DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS

WELFARE PLAN

SUMMARY PLAN DESCRIPTION

C-3-G PLAN

NOTE: Your Schedule Of Benefits Is In The Back Of This Booklet

Effective January 1, 2011

District No. 9, I.A.M.A.W.
Welfare Trust

Dear Participant:

The Trustees of the District No. 9, I.A.M.A.W. Welfare Trust are pleased to present you with this new Booklet describing the comprehensive major medical, dental, vision, life insurance, and weekly disability benefits provided by the Welfare Trust. This Booklet supersedes all previous booklets or summary plan descriptions.

You should read this Booklet very carefully and share it with your covered dependents because it sets forth a description of the benefits, the requirements for eligibility for benefits, important exclusions and limitations on benefits, and the procedures for submitting claims.

After you and your covered family members review this Booklet, keep it with your important papers to refer to when you or any of your family members need to use your benefits.

It is the function of the Trustees to administer and interpret the Welfare Plan. No representative of the Employer or the Union is authorized in such capacity to interpret the Welfare Plan, nor can any such person bind or obligate the Trustees or the Plan by representations concerning the Plan. Any inquiries you may have concerning your rights under the Welfare Plan should be directed to the Welfare Plan Office at the following address:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
Toll Free: 888-739-6442
Website: www.d9trusts.org

With our best wishes

Sincerely,

The Joint Board of Trustees

This Summary Plan Description describes the major medical, dental, vision, life insurance, and weekly income benefits provided by the Welfare Plan. Please check your collective bargaining agreement or call the Fund Office to determine the benefits you and your dependents are eligible for.

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SECTION 1. PLAN'S COST CONTAINMENT FEATURES

The Trustees of the District No. 9, I.A.M.A.W. Welfare Trust continue to strive to provide you and your family with the highest-quality benefits and at the same time to hold down costs to protect the future of those benefits. In pursuit of those dual goals, the Trustees have adopted a number of features that require your participation and cooperation:

- Medical pre-certification, utilization review and case management program
- Medical network (HMO and PPO)
- Mental, Drug and Alcohol Case Management and Provider Network
- Reimbursement and Subrogation when the Plan provides benefits for an injury or illness for which a third party is responsible.

A. Medical Pre-Certification, Utilization Review and Case Management

1. Pre-Certification (involving treatment other than for mental illness or drug or alcohol problems)*.

As is discussed further below, the Plan participates in a medical network which has made arrangements with a large number of doctors, hospitals, and other providers (collectively called Network Providers) to provide health care to you and your family, often at reduced costs. Under the terms of the Utilization Management Program applicable to Network Providers, the Network Providers must obtain pre-certification for elective hospital admissions, outpatient surgeries, ambulatory services, home health care and physical therapy. While you will not be penalized solely because of the failure of a provider to obtain pre-certification, it is in your interest that pre-certification be obtained in that the Plan does NOT pay for any care or treatment which is not medically necessary. Pre-certification is designed to greatly reduce the possibility that you will receive care or treatment which is not medically necessary and thus not covered by the Plan.

The pre-certification procedures are explained in detail at Section 8A2 of this Booklet. Generally, you obtain pre-certification by calling the number shown on your Plan identification card and on the Schedule of Benefits which is in the back of this Booklet.

2. Medical Utilization Review and Case Management Services.

The Trustees have made arrangements for a Case Management Program. This program is coordinated by medical network providers in conjunction with your health plan and offered at no additional cost to you.

Case Management is a voluntary program designed to help coordinate health care benefits for certain individuals who have serious immediate or long-term health care needs.

Case Management Program staff members work with your physician as your physician develops a care plan that meets your needs. In the event of such health care needs, a case manager will be assigned to work with you. All case managers are Registered Nurses with clinical experience.

The medical network provider shares information with health care providers who are involved in your treatment and the health benefit plan administrator so that your health plan administrator can determine the benefits that may be available under the health plan for medical care you receive.

You can always refuse any treatment or services that are recommended; however, you may not maximize your health plan benefits. You will be notified when case management services are changed or terminated and the reason(s) for such action will be explained to you.

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* The special rules concerning care or treatment for mental illness or drug or alcohol problems are discussed briefly in Part C of this Section 1 and in more detail in Part A4 of Section 8 of this Booklet.

B. Network Providers

The Plan participates in a medical network which has made arrangements with a large number of doctors, hospitals, and other providers of health care services to provide health care to you and your family, often at reduced costs. A current list of doctors, hospitals and other providers who are members of the network can be obtained online (see Section 14H for website address).

Under the medical network program, there are three levels of doctors, hospitals, and other providers:

- Level 1 – HMO Providers;
- Level 2 – PPO Providers; and
- Level 3 – Non-Network Providers.

The Level 1 HMO Providers generally charge the Plan the least for your care, and the Level 2 PPO Providers generally charge less than Level 3 Non-Network Providers. The level of your benefits is determined by which level of provider you choose. If you choose an HMO Provider, the Plan will pay 90% of the covered charges after the deductible, and you will pay 10%. If you choose a Level 2 PPO Provider, the Plan will pay 80% of the covered charges after the deductible, and you will pay 20%. If you use a non-network provider, the Plan will pay 60% of the covered charges, (non-network provider charges are limited to the reasonable and customary charges as defined in Section 2B of this Summary Plan Description), after the deductible, and you will pay 40% and any non-covered charges.

By using the Network Providers, you benefit in two ways. First, you benefit directly and immediately when you use one of the Network Providers, because the Welfare Plan pays 80% or 90% of the covered charges, rather than the 60% it pays when you use a non-network provider. Thus, you only have to pay 10% or 20% of the covered charges when you use a Network Provider. Further, the fees charged by the Network Providers are often lower than those charged by non-network providers. In such cases, you save by paying the lower percentage of a lower fee. Second, you benefit indirectly, because as indicated, the Network Providers have agreed in many cases to charge less for treating you and your family, so your Welfare Plan is required to pay less than it would have to pay if you used a non-network provider. Therefore, you help to maintain the financial stability of your Welfare Plan and to insure the availability of monies for your future health benefits.

You should always urge your doctor to refer you only to hospitals and other providers who are members of the Network.

Please note: While the Level 1 Providers are referred to as HMO Providers, this is not a traditional HMO. You do not have to choose a primary care physician. You do not have to obtain referrals to see a specialist. This is truly an "open access" program. Each time you seek medical care, you can choose any provider you wish. However, as you can see, if you choose an HMO provider, both the charges and your share of those charges will be lower. Both you and the Plan will save money. Therefore, we urge you to use HMO providers whenever you can.

The Network Provider will normally automatically contact the Plan for pre-certification, so you will not be penalized for failing to get pre-certification or pre-approval for a hospitalization. **However, even if you are using a Network Provider, you may confirm, and are encouraged to confirm, that pre-certification has been done by calling the pre-certification number shown on your identification card prior to your treatment.**

If you have any questions about the pre-certification requirements, about whether a provider of health care is a member of the Network, or about how to receive the benefits of using a Network Provider, please contact the Welfare Plan Office at (314) 739-6442 or 1-888-739-6442.

C. Mental, Drug and Alcohol Case Management and Provider Network

All treatment of any sort (except in the case of an emergency) for any mental illness or drug or alcohol problem must be pre-approved by the Mental Health Case Manager. The telephone number of the Mental Health Case Manager is shown on your identification card and on the Schedule of Benefits which is in the back of this Booklet. If you fail to contact the Mental Health Case Manager before you receive treatment for any mental, drug, or alcohol problem (or within 48 hours after an emergency hospital admission or the commencement of emergency treatment), the Plan simply will not pay for that treatment. The Mental Health Case Manager will normally only approve treatment by providers who are

in the Mental Health Provider Network. If, in special circumstances, it approves treatment by a provider that is not part of the Mental Health Provider Network, the Plan will pay only 60% of the covered charges of such specially approved providers who are not members of the Mental Health Provider Network. The Plan pays 90% of covered charges of Mental Health Network providers. See Section 8A4 of this Booklet for more information about the Mental Health Case Management requirements.

D. Reimbursement and Subrogation

The Plan has adopted reimbursement and subrogation provisions that will affect covered individuals who suffer an illness or injury for which some third person may be responsible. This means that if you or a dependent suffers any injury or illness caused by someone else, the Plan will have the right to be reimbursed for amounts (medical, prescription, disability) it pays out for treatment of that illness or injury, from any monies you recover from the responsible person or from any insurer, including your own insurer. In the alternative, the Plan will become "subrogated" to your claim against the responsible person or insurer. This means that to the extent of the benefits it pays out for the injury or illness, the Plan has the same rights you have against the responsible parties. In other words, the Plan "stands in your shoes" with respect to claims against the responsible parties. The Plan can bring its own lawsuit against the responsible parties or intervene in any lawsuit you bring.

