims:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(B) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(ii) If an internal rule, guideline, protocol, standard, or other similar criterion was relied upon in making the adverse determination, either the specific internal rule, guideline, protocol, standard, or similar criterion relied upon in making the adverse determination; or a statement that such a rule, guideline, protocol, standards, or other similar criterion of the Plan do not exist;

(iii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical

circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) A statement that the claimant is entitled to receive, upon 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 (whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to regulations issued under ERISA by the Department of Labor); and

(j) In the case of a final internal adverse benefit determination, a discussion of the decision.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this Section may be provided to the claimant orally within the timeframe prescribed in Section 2 of this Appendix, provided that a written or electronic notification in accordance with this Section is furnished to the claimant not later than three days after the oral notification.

You may have another person act for you in pursuing a claim or appeal.

10. Authorized Representative. An authorized representative of the claimant may act on his or her behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan Administrator may require, as a prerequisite to dealing with a representative, that the claimant verify in writing authority of the representative to act on behalf of the claimant. In the case of a claim involving urgent care, a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law, with knowledge of the claimant's medical condition, may act as the authorized representative of the claimant. An assignment of benefits by a claimant to a health care provider does not constitute the designation of an authorized representative. A claimant may contact the Missouri Department of Insurance for assistance with an appeal at (800) 726-7390.

Consistency requirements apply.

11. Consistency. The Trustees, the Plan Administrator, or both, shall conduct or have conducted on their behalf periodic reviews to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the Plan's provisions have been applied consistently with respect to similarly-situated claimants.

You may appeal an adverse benefit determination to the Trustees.

12. Deciding the Internal Appeal. A claimant may appeal an adverse benefit determination to the Trustees by mailing or delivering to the Plan Administrator a written notice of appeal. No action at law or in equity shall be brought to recover any benefit under the Plan until the rights to appeal described in this Section 12 have been exercised and the benefits requested in the appeal have been denied in whole or in part. The claimant may submit written evidence, testimony, comments,

documents, records, or other information relating to the claim for benefits to the Plan Administrator. The Plan Administrator shall provide to the claimant, upon 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. Whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with standards issued by the Department of Labor. The Trustees shall decide the appeal. (References to the Trustees shall include any committee of two or more Trustees authorized to decide an appeal.) The Trustees' decision shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator shall provide to a claimant, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale for a denial of the internal appeal. The claimant shall have a reasonable opportunity to respond to such new evidence or rationale. The Trustees will not, however, consider a claimant's appeal unless the Plan Administrator receives it within 180 days following receipt by the claimant of a notification of an adverse benefit determination. The appeal will be considered by the Trustees without deference to the original decision made by the Plan Administrator. In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, investigational, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan Administrator shall, when requested to do so by a claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged for purposes of a consultation under this Section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is subject of the appeal, nor the subordinate of any such individual.

There are special procedures for expediting internal appeals of urgent care claims.

13. Internal Appeal of Urgent Care Claims. In the case of a claim involving urgent care:

(a) A request for an expedited internal appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

These rules describe how quickly internal appeals are to be decided.

14. Notification of the Decision on Internal Appeal; Urgent Care Claims. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with the provisions of Section 17 of this Appendix, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

15. Notification of the Decision on Internal Appeal; Pre-Service Claims. In the case of a pre-service claim that is not a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with Section 17 of this Appendix, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

16. Notification of the Decision on Internal Appeal; Post-Service, Disability, and Other Claims. In the case of a claim other than an urgent care or pre-service claim, the Trustees will decide a claimant's appeal no later than the first meeting following the Plan Administrator's receipt of the appeal, unless the Plan Administrator received the appeal within 30 days prior to that meeting, in which case the Trustees will decide the claimant's appeal no later than the second meeting following receipt of the request for review. If special circumstances require a further extension of time for processing, the Trustees will decide the appeal no later than the third meeting following receipt by the Plan Administrator of the claimant's request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant, in accordance with Section 17 of this Appendix, of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

The Plan Administrator will provide you with a written or electronic notification of the decision on your internal appeal.