You must tell the Plan Office when you suffer an illness or injury for which a third person may be responsible. The Plan Office will, before paying out any benefits with respect to such an illness or injury, require that you provide information and documentation sufficient to permit the Plan to protect its rights and will require you to execute an agreement confirming the Plan's rights. See Section 11 of this Booklet for more information about subrogation and reimbursement.

E. Coordination of Benefits Rules

The coordination of benefits (COB) rules are used when a person is covered by more than one medical or dental benefits plan to determine which plan must pay its benefits first.

In applying the COB rules, the Plan will take into account any individually purchased health insurance policy or medical benefits plan or dental benefits plan or HRA (Health Reimbursement Account), FSA (Flexible Spending Account), HSA (Health Savings Account) by which a person is covered and will also take into account any vehicle or property insurance medical-pay benefits by which the person is covered. See Section 8I of this Booklet for more information about coordination of benefits.

F. Emergency Room Co-Payment

Each time you or a family member visits the emergency room, you will be required to pay a $75.00 co-pay. This $75.00 will not count toward the annual deductible or Stop Loss Amounts. To the extent an illness or accident can be addressed in a doctor's office, it obviously is less expensive for you to visit the doctor rather than the emergency room.

G. Injectable Drug Program

The Plan has an Injectable Drug Program under which the pharmacy benefit manager (PBM) is the preferred pharmacy provider. Under the Injectable Drug Program, the PBM establishes the allowable cost for injectable drugs. All injectable drugs should be obtained from the PBM, but if obtained from another source, the allowable cost as established by the PBM will be the maximum amount covered by the Plan. See Section 8G1b of this Booklet for more information about the Injectable Drug Program.

H. Other Cost Saving Features of Plan

You may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described at Section 8G1 of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

SECTION 2. DEFINITIONS

A. Introduction

This Section 2 contains important definitions that you should review carefully. There are additional definitions set out in other parts of this Booklet.

B. Definitions

Accident and Accidental Injury - An accident is an external event that is sudden, violent and unforeseen and exact as to time and place. An accidental injury is an injury that is caused by such an event and that is independent of all other causes.

"Actively at work," "active work" and "actively working" mean the active expenditure of time and energy in the service of the Employer. However, a covered individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is not disabled, provided he or she was actively at work on the last preceding regular working day.

Ambulatory Services – Services that are performed at a place other than:

1. a doctor's office; or
2. at a hospital while the person is an inpatient.

See the list of such services for which your doctor or provider is required to obtain pre-certification in Section 8A2 of this Booklet.

Audiologist – A specialist in the evaluation and treatment or rehabilitation of disorders of the hearing function who is licensed or certified as required by law in the state in which he or she practices.

Behavior Modification Therapy – Application of scientific principles regarding behavior in the attempt to change or control inappropriate patterns of behavior or correct disorders of self-control.

Beneficiary – A person or entity named, on a form and in a manner approved by the insurer or the Plan Office, to receive benefits for loss of life.

Calendar Month – Any one of the twelve months of the calendar.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, requires the opportunity for a temporary continuation of health coverage in certain instances called "qualifying events."

Cognitive Therapy – Treatment given to improve the covered individual's thinking processes and intellectual capabilities.

Co-Insurance – A percentage amount of covered charges which must be paid by the covered individual.

Concurrent Care Decisions – A Concurrent Care Decision is a decision by the Plan with respect to an ongoing course of treatment previously approved by the Plan to be provided over a period of time or number of treatments and which involves either:

1. a decision upon a request to extend the course of treatment; or
2. a decision to terminate or reduce the treatment before its scheduled expiration;

and any determination on an appeal from a decision to terminate or reduce the treatment.

Contributing Employer is:

1. Any employer (including an employer association) who now or hereafter has a collective bargaining agreement with this Union (or with another labor union which may, from time to time, bargain jointly with this Union), which collective bargaining agreement requires periodic contributions to the Welfare Trust, and who makes the contributions to the Welfare Trust as required by that agreement, or
2. Such other employer (related contributing employer) who has been accepted for participation by the Trustees, and who has agreed to contribute and does contribute on substantially the same basis as other contributing employers.

Co-Payment or Co-Pay – A set amount of covered charges which must be paid by the covered individual.

Cosmetic – Surgery or other treatment to enhance or improve a person's appearance.

Covered Charges – Charges covered under this Plan as set forth in Sections 8E and 8G of this Booklet.

Covered Employee is:

1. Any person who is covered by and currently performs work under a collective bargaining agreement between a contributing employer and District No. 9, I.A.M.A.W., or a related trade union, and for whom the employer is obligated to make contributions to the Welfare Trust, excluding any supervisory or managerial employees possessing the power to hire or fire other employees;

2. Any person who was formerly employed by a contributing employer and who was covered by and performed work under a collective bargaining agreement between the contributing employer and District No. 9, I.A.M.A.W., or a related trade union, and for whom the former employer is obligated pursuant to a collective bargaining agreement to continue to make contributions to the Welfare Trust even after the cessation of the employee's employment, excluding any supervisory or managerial employees possessing the power to hire or fire other employees.

3. Any employee of an employer which has signed a Special Participation Agreement for Non-Bargaining Unit Employees. (In this instance "employee" does not include the sole proprietor of the business or a partner in the business that constitutes the employer or any other person who is prohibited by law from participating in the Plan). Such employees may be covered only while the employer makes contributions on behalf of the bargaining unit employees.

4. Any employee of a related contributing employer where said employer has been accepted by the Trustees for participation in the Welfare Trust.

Covered Employment – Employment with a contributing employer in a position for which the employer is required to make contributions to the Welfare Trust.

Covered Individual – An individual who is eligible for benefits under this Plan.

Custodial Care – Health services or other related services (such as assistance in activities of daily living) which:

1. Are not intended to cure;

2. Are provided during periods when acute care is not required or when the medical condition of an insured individual is not changing; or

3. Do not require continued administration by licensed medical personnel.

Deductible – A set amount of covered charges which must be paid each calendar year by the covered individual before the Plan will pay any comprehensive major medical benefits. (See Section 8D1 of this Booklet and the Schedule of Benefits in the back of this Booklet).

Direct Care – Treatment in the presence of a physician.

Durable Medical Equipment – Equipment which can withstand repeated use, is not disposable, is prescribed only when medically necessary, is appropriate for use in the home and is not useful in the absence of an illness or injury.

Emergency – An emergency involves:

1. an acute or sudden illness or injury that without immediate medical care could result in death or cause serious impairment to bodily functions,

2. a medical situation which if not promptly addressed could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function, or

3. a medical situation which in the opinion of a physician with knowledge of the individual's medical condition, would, if not promptly addressed, subject the individual to severe pain that cannot be adequately managed without prompt care or treatment.

Emergency Room Co-Payment or Emergency Room Co-Pay - The amount the covered person must pay each time he or she visits the emergency room. (See Section 8D1d of this Booklet and Schedule of Benefits in the back of this Booklet).

Experimental or Investigative – A drug, device, treatment or procedure is experimental or investigative:

1. If, with respect to the illness being treated, the drug, device, treatment, or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or
2. If, with respect to the illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment or procedure, requires review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or
3. If, with respect to the illness being treated, reliable evidence shows the drug, device, treatment or procedure is the subject of on-going phase I, phase II, or phase III clinical trials, is the research, experimental, study or investigational arm of on-going phase II or phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If, with respect to the illness being treated, reliable evidence shows that the prevailing opinion among experts in the appropriate field regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in medical and scientific literature including the opinions of the FDA, Medicare, Council of Medical Specialty Services (CMSS), National Institute of Health (NIH) and Mental Health (NIMH), Office of Health Technology Assessment (OHTA), American Medical Association (AMA), American Dental Association (ADA) or Clinical Efficacy Assessment Program (CEAP); the written protocol(s) used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Flexible Spending Account or FSA – An employee-funded account which can be used to pay for qualified expenses under a cafeteria plan such as medical and dependent care expenses.

Health Reimbursement Account or HRA – An employer-funded plan that provides employees with reimbursement for the employee's (and often dependent's) medical expenses that are not otherwise paid by an insurance policy or health plan.

Health Savings Account or HSA – An account that can be funded by an employee or an employee and his employer if the employee is covered by a high deductible health plan, which can be used to pay for qualified medical expenses.

Hospital – A facility which:

1. Operates pursuant to law; and
2. Has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more doctors; and
3. Provides 24-hour nursing services by Registered Nurses on duty or call; and
4. Is not a convalescent home, nursing home, rest home or extended care facility, or facility operated exclusively for the treatment of the aged, drug addict or alcoholic, whether such facility is operated as a separate institution or as a section of an institution operated as a hospital; or
5. Is an approved ambulatory surgical center facility. An "ambulatory surgical center" is any public or private establishment operated primarily for the purpose of performing surgical procedures or primarily for the purpose of performing childbirth, and which does not provide services or other accommodations for patients to stay more than twelve hours within the establishment.

Hospitalization, Hospital Confinement or Hospital Admission – Any stay in a hospital for any reason or in any sort of room for more than 23 hours.

Illness – means:

1. A disorder or disease of the body or mind; or
2. An accidental bodily injury; or
3. Pregnancy of the covered employee or the covered dependent spouse of a covered employee. Pregnancy of a dependent child is not a covered illness under this Plan.

All illnesses due to the same cause, or to a related cause, will be deemed to be one illness.

The donation of an organ or tissue by a covered individual for transplanting into another person is considered to be an illness of the covered individual making the donation, but only if the recipient's health insurance or other medical plan does not cover the donor's expenses.

Lifetime Maximum – The maximum amount of benefits which may be payable on behalf of an individual while covered under this Plan. See Schedule of Benefits in the back of this Booklet

Medical Supplies – The following items, if prescribed by a legally qualified physician:

1. Drugs and medicines that require a written prescription of a physician and which must be dispensed by a licensed pharmacist or physician;
2. Blood and other fluids to be injected into the circulatory system;
3. Prosthetic or artificial limbs, breasts and eyes and their replacement, regardless of when the original loss of the limb, breast or eye occurred, and certain supplies necessary for the use of an artificial breast or limb;
4. Casts, splints, trusses, braces, surgical dressings; and
5. Crutches, wheelchairs, hospital beds, iron lungs, equipment for the administration of oxygen, and other durable medical equipment. (See definition of Durable Medical Equipment above.)

Medicare – Medical benefits provided under the Federal Social Security Act.

Mental Illness – Any illness or disorder which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental or nervous disorder will not be considered to be charges made for treatment of a mental or nervous disorder.

Month – A period starting at 12:01 a.m. on any day in a given Calendar Month, and ending at 12:01 a.m. on that same-numbered day in the next Calendar Month. If that next calendar Month does not have a same-numbered day, the month will end at 12:00 midnight of the last day of that next Calendar Month. (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 12:00 midnight of June 30.)

Necessary to the Care or Treatment of Illness or Medically Necessary – Recommended by a doctor and required to treat the symptoms of a certain diagnosis. The care or treatment must be:

1. Consistent with the diagnosis and prescribed course of treatment for the covered individual's illness;
2. Required for reasons other than the convenience of the covered individual or his or her doctor;
3. Generally accepted as an appropriate form of care for the illness being treated and not considered experimental or investigative treatment with respect to that illness; and
4. Likely to result in physical improvement of the patient's illness which is unlikely to ever occur if the care or treatment is not administered.

Non-Network Provider – A doctor or other provider of medical care or supplies who is not part of the network of providers who provide services to individuals covered under this Plan at negotiated rates.

Occupational Therapist – Someone who is licensed to perform occupational therapy by the state in which he or she performs his or her services, if that state requires licensing.

Occupational Therapy – Treatment which consists primarily of instructing a covered individual to perform the normal activities of daily living.

Outpatient Surgery – Surgery performed during a hospital stay that is 23 hours or less. Any hospital stay that exceeds 23 hours will be considered a hospital admission.

Participant – Covered employee.

Physical Therapist – Someone who is licensed to perform physical therapy by the state in which he or she performs his or her services, if that state requires licensing.

Physical Therapy – Treatment given to improve the physical capabilities of a covered individual in an attempt to restore such individual to a previous level of good health.

Plan – The plan of benefits provided by the District No. 9, I.A.M.A.W. Welfare Trust.

Pre-existing Condition – See Section 8H of this Booklet.

Qualified Medical Child Support Order (QMCSO) – An order issued by a court or issued through an administrative process established by state law which orders the District No. 9, I.A.M.A.W. Welfare Plan to provide medical benefits to the child of a participant in the Plan. In order to be qualified, the Order must clearly specify

1. the name and last known mailing address of each child of the participant to be covered (or the name and address of a state official who may be substituted for the name and address of the child);
2. a description of the coverage; and
3. the period to which the order applies.

A QMCSO may not require the Plan to provide any benefit or option not provided under the Plan.

An appropriately completed National Medical Support Notice promulgated under Section 401(b) of the Child Support Performance and Incentive Act shall be deemed to be a QMCSO.

Reasonable and Customary Charges – Charges which do not exceed the amount usually charged by most providers in the same geographic area for services, treatment or materials, taking into account the nature of the illness involved.

Related Contributing Employer – Any employer, other than an employer which has a collective bargaining agreement with the Union, which has been accepted for participation in the Plan by the Trustees and which has agreed to contribute and does contribute on substantially the same basis as other contributing employers.

Related Trade Union – A labor union other than District No. 9, I.A.M.A.W. which, from time to time, bargains jointly with District No. 9, I.A.M.A.W. or enters into a collective bargaining agreement requiring contributions to the Welfare Trust.

Restorative Speech Therapy – Services rendered by a physician or licensed speech therapist to restore or rehabilitate speech lost or impaired by illness (other than a functional nervous disorder) or by surgery due to an illness.

Room and Board Charges – Charges made by a hospital or skilled nursing facility for the room, meals, and routine nursing services for covered individuals confined as bed patients.

Skilled Nursing Facility – A facility considered as such under Medicare or licensed by the State of Missouri or the state in which it is located.

Speech Therapist – Someone who is licensed to perform speech therapy by the state in which he or she performs his or her services, if that state requires licensing.

Speech Therapy – Treatment administered by a speech therapist to improve or restore a covered individual's speech capabilities after a decrease in those capabilities following an illness.

Subrogation – "Subrogation" means the substitution of one person in the place of another with respect to a claim, demand or right.

Total Disability – Unless otherwise defined in specific sections of this Plan, a covered individual shall be deemed to have a total disability under the following circumstances:

1. If a covered employee is claiming benefits under any coverage provided in this Plan, then total disability is defined as the employee's inability, because of an illness, to perform the material and substantial duties of his or her normal job;

2. If a covered dependent is claiming benefits under any coverage provided in this plan, then total disability is defined as the inability, because of an illness, of the dependent to do the substantial and material duties of a person of the same age and sex in similar circumstances who is in good health.

"One continuous period of total disability" means a period of time during which an individual is totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When an employee has successive periods of total disability which are due to the same or related causes and which are not separated by:

    a. Three or more months of continuous active work with the Employer on a full-time basis for Weekly Income Benefits; and

    b. Two or more continuous weeks of active work with the Employer on a full-time basis for all other benefits; or

2. When a dependent or retired employee has successive periods of total disability which are due to the same or related causes and which are not separated by a period of three or more months during which the dependent or retired employee is free from total disability which stems from those same or similar causes.

Totally Disabled – Having a total disability as defined above.

Trustees – Trustees of the District No. 9, I.A.M.A.W. Welfare Trust.

The Union or This Union – District No. 9, I.A.M.A.W., and its affiliated local unions.

Vocational Rehabilitation – Teaching and training which allows a covered individual to resume his or her previous job or to train for a new job.

Working Day – Any day on which you are normally scheduled to work in covered employment for a contributing employer or any day on which you actually work in covered employment for a contributing employer.

You – Covered employee.

SECTION 3. ELIGIBILITY

A. Eligibility of Employees

1. Generally

The covered employees of contributing employers who satisfy the eligibility requirements set forth below are eligible to participate in the District No. 9, I.A.M.A.W. Welfare Plan.

2. Commencement of Eligibility

a. Present and New Employees

Present full-time covered employees and new full-time covered employees will become eligible for life insurance and accidental death, dismemberment, and loss of sight insurance on the first working day of the calendar month coincident with or immediately following their commencement in covered employment. Present full-time covered employees and new full-time covered employees will become eligible for weekly income, comprehensive major medical, dental and vision benefits on the first day of the first calendar month that commences coincident with or immediately following the commencement of covered employment.

To the extent the collective bargaining agreement or other agreement pursuant to which you work requires a waiting period before your employer is required to contribute to this Plan on your behalf, your eligibility will not begin until the first day (working day for life and accidental death and dismemberment insurance and calendar day for other benefits) of the calendar month for which contributions are first due on your behalf.

b. Returning Employees

(1) **Generally.** If your employment is terminated after you have satisfied the above eligibility requirements and you are subsequently re-employed, you will be eligible for all benefit coverages on the date that you resume covered employment, provided:

(a) that your employer makes a contribution on your behalf in the month in which you resume covered employment or for the month immediately following the month in which you resume covered employment, and

(b) you resume covered employment within 12 months of your termination of coverage under the plan.