17. Content of Notification of the Decision on Internal Appeal. The Plan Administrator shall provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by the Department of Labor by regulations issued under ERISA. In the case of an adverse benefit determination, the notice shall set forth, in a culturally and linguistically appropriate manner, and in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the claim involved (including the date of service, health care provider, claim amount (if applicable), and a statement describing the availability upon request of the diagnosis code and

its corresponding meaning and the treatment code and its corresponding meaning);

(b) The specific reason or reasons for the adverse determination, including a description of the Plan's standard, if any, that was used in denying the claim;

(c) Reference to the specific plan provisions on which the determination is based;

(d) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including information regarding how to initiate an appeal; and including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; including, in the case of a disability claim, a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(e) Information about the availability of, and contact information for, any office of health insurance consumer assistance established under applicable law to assist individuals with the internal claims and appeals and external review process;

(f) In the case of an adverse benefit determination with respect to a claim involving health benefits,

(i) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or

(ii) If the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited external review process applicable to such claims;

(h) In the case of notification of an adverse benefit determination for a disability claim:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(B) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(C) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(ii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) If an internal rule, guideline, protocol, standard, or other similar criterion was relied upon in making the adverse determination, either the specific internal rule, guideline, protocol, standard, or similar criterion relied upon in making the adverse determination; or a statement that such a rule, guideline, protocol, standards, or other similar criterion of the Plan do not exist; and

(i) In the case of a final internal adverse benefit determination, a discussion of the decision.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this Section 17 may be provided to the claimant orally within the timeframe prescribed in Section 2 of this Appendix, provided that a written or electronic notification in accordance with this Section is furnished to the claimant not later than three days after the oral notification.

Filing an internal appeal generally triggers the running of periods of time under these procedures.

18. Calculating Time Periods on Internal Appeal. For purposes of Sections 14, 15 and 16 of this Appendix, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with Section 12 of this Appendix, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to Section 16 of this Appendix due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

19. Extensions of Time. A claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a claim or an appeal.

If the Trustees deny your claim for benefits, you may be eligible to request an external review.

20. Deciding the External Appeal. If the Trustees deny a claimant's internal appeal, the claimant shall have four months from the date of receipt of the denial notice to request external review. External review is limited to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or (2) a rescission of coverage. Requests for external review should be sent to the Plan Administrator. The Plan Administrator will complete a preliminary review of the claimant's external review request within five business days after receiving the request. The preliminary review will determine whether:

(a) The claimant is or was covered under the Plan when the health care item or service was requested;

(b) The claimant was covered under the Plan when the health care item or service was provided (for retroactive reviews);

(c) The benefit denial involves either medical judgment or rescission of coverage;

(d) The claimant has exhausted the Plan's internal appeals process; and

(e) The claimant has provided all the information and forms needed to process the external review.

The Plan Administrator will provide you with a written notification of the Plan's

The Plan Administrator will provide the claimant with written notice of the Plan's preliminary review determination within one business day after completing the review. If the claimant's request is complete but not eligible for external review, the Plan Administrator will provide the claimant with the reasons for ineligibility. If the claimant's request is incomplete, the Plan Administrator will provide the claimant with a notice

preliminary review determination.

that describes the information or materials needed to complete the request. The claimant will then have the opportunity to complete the claimant's external review request within the four-month filing period or, if later, 48 hours after receipt of the notice.

If your request for external review is approved, the Plan Administrator will forward your claim to an accredited IRO to perform the external review.

Within five business days of approving the claimant's request for external review, the Plan Administrator will forward all documents and any information considered in denying the claimant's benefits claim to an accredited Independent Review Organization ("IRO") to perform the external review. The IRO will provide the claimant with written notice of the request's eligibility and acceptance for external review. The claimant may then submit additional information in writing to the IRO within ten business days following receipt of the notice. The IRO will forward this additional information to the Plan Administrator within one business day. The Plan Administrator will then reconsider the initial benefits denial, though such reconsideration will not delay the external review. If the Plan Administrator decides to reverse the initial decision to deny the claimant's benefits claim, the external review will be terminated and the Plan Administrator will notify the claimant and the IRO within one business day after making this decision.

If the Plan Administrator does not reverse the initial decision to deny the claimant's benefits claim, the IRO will continue its external review. In addition to any information that the claimant or the Plan Administrator provides, the IRO will consider the following items in reaching its decision:

(a) The claimant's medical records;

(b) The recommendation of the attending health care professional;

(c) Reports from appropriate health care professionals and other documents submitted by the claimant, the Plan Administrator, or the claimant's treating provider;

(d) The governing plan terms;

(e) Appropriate practice guidelines, which include applicable evidence-based standards;

(f) Any applicable clinical review criteria developed and used by the Plan Administrator; and

(g) The opinion of the IRO's clinical reviewer.

A claimant may contact the Missouri Department of Insurance for assistance with the external review process at (800) 726-7390.

The IRO will provide you with a

21. Notification of the Decision on External Appeal. Within 45 days after the IRO receives the external review request, it will provide

written notification of its final external review decision.

notice to both the claimant and the Plan Administrator of its final external review decision. If the IRO's decision is to reverse the Plan Administrator's benefits denial, the Plan will immediately provide coverage or payment for the claim.

22. Content of Notification of the Decision on External Appeal. The IRO shall provide the claimant and the Plan Administrator with written or electronic notification of the IRO's final external review decision. Any electronic notification shall comply with the standards imposed by the Department of Labor by regulations issued under ERISA. The notice shall set forth, in a manner calculated to be understood by the claimant:

(a) A general description of the reason for the external review request, including information sufficient to identify the claim;

(b) The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision;

(c) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;

(e) A statement that the IRO's determination is binding, unless other remedies are available to the plan or claimant under state or federal law;

(f) A statement that judicial review may be available to the claimant; and

(g) The phone number or other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

In certain circumstances, you may request an expedited external review.

23. Expedited External Review Procedures. If the Trustees deny a claimant's claim for benefits, the claimant may request expedited external review when the claimant receives:

(a) A benefits denial involving the claimant's medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the claimant's life or health or jeopardize the claimant's ability to regain maximum function and the claimant has filed an expedited internal appeal request; or

(b) A final internal benefits denial involving (1) the claimant's medical condition where the timeframe for completing standard external review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function, or (2) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Requests for expedited external review should be sent to the Plan Administrator. Immediately upon receipt of the external review request, the Plan Administrator will assess whether the request meets the reviewability requirements applicable under the standard external review process. The Plan Administrator will then immediately send the claimant a notice regarding the Plan's reviewability assessment.

Following a preliminary review determination that a request is eligible for external review, the Plan Administrator will forward all documents and any information considered in denying the claimant's benefits claim to an IRO to perform the expedited external review. The IRO will consider the same information or documents used for standard external review. The IRO will provide notice to both the claimant and the Plan Administrator of its final expedited external review decision within 72 hours after the IRO receives the expedited external review request.

A claimant may contact the Missouri Department of Insurance for assistance with the expedited external review process at (800) 726-7390.

COORDINATION OF BENEFITS, SUBROGATION, AND REIMBURSEMENT APPENDIX

1. Benefits Subject to this Appendix. All benefits provided under this Plan are subject to this Appendix.

These special definitions apply to this Appendix.

2. Definitions. For purposes of this Appendix the following definitions shall apply:

"Plan" means any plan providing payments or services for or by reason of an injury or illness resulting in Hospital, medical, or dental care or treatment in which you are a participant or in which any other person who caused the injury or illness or who may be liable for the injury or illness is a participant, member or party; including but not limited to:

(a) group, blanket or franchise insurance coverage;

(b) group Blue Cross, Blue Shield, service plan contracts, group practice, individual practice and other prepayment coverage provided on a group basis;

(c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group;

(d) any coverage under governmental program, and any coverage required or provided by any federal or state statute; or

(e) any individual or family insurance policy or contract or arrangement, excluding only one which provides solely medical benefits (including but not limited to automobile accident, no fault or liability insurance; thus, for example, the term "plan" is not limited to the medical expense benefit provisions of an automobile accident, no fault, or liability insurance policy).

The term "plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expense" means any item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

When a plan provides benefits in the form of services rather that cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year or any portion thereof during which a person subject to this Appendix is covered under this Plan.

"Protected Person" means an employee, retired employee or dependent.

In certain circumstances the Plan will be primary even if you are entitled to receive Medicare.