(2) **Limitations on Eligibility of Returning Employees.** If you return to covered employment after your coverage, including continuation coverage, has terminated, you and your dependents may be subject to the Plan's pre-existing condition limitations when your coverage under the Plan is reinstated. The following rules determine whether and to what extent the pre-existing condition limitation applies.

First, the normal rules about pre-existing conditions will be applied. (See Section 8H of this Booklet). If under those rules you or your dependents are subject to the Plan's pre-existing condition limitation for some period, then the next three paragraphs will determine whether and how long the pre-existing condition limitation applies, but only to the extent they shorten the period during which the pre-existing condition limitation applies to you or your dependents.

(a) If you return to covered employment within 90 days after the termination of your coverage under the Plan, the pre-existing condition limitation will not apply to you or your dependents.

(b) If you return to covered employment more than 90 days, but less than one year after the termination of your coverage, the pre-existing condition limitation will apply generally, but will not apply to any illness for which the affected individual had previously received benefits from this Plan.

(c) If you return to covered employment more than 12 months after the termination of your coverage, you will be treated in all respects – commencement of coverage and the application of the pre-existing condition limitation – as a new employee. Thus, you must again fulfill the eligibility requirements, and the pre-existing condition limitation will apply to all of the illnesses of you and your dependents.

B. Eligibility of Dependents

1. Generally

Dependents who are eligible to participate include only your spouse and your unmarried children. Their eligibility commences on the later of the date your eligibility commences or the date on which they first become dependents within the meaning of this Plan.

Benefits, however, will not be provided for any expenses incurred or losses suffered prior to the date that you provide the Plan Office with proof that your dependent is eligible unless you provide such proof within 30 days after your dependent first becomes eligible.

Your dependent's coverage will be subject to the rules regarding pre-existing conditions described at Section 8H of this Booklet.

2. Children

For the purposes of eligibility for coverage under the Plan, "Children" includes only the following unmarried children who have the same residence as you* for more than one-half the calendar year and who receive more than one-half of their support from you* during the calendar year and only until they reach the limiting age for dependent children:

a. Your natural children;

b. Your adopted children or children placed with you for adoption who are full-time members of your household and dependent upon you for support;

c. Your step-children but only those who live in your household on a full-time basis and who are dependent on you for support;

d. Children of whom you have been granted physical custody by a court of competent jurisdiction and of whom you have been ordered to assume legal or financial responsibility by a Court.

*or you and the other parent combined, if you and the other parent are divorced, separated or living apart for the last six months of the year.

You will be asked to certify your children meet this definition.

3. Limiting Age for Dependent Children

a. Generally. The general limiting age for children is 19. This means that, assuming you remain eligible, your eligible child will remain eligible through the day before the child's nineteenth birthday. However, the child will continue to receive benefits until the end of the calendar year in which the child reaches age 19, unless the child's eligibility terminates for another reason before the end of that calendar year.

b. Full-time students. For full-time students, the limiting age is 25. This means, that assuming you remain eligible, if your child is a full-time student in an accredited educational institution, the child will remain eligible through the day before his or her twenty-fifth birthday. A student is considered to be a full-time student if he or she is enrolled for at least 12-semester hours or the school's equivalent of 12-semester hours. In order to continue coverage after your child reaches age 19, you must submit an updated Student Verification Form each semester from your child's school. You may obtain a copy of the Student Verification Form from the Fund's website at **www.d9trusts.org** or by calling the Fund Office and requesting it be mailed to you.

Under a federal law called Michelle's Law, effective July 1, 2010, in the event your child is attending a postsecondary school and because of a serious illness or injury must take a

medically necessary leave of absence or make some other change from full-time attendance at school, your child will continue to be eligible for health benefits under the Plan. While your child remains on a medically necessary leave of absence, your child will continue to be eligible for coverage on that basis for up to one year from the start of the leave, unless your child's coverage ends sooner for some other reason provided by the Plan. In order for your child to qualify for coverage during a medically necessary leave of absence, the Plan must receive a written certification from your child's treating physician that states the following:

(1) Your child is suffering from a serious illness or injury; and

(2) It is medically necessary for your child to take a leave of absence or make some other change in your child's full-time student enrollment.

c. Incapacitated Children. If your unmarried child is incapable of self-sustaining employment because of physical handicap or mental retardation and is dependent on you for support, the child's benefits will be continued beyond the limiting age, provided his or her incapacity existed before the attainment of the applicable limiting age and while he or she was an eligible dependent under this Plan, and provided proof of the child's incapacity is furnished to the Welfare Plan Office not later than 31 days after the child's coverage would otherwise terminate.

Coverage will not be reinstated for a child who becomes incapacitated after the applicable limiting age. Further, if you became covered before November 1, 2006 and your incapacitated child had already attained the limiting age when your coverage began, such child will not be covered under this Plan. If your coverage starts on or after November 1, 2006 and your incapacitated child has already attained the limiting age when your coverage starts, such child will be covered under this Plan.

4. Proof of Status as an Eligible Dependent

a. Generally

The Trustees or their representatives may require proof, satisfactory to the Trustees, that an individual is, in fact, your eligible dependent. The following documents may be required.

(1) Certified Marriage Certificate from the Recorder of Deeds or other government agency

(2) Children's Certified Birth Certificate from the Bureau of Vital Statistics or other government agency

(3) Copy of Social Security Cards

(4) Adoption Papers

(5) Divorce Decree

(6) Any legal document that would apply to you, your spouse or your dependents.

You will also be required to submit a Student Verification Form verifying that your child who is age 19 or older is enrolled in and attending school as a full-time student. An updated Student Verification Form is required for each semester your child is a student in order to continue coverage until he or she reaches age 25. Effective July 1, 2010, under Michelle's Law, if your child must take a medically necessary leave of absence or make some other change from full-time attendance at a postsecondary school because of a serious illness or injury, you will be required to submit a written certification from your child's treating physician stating that your child is suffering from a serious illness or injury and that it is medically necessary for your child to take a leave of absence or make some other change in your child's full-time student enrollment. You may also be required to submit periodic proof that your child who is age 19 or older continues to be incapacitated.

b. Natural Children of Unmarried Male Employees

The natural child of a male employee who was not married to the child's mother at the time of the child's birth will be eligible only if the Welfare Plan Office receives a birth

certificate naming the employee as the child's father and a satisfactory statement establishing the employee's financial responsibility for the child or a Qualified Medical Child Support Order.

c. Children Other than Natural Children or Step-Children

Children other than natural children and step-children will be considered eligible only upon the Welfare Plan Office's receipt of an order from a court of competent jurisdiction granting the employee physical custody of the child and imposing on the employee legal and financial responsibility for the child, or upon receipt of preliminary or final adoption papers naming the eligible employee as the adoptive parent.

d. No Benefits for Period Prior to Furnishing Proof of Dependent Status

No benefits will be paid for any loss that occurs or service that is rendered prior to the date you provide the Plan Office with necessary proof of your dependent's eligibility, unless you provide such proof within 30 days after your dependent first becomes eligible. Therefore you should provide the Plan Office with such proof immediately when your dependent becomes eligible or you acquire a new dependent.

C. Effect of Employer's Failure to Make Required Contributions

IF YOU ARE A COVERED EMPLOYEE OF A CONTRIBUTING EMPLOYER WHO FAILS TO MAKE THE REQUIRED CONTRIBUTIONS ON BEHALF OF HIS EMPLOYEES, YOU AND YOUR DEPENDENTS, AS WELL AS THE OTHER EMPLOYEES OF THAT CONTRIBUTING EMPLOYER AND THEIR DEPENDENTS, WILL BE INELIGIBLE FOR BENEFIT COVERAGE FOR CLAIMS INCURRED DURING THOSE MONTHS FOR WHICH YOUR EMPLOYER FAILED TO MAKE THE REQUIRED CONTRIBUTIONS. CONTRIBUTIONS RECEIVED FROM A DELINQUENT EMPLOYER WILL BE CREDITED BACK TO THE FIRST MONTH OF DELINQUENCY. WHEN THE REQUIRED CONTRIBUTIONS ARE FINALLY RECEIVED FOR A MONTH, ALL CLAIMS INCURRED DURING THAT MONTH WILL BE CONSIDERED FOR PAYMENT.

D. Special CHIPRA Enrollment Rights

Effective April 1, 2009, CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are an eligible participant in the Plan but not enrolled in the Plan. First, if you or your dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your dependents are entitled to a special enrollment period in this Plan. Second, if you or your dependents become eligible for the state's premium assistance, you are entitled to a special enrollment period. You have 60 days to notify the plan of the event, and 31 days to provide proof of eligibility and enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Fund Office at (314) 739-6442 or toll-free at 1-888-739-6442.