3. Medicare Coordination Rules. The coordination of benefits rules set forth in this Appendix do not apply in coordinating benefits with those you are entitled to receive from Medicare. Instead, rules determining when the Plan will be primary to Medicare are set forth on pages 48 and 49; rules on benefits the Plan will pay to supplement Medicare are set forth on pages 46 and 47. In any case, in determining your rights under Medicare coordination rules, applicable Medicare secondary payment requirements of federal law shall govern.

You are still eligible for coverage even if you are eligible for or receive care under Medicare.

4. Medicaid Coordination Rules. Your eligibility for coverage under this Plan shall not be affected by the fact that you are eligible for or are provided medical assistance under Medicaid, that is, a State plan for medical assistance approved under Title XIX of the Social Security Act. In addition, the coordination of benefits rules set forth in this Appendix will not apply to benefits you are entitled to receive under Medicaid. See also page 58 for other provisions involving Medicaid.

Here is how benefits will be coordinated.

5. Coordination of Benefits. The benefits provided by this Plan will be reduced in accordance with the rules set forth in Section 6 if during any Claim Determination Period, for the Allowable Expenses incurred by such person during such period, the sum of:

(a) the benefits that would be payable under this Plan in the absence of the coordination of benefits and

(b) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to these coordination of benefits provisions exceed such Allowable Expenses. In order to prevent total payments from exceeding your medical expenses, this Plan may, at its option, defer payment of benefits until the amount of benefits payable under any other plan has been determined.

You will receive reduced benefit payments under these circumstances.

6. Reduced Benefit Payments. During any Claim Determination Period to which this Appendix applies, the benefits that would be payable under this Plan in the absence of the coordination of benefits for Allowable Expenses incurred by such person during such Claim Determination Period will be reduced so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other plans, shall not exceed the total of such

allowable Expenses. Benefits payable under another plan include benefits that would have been payable had claim been duly made therefor.

However, if such another plan contains a provision coordinating its benefits with those of this Plan and would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and if the rules set forth in Section 7 require this Plan to determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining benefits under this Plan.

This is the order in which benefits will be determined.

7. Order of Benefit Determination. For the purposes of Section 6, the rules establishing the order of benefit determination are:

(a) The benefits of a plan described in paragraph 2(e) of this Appendix will be determined before the benefits of any other plan;

(b) the benefits of a plan which covers the person on whose expense a claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(i) secondary to the plan covering the person as a dependent; and

(ii) primary to the plan covering the person as other than a dependent (e.g., as a retired employee),

then the benefits of the plan covering the person as a dependent are determined before those of the plan covering the person as other than a dependent;

(c) except for cases of a person for whom claim is made as a dependent child, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, the provisions of this paragraph shall not apply, and the benefits of a plan which covers the person on whose expense a claim is based as a dependent of a male person will be determined before the benefits of a plan which covers such person as a dependent of a female person.

In the case of a person for whom a claim is made as a dependent child, the following rules shall apply:

(i) in the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried (or where the parents have never been married to each other, are separated, and the parent with custody of the child is not married), the benefits of a plan which covers the child as a dependent of a parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

(ii) in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried (or where the parents have never been married to each other, are separated, and the parent with custody of the child is married), the benefits of a plan which covers the child as a dependent of a parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parents without custody; and

(iii) in the case of a person for whom claim is made as a dependent child whose parents are separated (whether by legal separation or otherwise) or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs (c)(i) and (ii) above, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child; and

(d) When rules (a), (b), or (c) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expense a claim is based for the longest period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(i) the benefits of a plan which covers the person on whose expense a claim is based as a laid-off or retired employee, or as a dependent of such employee, will be determined after the benefits of a plan which

covers such person as an employee, other than as a laid-off or retired employee, or as a dependent of such person; and

(ii) if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of paragraph (d)(i) will not apply.

In coordinating the Plan's secondary prescription drug coverage with any other secondary prescription drug coverage, the current model National Association of Insurance Commissioner rules on coordination shall apply to the extent they differ from the rules on coordination set forth in the Plan.

8. Proportionate Reduction of Benefits. When this Appendix operates to reduce the total amount of benefits otherwise payable to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this Appendix will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.

Trustees may make payments directly to other plans.

9. Payment to Other Organizations. Whenever payments which should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any other plans, the Trustees shall have the right, exercisable alone and in their sole discretion, to pay to any organizations making such other payments any amounts they shall determine to be warranted in order to satisfy the intent of this Appendix. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Trustees shall be fully discharged from liability under this Plan.

The Plan can cover excess payments from you.

10. Reimbursement and Set-Off. Whenever payments have been made by the Trustees with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Appendix, the Trustees shall have an equitable right to reimbursement for such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine: any person to or for whom such payments were made, any insurance companies, any trust, or any other organizations. This right entitles the Plan to priority over all claimants to any funds recovered in connection with the incidents giving rise to such payments. You agree that an equitable lien attaches to any excess payments to which the Plan has a right to reimbursement, and that you or other parties possessing such funds will hold them in constructive trust for the benefit of the Plan. Unless the Plan explicitly agrees otherwise, the Plan's rights to subrogation and reimbursement take priority over any other use of monies you recover, including payment of your attorney's fees and expenses and regardless of whether you obtain a full or partial recovery of your injury or illness.

Alternatively, the Trustees may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, to one or more of the following, as the Trustees shall determine: any person to or for whom such payments were made, any insurance companies, any trust, or any other organizations. In addition, the Trustees may set off unrecovered payments against the amount of any Allowable Expenses otherwise payable to any other Protected Person in your family or on his or her behalf. This right of set-off extends to all Allowable Expenses otherwise payable at any time by the Plan whether or not such amounts are related to the injury or illness that led to the payments.

The recovery provisions of this Section 10 apply, among other circumstances, where the Plan makes payment of Allowable Expenses incurred for treatment of an injury or illness for which another person is or may be liable. If another person or plan (or an insurer on behalf of either) makes payment to you, a relative, a trust under which you or a relative are a beneficiary, or to any other party on your behalf or for your benefit as compensation (regardless of how the payment is characterized) for the injury or illness, and this Plan does not recover these payments through application of its subrogation provisions, as set forth in paragraph 11, this Plan is entitled to enforce its right to reimbursement. You agree that an equitable lien will attach to any funds recovered in connection with an injury or illness for which the Plan has paid benefits, up to the amount of the Plan's right to reimbursement. The sum to which the Plan has a right to reimbursement shall be an amount equal to the lesser of the benefits paid by this Plan for treatment of the injury or illness, or the amount paid to you, a relative, a trust under which you or a relative are a beneficiary, or to any other party on your behalf or for your benefit by the other person, plan or insurer as compensation (regardless of how the payment is characterized) for the injury or illness. The Plan may enforce its equitable right to reimbursement through any remedy (including set-off) and against any party it chooses.

This paragraph 10 shall not apply where the other person, plan, or its insurer is a medical plan providing solely medical or other welfare benefits and with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of your Allowable Expenses. For example, this paragraph 10 applies where the person paying compensation to you is an automobile or liability insurer, but not where the compensation is paid to you by a group medical plan with respect to which this Plan is the primary payer.

In addition, where another person, plan, or its insurer pays compensation to you or on your behalf for an injury or illness for which the other person or plan is or may be liable, and you incur (either before or after payment of such compensation) otherwise Allowable Expenses for treatment of the injury or illness, a special exclusion applies. In that case, such otherwise Allowable Expenses which were incurred after the date on which the compensation was paid, or which were incurred prior to such date but not paid by this Plan as of such date, shall be excluded

from coverage by this Plan to the extent of the excess (if any) of the compensation you receive over the Allowable Expenses which the Plan has already paid for treatment of the injury or illness.

The characterization of any amounts paid to you, a relative, a trust under which you or a relative are a beneficiary, or to any other party on your behalf or for your benefit, whether in a settlement agreement or otherwise, shall not affect this Plan's equitable rights to reimbursement and set-off (whether such amounts represent a full or partial recovery for your injury or illness), the equitable lien that you have agreed attaches to any funds to which the Plan is entitled, or the characterization of otherwise Allowable Expenses as excludable expenses pursuant to the provisions of this Section 10. The Plan's reimbursement rights are not limited by the "make whole" doctrine sometimes applicable in other legal contexts.

This Plan shall be equitably subrogated with respect to monies recovered from any other plan or person.