SECTION 4. TERMINATION OF ELIGIBILITY

A. Employees

1. Generally

Your eligibility and the eligibility of your dependents automatically terminates on the earliest of the following dates.

a. The last day of the calendar month during which you cease to be employed in covered employment, or if later, the last day of the last calendar month in which your employer is required by a collective bargaining agreement or other agreement to make contributions to the Welfare Trust on your behalf.

b. The last day of the last calendar month for which contributions are received on your behalf; or

c. The date on which the Plan no longer provides benefits.

2. Active Employees and Medicare

If you are actively employed in covered employment and are eligible for Medicare, this Plan will in almost all instances be the primary payor of your benefits, unless you reject this Plan. If you reject this Plan, Medicare will become the primary payor and you will no longer be eligible for benefits from this Plan. (See Section 8I of this Booklet for more information about this Plan and Medicare.)

B. Dependents

1. Generally for All Dependents

The eligibility of all of your dependents automatically terminates on the earliest of the following dates:

a. The date the Plan no longer provides coverage to dependents;

b. The date your eligibility terminates;

c. The date your dependent child becomes eligible as an employee under the Plan; or

d. The date of your death (See Section 5D of this Booklet).

2. Spouse

In addition to the reasons set forth in Section B1 above, the eligibility of your spouse will end on the date on which you and your spouse are divorced or legally separated. The date of divorce or legal separation is the date on which a court of competent jurisdiction first enters a decree of divorce or legal separation.

3. Children

In addition to the reasons set forth in Section B1 above, the eligibility of your children will end for the reasons and on the dates set forth here.

a. If your child is not a full-time student (or effective July 1, 2010, is not a full-time student taking a medically necessary leave of absence or some other change from full-time student status because of a serious illness or injury under Michelle's Law) and is not incapacitated (as described at Section 3B3 of this Booklet), his or her eligibility will automatically terminate on the earlier of the date on which your child gets married or the date on which the child attains the limiting age of 19. However, when the covered child reaches age 19, benefits will continue for the child until the end of the calendar year in which the child reaches age 19, unless the child's eligibility terminates for a reason other than attainment of age 19.

b. If your child is a full-time student (as described at Section 3B3 of this Booklet), his or her eligibility will automatically terminate on the earliest of the following dates:

(1) The last day of the last month in which the child is a full-time student or effective July 1, 2010, one year from the start of the child's medically necessary leave of absence

or other change from full-time student status because of a serious illness or injury under Michelle's Law;

(2) The date on which the child gets married; or

(3) The day before the date on which the child attains the limiting age of 25.

c. If your child is incapacitated and covered beyond the normal limiting ages (as described at Section 3B3 of this Booklet), his or her eligibility will terminate on the earlier of the date on which the child is no longer incapable of self-sustaining employment or the date on which the child gets married.

C. Coverage During Family and Medical Leave

If you are granted leave under the Family and Medical Leave Act, please notify the Welfare Plan Office, so that the Plan can make sure your employer continues to make contributions on your behalf to continue your coverage during such leave.

D. Continuation of Coverage

In certain circumstances where your benefits or those of your dependents would otherwise terminate, you or your dependents may be entitled to continued coverage as set forth in Section 5.

E. Your Duty to Inform Plan of Termination of Dependent's Eligibility

If any of the following occur, it is your responsibility to inform the Welfare Plan Office:

- you get divorced or legally separated;
- your child reaches the limiting age;
- your child gets married;
- your child, over 19, is no longer a full-time student or no longer qualifies for a medically necessary leave of absence or other change from full-time student status because of a serious illness or injury under Michelle's Law; or
- your incapacitated child recovers.

If you fail to inform the Welfare Plan Office when one of these events occurs, your dependent may lose his or her right to COBRA continuation coverage. Further, if because you have failed to inform the Welfare Plan Office, the Plan pays out benefits for an ineligible dependent, the Plan will have the right to recover such benefits from you, your dependent, or any provider to whom such benefits were paid. The Plan may at its option withhold future benefits due to you and your other covered dependents in order to recoup amounts it paid on behalf of an ineligible dependent. If the Trustees bring a legal action to collect such benefits, the Trustees, upon prevailing, will be entitled to receive and you will be required to pay not only the overpayments, but also pre-judgment interest and the reasonable attorney's fees and costs the Trustees incur in such action.

F. HIPAA Certificates

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the Welfare Plan will provide you and your dependents with a HIPAA certificate when coverage under the Plan terminates. This certificate will show the length of time you, your dependents, or both were covered under this Plan. You or a dependent may need to show such a certificate to the next group health plan under which you or a dependent has coverage so that plan can determine whether it can apply a limit to any pre-existing condition you or a dependent may have.

This Plan will furnish such a certificate when regular coverage under this Plan ends, when COBRA coverage ends, and upon the request of the covered person within the two years following the termination of coverage. Call the Plan Office if you want a HIPAA certificate.

SECTION 5. EXTENSIONS OF COVERAGE

A. Introduction

There are a number of circumstances in which your coverage and the coverage of your dependents can be continued beyond the date it would normally terminate. The Plan provides some short-term extensions free of charge and others you or your dependents must pay for. Please note that most extensions of coverage are counted toward the maximum COBRA continuation periods described below in Part E of this Section 5. Some of the extensions do not include coverage for weekly income benefits and some do not include life insurance. However, under COBRA, there is no coverage for life insurance or weekly income benefits.

B. Branch O Coverage (Self-Pay)

In the event your covered employment terminates for any reason, you may continue your medical, dental, vision, life, and accidental death and dismemberment coverage on a self-pay basis, for a period not to exceed 12 months. This extended coverage is called Branch O coverage. In order to elect Branch O coverage you must notify the Welfare Office of your intention to purchase Branch O coverage no later than the 30th day of the month following the month in which your covered employment terminates and must pay the required monthly amount by the 1st day of each month commencing with the first month following the month in which your covered employment terminates.

After your Branch O coverage has ended, you have the right to COBRA coverage for the balance of the maximum COBRA continuation period described in Section 5E5 below. (The benefits provided under Branch O are the same as those provided under COBRA, except that under COBRA, you cannot continue the life insurance and accidental death and dismemberment insurance).

C. Continued Coverages When You Cannot Work Due to Illness or Injury

Many collective bargaining agreements and other agreements that provide for contributions to this Plan require employers to continue to make contributions for either 6 or 12 months for individuals who cannot work due to illness or injury. If the agreement pursuant to which you are employed includes this requirement, you and your family will continue to be covered, free of charge, for as long as your employer is required to and does make such contributions.

After your employer's obligation to make contributions has terminated, you may continue your coverage by electing and paying for COBRA coverage as described below in Section 5E. The extended coverage provided by your employer's contributions will count toward the maximum COBRA continuation period.

D. Dependents of Deceased Employee

If you die while eligible for benefits as an active employee, your eligible dependents will continue to be covered, at no charge, for three months following the month in which your employer last made a contribution to the Plan on your behalf, or, if sooner, until the dependent's coverage would otherwise end under the terms of the Plan.

This extension of coverage will be counted toward the maximum COBRA continuation period described in Section 5E.

E. COBRA Continuation Coverage

1. Generally

a. What COBRA Coverage Is

The District No. 9, I.A.M.A.W. Welfare Plan provides continued health and welfare coverage on a self-pay basis pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible employees and their dependents are offered the opportunity for a temporary extension of health coverage called "continuation coverage" in certain instances called "qualifying events," which would normally otherwise cause coverage to end.

You do not have to show that you are insurable to qualify for continuation coverage. However, you must pay the cost of the continuation coverage.

b. Things to Consider When Deciding Whether to Take COBRA Coverage

Your decision to elect or reject COBRA can have an effect on your rights regarding health benefits under federal law. First, under federal law, if you have had health coverage continuously for 12 (or in some cases 18) months and you have less than a 63-day gap in your health coverage when you become covered under another group health plan, that next group health plan cannot limit coverage of any pre-existing conditions you may have. Taking COBRA coverage may help you complete 12 (or 18) months of coverage under this Plan and may help you avoid a 63-day gap in coverage.

Second, federal law generally requires that insurance companies offer individual health insurance policies with no pre-existing condition limitations to individuals who have exercised their right to take COBRA continuation coverage from a group health plan for the maximum period. If you do not take COBRA, you will lose this protection.