11. Subrogation. This Plan shall be equitably subrogated to the extent of benefits paid under this Plan to any monies recovered from any other plan or person by reason of the injury or illness which occasioned the payment of benefits under this Plan. This Plan shall not be responsible for any costs or expenses you incur in connection with any recovery from any other plan or person unless this Plan so agrees in writing to pay a part of these expenses. This Plan shall also be equitably subrogated to the extent of benefits paid under this Plan to any claim you may have against any other plan or person for the injury or illness which occasioned the payment of benefits under this Plan. Upon written notification to you, this Plan may (but shall not be required to) collect the claim directly from the other plan or person in any manner this Plan chooses without your consent. This Plan shall apply any monies collected from the other plan to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement.

The characterization of any amounts recovered, whether in a settlement agreement or otherwise, shall not affect the priority given this Plan under this Section 11 with respect to such amounts. The Plan has priority over all claimants to such amounts recovered, whether they represent a full or partial recovery for your injury or illness. In other words, the Plan's subrogation rights are not limited by the "make whole" doctrine sometimes applicable in other legal contexts. Any balance remaining shall be paid to you as soon as administratively practical. The Trustees or their designee may, within their sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

The Trustees will determine which of the Plan's rights and remedies they pursue.

12. Implementation. The Plan's equitable rights to subrogation and reimbursement take priority over any other use of monies recovered, including payment of your attorney's fees and expenses and regardless of whether you obtain a full or partial recovery for your injury or illness. Although the Plan may agree to accept less than a full recovery of the benefits it has paid on your behalf — for

example, by agreeing to share in payment of reasonable attorney's fees you incur in obtaining reimbursement from another person or plan — the Plan is not required to accept less than full recovery, regardless of the attorney's fees and costs you incur. In particular, the Plan's equitable rights to subrogation and reimbursement under this Appendix are not limited by the "common fund" doctrine. The Trustees within their sole discretion shall determine which of this Plan's rights and remedies it is within the best interests of this Plan to pursue. The Trustees may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (a) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances, and (b) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Wherever in this Appendix this Plan refers to "payments" made by this Plan, or "benefits" paid by this Plan, the terms "payments" and "benefits" include amounts paid by this Plan to its managed care network in exchange for discounts in fees and expenses charged by health care providers participating in the network.

For example, where a participant incurs a $1,000 covered expense for treatment by a participating health care provider, the Plan's managed care network may reduce the charge to, for example, $600. The Plan may then pay the network a fee equal to a specified percentage of the savings realized by the Plan, or a fee determined in some other manner. In the example described above, if the fee were fifteen percent of the savings, the Plan would pay the network $60. The sum of this fee, and the benefits paid by the Plan on the claim as adjusted by the network, comprise the Plan's "payment" with respect to the claim, or the "benefits" paid by the Plan with respect to the claim, for purposes of the Plan's equitable rights to subrogation, reimbursement, or set-off.

NOTICE OF PRIVACY PRACTICES

We provide this Notice of Privacy Practices ("Notice") to you, to describe how we may use and disclose your protected health information for purposes of payment or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights with respect to your protected health information and how you can exercise those rights. We do so consistent with the Health Insurance Portability and Accountability Act of 1996, and its regulations (the "Privacy Rule"). Throughout this document, the terms "you" or "your" refer to each individual who is covered by the Plumbers Local No. 8 Health and Welfare Plan (the "Plan"). The terms "we," "us," and "our" refer to the Plan. **"Protected health information" or "PHI" is individually identifiable health information relating to your past, present, or future physical or mental health, treatment, or payment for health care.** This Notice does not apply to weekly disability, death, or accidental death and dismemberment benefits under the Plan.

HOW WE USE AND DISCLOSE YOUR PHI. We use and disclose your PHI for the following purposes:

- **For Treatment:** We may use and disclose your PHI for the coordination or management of your health care and related services with your health care providers. For example, we may disclose your PHI to your health care provider to assist in the provider's development of an appropriate treatment plan for you.

- **For Payment:** We may use and disclose your PHI to determine eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, to coordinate benefits, to manage claims, to obtain payment under a contract of reinsurance, or to collect premiums. For example, we may use PHI in the form of your medical history from your provider to determine whether a particular treatment is Medically Necessary, or to determine whether a treatment is covered. Other examples include disclosure of information to a third party to assist with the subrogation of claims, or to another plan to coordinate benefit payments.