Finally, it is important that you know that under the federal law, you have the special right to enroll in any other group health plan for which you may be eligible (such as a plan sponsored by your spouse's employer) within 30 days after your regular coverage under this Plan terminates due to a qualifying event. You will not have to wait until that other plan's next open enrollment period. If you elect COBRA continuation coverage under this Plan, you will have that same special right to enroll in another group health plan at the end of your COBRA coverage if you keep the COBRA coverage for the maximum period it is available to you.

c. Contact for COBRA Questions

If you have any questions regarding this Plan's COBRA continuation coverage, you should call or write:

District No. 9, I.A.M.A.W. Welfare Plan
ATTENTION: COBRA Coordinator
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
1-888-739-6442

2. Qualifying Events That Give Rise to Right to Elect COBRA Continuation Coverage

a. For Employees

As an eligible employee of a contributing employer for whom the contributing employer is making contributions to the Welfare Trust, you will have the right to choose COBRA continuation coverage, if you lose your coverage under the Plan due to:

(1) A reduction in hours of employment; or

(2) Termination of employment for reasons other than gross misconduct on your part.

b. For Spouses

The spouse of an eligible employee covered by the Plan has the right to choose continuation coverage if the spouse loses coverage under the Plan for any of the following reasons:

(1) Death of the employee;

(2) The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;

(3) Divorce or legal separation from the employee; or

(4) The employee's becoming eligible for Medicare.

c. For Dependent Children

The eligible dependent child of an eligible employee has the right to choose continuation coverage if the child loses group health coverage under the Plan for any of the following reasons:

(1) Death of the employee parent;

(2) The reduction of hours of employment or the termination of the employee parent's employment (for reasons other than gross misconduct);

(3) Employee parent's divorce or legal separation;

(4) Employee parent's becoming eligible for Medicare;

(5) Child's ceasing to be an eligible "dependent child" under this Plan.

d. For Certain Retired Employees and Their Dependents

A retired employee, or the dependent of a retired employee, whose former employer is bound to continue making contributions to the Welfare Plan for the retired employee, has the right to choose continuation coverage if the retired employee or dependent loses group health coverage under the Plan by reason of the former employer's filing a bankruptcy proceeding under Chapter 11 of the United States Code on or after July 1, 1986.

3. Benefits Available Under COBRA Continuation Coverage

The only benefits available under COBRA continuation coverage are comprehensive major medical benefits and, if you were eligible while you were a covered employee for vision and dental benefits, the vision and dental benefits. At the time you or your dependents elect COBRA coverage, you will be permitted to choose either "core" coverage (comprehensive major medical benefits) or, for an additional premium, core coverage plus dental and vision. You or your dependents can choose the dental and vision coverages in addition to the core coverage only if you had those coverages as an active employee. Further, you may not continue the dental and vision coverages unless you continue the major medical coverage.

Life insurance and accidental death and dismemberment coverage may not be continued under COBRA.

If you choose COBRA continuation coverage, the Plan is required to provide you coverage which, at the time the coverage is being provided, is identical to the medical coverage provided under the Plan to similarly situated eligible employees or dependents.

4. Required Notices, Election, and Payments

a. Notice to the Plan

Under the law, the **eligible employee or dependent** has the responsibility to provide written notice to the Welfare Plan Office of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of such event or, if later, within 60 days after coverage would terminate because of that event. Otherwise all rights to continue coverage are lost.

In addition, if a person who has COBRA continuation coverage has a second qualifying event, he or she (or someone on his or her behalf) must provide written notice to the Plan of that second qualifying event within 60 days after the occurrence of that second event in order to qualify. If the Plan Office does not receive written notice of the second qualifying event, rights to additional COBRA coverage, if any, will be lost.

To give any of the above notices, you or your dependent should write to the Plan Office at the address listed below and include the following information:

(1) Name and Participant ID of Employee.

(2) Names and addresses of dependents who will lose coverage.

(3) Date of Qualifying Event.

(4) Nature of Qualifying Event.

District No. 9, I.A.M.A.W. Welfare Plan
ATTENTION: COBRA Coordinator
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

The employer making contributions on behalf of an employee has a responsibility to notify the Plan of the employee's death, termination of employment or reduction in hours of employment, Medicare eligibility, or the employer's bankruptcy. Nevertheless, employees and their dependents are encouraged to provide the Welfare Plan Office with written notification of these events as well.

b. Plan's Notice to Employee and Dependents

Within 30 days after the Plan Office receives notice that one of the qualifying events has occurred, it will in turn notify you, your dependents, or both of the procedures for electing COBRA continuation coverage.

c. Election

(1) Time Limit for Election

Under the law, you and your dependents have 60 days from the later of the date you would lose coverage because of one of the events described above or the date you are notified of your continuation rights to inform the Welfare Plan Office that you want continuation coverage.

If you or your dependents do not choose continuation coverage within the required time, all rights to continue coverage will end.

(2) Who May Elect COBRA Coverage

Each employee and eligible dependent who was covered under the Plan on the day before the qualifying event and whose coverage will terminate because of the qualifying event is entitled to make his or her own decision regarding COBRA continuation coverage. This is true even if the former employee chooses not to continue coverage. However, one family member can elect and pay for coverage on behalf of all qualified beneficiaries.

In addition to your dependents who were covered under the Plan on the day before the qualifying event, any child born to you or placed with you for adoption while you have COBRA continuation coverage will also have an independent right to elect to retain COBRA coverage for the balance of the original COBRA period in the event your continuation coverage ends before the end of the maximum period.

d. Payment

COBRA continuation coverage is not free. You must pay for it. The initial payment is due within 45 days after the date you make your election. The first payment must include payment for all months between the termination of regular coverage and the date of payment. Subsequent payments are due on the first day of each month, but will be accepted for up to 30 days after the due date.

e. Coverage During Election and Payment Period

During the period between the termination of your regular coverage and your election and payment for COBRA continuation coverage, the Welfare Plan cannot pay for any expenses incurred after the termination and will notify providers of health care that you have not yet elected or paid for COBRA continuation coverage. If you do ultimately elect and pay for COBRA continuation coverage, the Welfare Plan will then adjudicate claims you may have incurred in the interim.

5. Duration of COBRA Continuation Coverage

a. Termination or Reduction of Hours of Employment

(1) Generally

If the qualifying event is the termination or reduction in hours of employment, the required period of COBRA continuation coverage ends 18 months after the date of the qualifying event.

(2) Extensions

(a) Disability

If prior to the end of that 18-month period, any of the qualified beneficiaries who elected COBRA is determined by Social Security to have been disabled during the first 60 days of COBRA continuation coverage, the maximum COBRA continuation period is extended for an additional 11 months. The disabled person and all other qualified beneficiaries who have COBRA coverage by virtue of the same qualifying event, may purchase coverage for up to a total of 29 months from the date of the original qualifying event. If the disabled person is covered during this 11-month extension, the premium will be 50% higher.

Note: The affected person must notify the Welfare Plan Office, in writing, of the Social Security disability determination before the end of the original 18-month period and within 60 days after Social Security makes the determination. The persons who get this extended coverage must also notify the Plan Office within 30 days after the Social Security Administration determines the disability has ended.

(b) Medicare Eligibility

If the former employee was eligible for Medicare at the time of the qualifying event, the COBRA continuation coverage period of the employee's dependents will not end until 36 months after the date the employee became eligible for Medicare. For example, if you became eligible for Medicare in May of 2007, and then terminated employment in June of 2007, <u>your</u> COBRA period ends December of 2008, but your eligible dependents can continue their COBRA coverage until May of 2010, which is 36 months after your Medicare entitlement.

(c) Second Qualifying Event

If a second qualifying event occurs during the 18-month (or 29-month) period, the maximum continuation period will be extended to 36 months from the date of the original qualifying event for the qualified beneficiaries affected by that second qualifying event. For example, if your employment is terminated on December 31, 2007, you and your eligible dependents are entitled to COBRA continuation coverage until June 30, 2009. However, if in May of 2008, your son turns 19 and is not a full-time student, he has had a second qualifying event, and his COBRA continuation period can continue until December 31, 2010 (36 months from the date of the original qualifying event).

Note: The affected person must notify the Welfare Plan Office, in writing, of this second qualifying event within 60 days after the occurrence of the second qualifying event. Otherwise, the COBRA period will not be extended to 36 months.

b. Other Qualifying Events

For all qualifying events other than the termination of employment or the reduction in hours of employment, the maximum COBRA continuation period is 36 months from the date of the qualifying event.

6. Termination of COBRA Continuation Coverage

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

a. The expiration of the applicable maximum COBRA continuation period;

b. The failure to make a payment before the end of the applicable grace period;

c. After the date that COBRA is elected, the covered individual becomes covered under Medicare or under another group plan, unless that other plan limits coverage of the individual due to the individual's pre-existing condition.

d. The District No. 9, I.A.M.A.W. Welfare Plan or the contributing employer for whom the employee worked or works stops providing group health benefits.