- **For Health Care Operations:** We may use and disclose your PHI in connection with our health care operations, including quality assessment, customer service, legal and auditing functions, fraud and abuse detection and compliance programs, business planning and development, and general administrative activities. For example, we may share your PHI with a private investigator to help detect potential fraud or abuse. To the extent that we use or disclose your PHI for underwriting purposes, however, we are prohibited from using or disclosing any of your genetic information for such purposes.

- **To the Board of Trustees:** We may disclose summary health information to the Board of Trustees for the purpose of obtaining premium bids from other health plans, or modifying, amending, or terminating the Plan. We may also disclose information to the Board of Trustees regarding whether you are participating in or have enrolled in or disenrolled from the Plan. The Trustees will not use your PHI for any employment related decisions.

- **To Your Personal Representative:** We may disclose your PHI to your personal representative. A person is your personal representative only if he or she has legal authority to act on your behalf in making decisions related to health care. We may require your personal representative to produce evidence of his or her authority to act on your

behalf. We may choose not to recognize a person as your personal representative if we have a reasonable belief that treating that person as your personal representative could put you in danger and we decide that it is not in your best interest to treat him or her as such. In the event of your death, we will treat an executor, administrator, or other person authorized under the law to act on behalf of you or your estate as your personal representative.

- **To Others Involved in Your Care:** Unless you object, we may disclose your PHI to a member of your family, a relative, a close friend, or any other person you identify, who is involved in your care or the payment for your care. We will disclose only PHI that directly relates to that person's involvement in your care or payment for care. If you are not present, or in the event of your incapacity or an emergency, we may disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest. Additionally, we may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. We may also use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

  Following your death, we may disclose your PHI to family members and others who, prior to your death, were involved in the care or payment for care provided to you, unless doing so would be inconsistent with any prior expressed preference of yours that is known to us.

- **For the Public Interest:** We may disclose your PHI, to the extent the disclosure is:

  - Required by law;
  - Pursuant to a state or other law that requires a school to have proof of immunization prior to admitting a student;
  - Pursuant to a judicial or administrative order;
  - Pursuant to a subpoena, discovery request, or other lawful process, provided we obtain satisfactory assurances that reasonable efforts have been made to either notify you of the request or to obtain a protective order;
  - To a public health authority, for the purpose of controlling disease, reporting vital statistics, the conduct of public health investigations, or reporting child abuse or neglect;
  - To a governmental authority, for the purpose of reporting suspected abuse, neglect or domestic violence;
  - To a health oversight agency, for purposes of oversight activities authorized by law, including audits, investigations, inspections, licensure and disciplinary actions;
  - To law enforcement officials for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or if you are suspected to be a victim of a crime;

- To a coroner or medical examiner, for purposes of identification or to determine cause of death;
- To funeral directors, as necessary to carry out their duties with respect to a decedent;
- To organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation or transplantation;
- To prevent serious threats to health or safety;
- To military command authorities to assure the proper execution of a military mission;
- To authorized federal officials for national security and intelligence activities;
- For protective services for the President and others;
- To correctional institutions and law enforcement officials if you are an inmate or in custody, for purposes of the health and safety of you and others; and
- To comply with laws relating to workers' compensation or other similar programs.

- **For Required Uses and Disclosures:** Under the law, we must disclose your PHI to you when you request it as part of your right to inspect and copy or your right to receive a list of disclosures. We also must disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

- **For Fundraising Purposes:** We may use or disclose to a business associate or to an institutionally related foundation certain PHI for the purpose of fundraising without your authorization if certain conditions are met. Specifically, with each fundraising communication made to you, we must provide you with a clear and conspicuous opportunity to opt out of receiving any further fundraising communications.

- **With Your Authorization:** We may not use or disclose your PHI other than as described in this Notice unless we have your written authorization. For example, we may not use or disclose your PHI when it relates to psychotherapy notes or for marketing purposes without your written authorization. We also must obtain your written authorization before making any disclosure of PHI that constitutes a sale of PHI. You may revoke an authorization at any time in writing, except to the extent that we have taken action in reliance on the authorization.