7. Coordination of COBRA Continuation Coverage With Other Periods of Continued Coverage

The maximum period of COBRA continuation coverage for employees and dependents will be reduced by the number of months during which the employee was covered by virtue of his or her making self-payments for Branch O coverage and by virtue of his or her employer's making continued contributions after his or her employment ended. The maximum period of COBRA continuation coverage for a dependent child will also be reduced by the number of months during which the Plan extends coverage for disability and by the number of months during which the Plan extends coverage under Michelle's Law while the child is on a medically necessary leave of absence or other change from full-time attendance at a postsecondary school because of a serious illness or injury. The maximum period of COBRA continuation coverage for the dependent child or spouse will also be reduced by the number of months during which the Plan extends coverage after the death of the employee spouse or parent.

If a participant or dependent initially chooses COBRA coverage rather than any other extended coverage available to the participant or dependent, the participant will have no right at the end of the COBRA period to elect the other extended coverage.

8. Keep Plan Office Informed of Addresses

In order that the District No. 9, I.A.M.A.W. Welfare Plan can make sure that you and all of your covered dependents get all of the notices about COBRA, please keep the Plan Office informed of your current address and the addresses of any covered dependents.

9. Special COBRA Rules For Individuals Eligible For Trade Adjustment Assistance

a. Trade Act – Generally

The Trade Act of 2002 provides that certain workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may be determined by the United States Department of Labor or other government agency to be eligible for "trade adjustment assistance" or "TAA." TAA consists primarily of career counseling, up to two years of training, income support during training, job search assistance, and relocation allowances.

b. Special Election Period

If you do not take COBRA during the normal election period and are determined to be eligible for TAA, you will be entitled to a second 60-day COBRA election period. That second 60-day period will begin on the first day of the month in which you are determined to be eligible for TAA, but you must make your election no later than six months after your active coverage under the Plan ends.

c. Commencement of Premiums and Coverage

If you elect to take COBRA during this second special election period, your COBRA coverage will begin the first day of the special second 60-day election period. Your first payment will be due within 45 days after you make your election and must include all payments due between the first day of the second election period and the date of payment.

d. Pre-Existing Condition Rules

If you elect coverage under these rules, the period of time between your original loss of coverage and the date your coverage recommences under these special rules will not be counted for purposes of determining whether you have had a 63-day gap in coverage for purposes of applying this Plan's (or any other plan's) pre-existing condition limitations.

e. Possible Help in Paying Costs of COBRA

The Trade Act of 2002 created a tax credit for TAA-eligible individuals. You may either take a tax credit or get advance payment of a certain percentage of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information is available online at: www.doleta.gov/tradeact.

10. Special COBRA Subsidy for Individual Eligible Under ARRA

The American Recovery and Reinvestment Act of 2009 "ARRA" provides federal subsidies for payment of COBRA premiums to employees and covered family members who lost coverage due to involuntary termination of employment between September 1, 2008 and May 31, 2010. If you were eligible for and elected the federal subsidy you and your dependents may receive the subsidy for up to 15 months.

F. Extended Continuation of Coverage For Surviving Spouses

1. Generally

A surviving spouse of a deceased employee who became entitled to COBRA continuation coverage because of the death of the employee is entitled to extended continuation coverage for the surviving spouse and the eligible dependent children only if the surviving spouse is 55 years of age or older at the time the COBRA continuation coverage period expires.

2. Procedures for Electing Extended Continuation Coverage

a. Exercise of COBRA Rights Required

In order to be eligible for this extended continuation coverage, the surviving spouse must have properly exercised his or her rights to COBRA continuation coverage and must have maintained that COBRA continuation coverage for the full 36 months permitted under COBRA.

b. Extended Continuation Automatic

If the spouse has complied with paragraph 2a above, the continuation coverage for that spouse and any eligible dependent children will automatically continue if the spouse is 55 or older on the date the COBRA continuation period expires.

c. Notices Required

While the extended continuation coverage should be automatic, the spouse should contact the Plan Office toward the end of the COBRA period to confirm that he or she is eligible for the extended continuation coverage.

3. Terms and Conditions of Extended Continuation Coverage

a. Payment

The spouse is required to pay for this extended continuation coverage. The Plan may charge more for this extended continuation coverage than it charges for COBRA continuation coverage, and the Plan will notify the spouse of the cost and the payment due dates at the time the extended continuation coverage becomes effective.

b. Benefits

The benefits provided under this extended continuation coverage will be the same as those that would be provided to similarly situated persons then eligible for COBRA continuation coverage.

4. Termination of Extended Continuation Coverage

a. Spouse and Eligible Dependent Children

This extended continuation coverage will terminate on the earliest of the following dates:

(1) The date on which the spouse fails to make a required payment when due;

(2) The date the Welfare Plan no longer provides benefits;

(3) The date the surviving spouse becomes insured under any other group plan;

(4) The date on which the surviving spouse attains the age of 65 or otherwise becomes eligible for Medicare.

In addition to the above reasons, the extended continuation coverage for dependent children shall terminate on the date the child ceases to be eligible by getting married or attaining the age of 19 (or the age of 25 for full-time students), except the coverage for an incapacitated dependent child will not terminate while the surviving spouse is covered if the conditions set forth in Section 3B3c of this Booklet are met.

G. Family and Medical Leave

If you take a leave of absence under the Family and Medical Leave Act (FMLA), your employer is required, in most cases, to continue to make contributions to the Plan on your behalf. You should notify the Plan Office if you take FMLA leave so the Plan can make sure it continues to receive the contributions.

H. Extended Coverage for Some Retirees

Some collective bargaining agreements or other agreements require the employer to continue to make contributions on behalf of retirees who meet certain requirements. Consult your collective bargaining agreement to determine whether your employer is required to make such contributions and to determine which coverages are included. This extended coverage never includes coverage for the weekly income benefit.

I. Coverage When You Enter Active Duty in the Uniformed Services

If you, the covered employee, leave covered employment to enter active duty in one of the uniformed services of the United States (Army, Navy, Air Force, Marines, Coast Guard, or uniformed Public Health Service) your coverage and that of your dependents will continue for one month without charge. Thereafter, you and your dependents may purchase COBRA for an additional 23 months. If, after your active duty ends, you return to covered employment within the time set by federal law (which varies depending on the length of your active duty), your coverage under the Plan will resume upon your return as if you had not left covered employment.

You must inform the Plan Office if you enter the uniformed services to insure your rights are protected under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Please Note: No benefits are provided for injuries or illnesses arising out of or in connection with your service in the uniformed services of the United States or any other country.

Summary of Continuation Coverages Available						
Type of Continuation Coverage	Pre-Requisites	Maximum Duration	Payment	Dependents Covered	Benefits	Counts Toward COBRA Period
Branch O	Employment Ends	12 months	You must pay	Yes	All but weekly income	Yes
Employer-paid Extension	Cannot Work Due to Illness or Injury	Varies	Employer must pay	Yes	Medical, Dental, Vision, Weekly Income, Life and AD&D	Yes
Surviving Dependents	You die while Active Participant	3 months	Not required	Yes	All but weekly income	Yes
COBRA	A Qualifying Event	Depends on event	Yes	If coverage elected for dependents	Medical and dental and vision, if elected	Yes
Extended COBRA	Surviving Spouse is 55 at end of COBRA period	Until Age 65	Yes	Yes	Same as those under COBRA	Not applicable

NOTE: Read the descriptions of each type of continuation coverage set forth in this Section 5.

BENEFITS

Note: Your Schedule of Benefits is in the Back of this Booklet.

SECTION 6. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. Introduction

The life insurance benefits for you and your dependents and the accidental death and dismemberment (AD&D) insurance benefits that cover you are provided under a policy of insurance issued by the Life Insurance Company selected by the Trustees. We have set out here a summary of the provisions of that policy. If you would like a complete copy of the policy or certificate of insurance issued by the life insurance company, please contact the Plan Office. In the event of a dispute between this summary and the insurance policy, the policy controls.

B. Eligibility

You and your dependents generally are eligible for life insurance and you are eligible for AD&D insurance at the same time you are eligible for the other benefits provided under the Plan. However, there are some differences. Life insurance and AD&D begins on the first working day of the month. Further, in order to initially qualify for insurance under the life insurance policy, you must be actively at work on the date you would otherwise become eligible, and your dependent cannot be in a hospital or nursing home and your dependent child is covered beginning at the child's live birth. Also, in order for you or any of your dependents to qualify for any increase in coverage you must be actively working in covered employment, and your dependent cannot be in a hospital or nursing home. Also, as described in Sections 4 and 5 of this Booklet, life and AD&D are not provided under a number of the continuation provisions.