- **In Accordance With Applicable State Law:** State law may prohibit or materially limit our uses and disclosures of your PHI. We will restrict our uses and disclosures in accordance with any more stringent provisions of state law that relate to privacy of your PHI, except to the extent that such state laws are preempted by applicable federal law.

YOUR INDIVIDUAL RIGHTS. You have certain rights with respect to the PHI that we maintain about you. These are:

- **Right to Request Restrictions:** You have the right to request that we not use or disclose any part of your PHI. You also have the right to request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. We are not required to agree to a restriction that you request. If we do agree to the requested restriction, we will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment to you. You must send a request in writing to us and tell us what PHI you want restricted and to whom the restriction applies.

- **Right to Receive Confidential Communications:** You have the right to request that we communicate with you regarding your PHI by alternative means or at alternative locations. We will accommodate reasonable requests if you tell us that the disclosure of all or part of that information could put you in danger. You must send a request in writing to us, and tell us what alternative method of contact or address you want us to use.

- **Right to Inspect and Copy:** You have the right to inspect and obtain either a paper or electronic copy of PHI about you that is contained in a designated record set. A "designated record set" includes the enrollment, medical, and payment records and any other records that we use for making decisions about you. We may charge a reasonable fee for copying and postage. This right does not apply to psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. If we deny your request, you may have a right to have this decision reviewed by an independent health care professional chosen by us. You must send a request in writing to us, and tell us what PHI you are requesting and in what format you would like to receive it. In most cases, we will provide the requested information within 30 days. An additional 30-day extension may be necessary if the information is maintained offsite or where other constraints prevent us from providing the requested information within 30 days. In all situations in which we are unable to provide the requested information within 30 days, we will notify you in writing of the reasons for the delay and the date by which we expect to fulfill your request.

- **Right to Amend:** You have the right to request an amendment of your PHI in a designated record set if you believe it is incomplete or incorrect. We may deny your request if we determine that the PHI or record that is the subject of the request was not created by us, would not be available for inspection, or is accurate and complete. In most cases, we will act upon your request within 60 days. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You must send a request in writing to us, and tell us the reason for your request.

- **Right to Receive a List of Disclosures:** You have the right to request a list of disclosures of your PHI that we have made. This right does not apply to disclosures we have made for purposes related to treatment, payment or health care operations, disclosures we have made to you, to family members or friends involved in your care, or to a personal representative, or any disclosures you have specifically authorized. This right is limited to disclosures that occur after April 14, 2004, and for a specified period of time up to six years. In most cases, we will act upon your request within 60 days. If you make more than one request in a 12-month period, we may charge you a reasonable fee for responding to the additional requests. You must send a request in writing to us, and tell us the time period and format in which you want the list.

- **Right to Obtain a Copy of This Notice:** You have the right to obtain an additional paper copy of this Notice upon request.

OUR LEGAL DUTIES REGARDING YOUR PHI. We are required by law to maintain the privacy of your PHI and give you this Notice of our legal duties and privacy practices. We are required to notify you following any breach of your unsecured PHI. We are required to follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of our Notice at any time, and to make the new notice provisions effective for all PHI that we maintain, including PHI created or received prior to the effective date of the revision. We will distribute a revised Notice of Privacy Practices to you within 60 days if there is a material change in our privacy practices.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a written complaint with us. You may also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 601 East 12th Street, Room 248, Kansas City, Missouri 64106. We will not retaliate against you for filing a complaint.

CONTACT. You may contact the Privacy Officer for further information about the complaint process, or for further information about matters covered by this Notice. The Privacy Officer can be reached by mail at 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130, by e-mail at danielle@local8ebo.com, or by phone at (816) 361-0666.

DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your Dependents lose coverage under Medicaid or the Children's Health Insurance Program ("CHIP"), or become eligible to participate in a Medicaid or CHIP premium assistance program, you may be able to enroll yourself and your Dependents in this Plan. However, you must request enrollment within 60 days after your or your Dependents' other coverage ends or after becoming eligible for premium assistance.

To request special enrollment or obtain more information, contact Danielle Wiley, Plan Administrator, at 5950 Manchester Trafficway, Suite 1, Kansas City, Missouri 64130, phone (816) 361-0666.