Only those retirees whose former employer pursuant to a collective bargaining agreement with the Union (or a participation agreement with the Welfare Trust) is required to contribute to the Welfare Trust for life insurance and AD&D benefits are eligible for life insurance and AD&D benefits. All other retirees are ineligible for the life insurance and AD&D benefits provided under this Section 6.

C. Death Benefits

As a result of your death from any cause, life insurance benefits are payable to the beneficiary you have designated in writing. The amount of the benefit is set out in the Schedule of Benefits which is in the back of this Booklet.

As a result of a covered dependent's death from any cause, life insurance benefits in the amount set out in the Schedule of Benefits will be paid to you.

D. Accelerated Death Benefit (Employees and Retirees Only)

If you are under age 60 and furnish proof acceptable to the life insurance company that you have been diagnosed with a terminal illness and are expected to die within 12 months, you will be eligible for a lump-sum payment, while you are alive, from the life insurance company of up to 80% of the amount of the life insurance benefit. This lump sum payment will reduce the amount of the life insurance benefit payable to your beneficiaries.

If you are diagnosed with a terminal illness, please contact the Plan Office for complete details about this benefit.

E. Accidental Death and Dismemberment (AD&D) Benefits (Employees and Retirees Only)

1. When Payable

Benefits will be paid if you sustain a loss which results from an accidental bodily injury directly and independently of all other causes, which was sustained while you were eligible for benefits, and the loss occurs within 365 days after the injury.

2. Amount of Benefit Payable

The full amount of the benefit shown in the Schedule of Benefits in the back of this Booklet is payable if the nature of your loss is:

a. life;

b. both hands or both feet or sight of both eyes;

c. one hand and one foot;

d. speech and hearing in both ears;

e. either hand or foot and sight of one eye;

f. movement of both upper and lower limbs quadriplegia.

Three-fourths of the amount shown in the Schedule of Benefits is payable if the nature of your loss is:

g. movement of both lower limbs (paraplegia); or

h. movement of three limbs.

One-half of the amount shown in the Schedule of Benefits is payable if the nature of your loss is:

i. movement of the upper and lower limbs on one side of the body (hemiplegia);

j. either hand or foot;

k. sight of one eye; or

l. speech or hearing in both ears.

One-quarter of the amount shown in the Schedule of Benefits is payable if the nature of your loss is:

m. movement of one limb (uniplegia); or

n. thumb and index finger of either hand;

With respect to hands or feet, "loss" means the permanent severance at or above the wrist or ankle joint. With respect to eyesight, "loss" means the entire and permanent loss of sight.

No more than the full amount shown in the Schedule of Benefits shall be paid for all losses resulting from one accident.

F. Exclusions

No Accidental Death and Dismemberment Benefits and no Accelerated Death Benefits will be paid for any loss which results directly or indirectly, wholly or partially from:

1. intentionally self-inflected injury;
2. suicide or attempted suicide, while sane;
3. war or act of war, whether declared or not; or
4. injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority; or
5. injury sustained while taking of drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician; or
6. injury sustained while committing, or attempting to commit a felony.

G. Seat Belt, Air Bag, and Reparation Benefits (Employee Only)

Your beneficiary will receive an additional benefit if you die while wearing a seat belt, or while wearing a seat belt in an automobile equipped with an air bag. The seat belt benefit is 10% of the AD&D amount up to a $10,000 maximum. The air bag benefit is 5% of the AD&D amount up to a $5,000 maximum. The seat belt and air bag benefit will not be payable if you are driving while intoxicated or taking drugs unless as prescribed or administered by a Physician.

If you die outside the territorial limits of the state or country of your permanent place of residence and life and AD&D benefits are payable, then reimbursement is available for expenses incurred for preparation of your body for burial or cremation and transportation of your body to the place of burial or cremation. This is called a reparation benefit. The reparation benefit is 5% of the AD&D amount up to a $5,000 maximum.

H. Travel Assistance Benefits

The life insurance company provides travel assistance benefits which include pre-trip information, emergency medical assistance, and emergency personal services. The travel assist program provider must be contacted at the time of service in order to arrange and/or approve payment or reimbursement.

I. Termination of Insurance

The life insurance and AD&D benefits generally end at the same time as the other benefits under the Plan, but, as noted, these benefits are not available with all of the types of continuation coverage described in Section 5. In addition, those benefits will end if the Plan fails to pay the premiums.

J. Conversion to Individual Policy

You or a dependent may be able to convert a part or all of the group term life insurance under the Life policy to an individual life insurance contract when your coverage or your dependent's coverage ends due to the termination of employment, due to the end of your or your dependent's membership in an eligible class, or due to the termination of the group policy. If your coverage ends because the Plan's contract with the life insurance company to provide life insurance ends, you must have been covered for five years in order to be eligible for conversion. The life insurance company will determine the individual premium. You must apply and pay for conversion coverage within 31 days after your group coverage ends. If the Plan Office fails to notify you of your conversion rights within 15 days after your group coverage ends, the application period may be extended for up to 15 days from the date the Fund sends or gives you such written notice. In no event will the application period extend beyond 91 days from the date of the termination of group coverage.

If you are interested in obtaining a conversion policy, contact the Plan Office as soon as you determine your or your dependent's coverage under the group policy is going to end.

NOTE: If you or a dependent dies during the 31-day conversion application period, the insurer will pay the maximum amount you or the dependent could have converted, but will pay no other benefits.

SECTION 7. WEEKLY INCOME BENEFITS FOR ILLNESS OR ACCIDENTAL INJURY

A. Generally

In the event you suffer a loss of earnings due to an illness or injury which prevents you from performing your job, weekly benefits are payable up to the maximum shown in the Schedule of Benefits.

Weekly benefits begin on the first day of accidental injury, and on the eighth day of illness, and continue for the maximum number of weeks set forth in the Schedule of Benefits during any one continuous period of disability.

There is no reduction or restriction of benefits because of age.

Weekly Income Benefits do not require you to be house confined, however, you must be under the direct care of a physician.

No weekly income benefits are provided to dependents.

B. Continuous Period - New Period

For this coverage, a continuous period of illness of injury includes all periods of illness or injury due to the same or related cause or causes, separated by less than three months of continuous, full-time, active work.

C. Limitations

Coverage for Weekly Income Benefits is limited to the maximum number of weeks shown on the Schedule of Benefits *per calendar year*. Accordingly, if you have more than one illness or accidental injury during a calendar year that prevents you from working, all Weekly Income Benefits added together cannot exceed the maximum number of weeks shown on the Schedule of Benefits.

D. No Weekly Income Benefit for Work-Related Illness or Injury

The Plan will not pay you weekly income benefits if your illness or injury arises out of or in the course of any employment for any employer or any self-employment or for which the individual is entitled to benefits under any workmen's compensation or occupational disease law or for which the individual receives any settlement from a worker's compensation carrier or self-insured employer.

Once you allege an injury is work-related, the Plan will not pay weekly income benefits until:

1. an Administrative Law Judge (ALJ) determines the injury is not work-related, or
2. until the worker's compensation claim is dismissed and the Plan receives medical evidence that the injury is not work-related.

E. Other Exclusions

No weekly income benefits are payable for any injury or illness that results from or is due to any war or act of war, whether declared or undeclared.

No benefits are payable for any illness or injury that occurs during or as a result of your engaging in conduct that constitutes a crime, as determined by the Plan and the Trustees.

F. Guidelines Applied

The Plan applies the guidelines in the "Official Disability Guidelines Treatment in Workers' Comp" (ODG Treatment in Workers' Comp) published by the Work Loss Data Institute in determining weekly income benefits provided under this Section 7.

SECTION 8. COMPREHENSIVE MAJOR MEDICAL BENEFITS

A. Pre-certification, Utilization Review and Case Management

1. Generally

a. Pre-Certification

As previously mentioned, under the terms of the Utilization Management Program, a Network Provider must obtain pre-certification for elective hospital admissions, outpatient surgeries, ambulatory services, home health care and outpatient physical therapy. While you will not be penalized solely because of the failure of a Network Provider or other provider to obtain pre-certification, it is in your interest that pre-certification be obtained in that the Plan does NOT pay for any care or treatment which is not medically necessary. While pre-certification does not automatically guarantee that all expenses will be paid by the Plan, it does significantly reduce the possibility that medically unnecessary care or treatment will be provided. Accordingly, both you and your provider are encouraged to obtain pre-certification through the medical network provider.

Special rules apply to any care or treatment for mental illness or drug or alcohol problems. For any treatment of any sort for a mental illness or a drug or alcohol problem (except emergencies) you must obtain pre-certification or pre-approval from the Plan's Mental Health Case Manager, before the treatment begins. Only treatment approved by the Mental Health Case Manager will be covered. In the case of an emergency, you must notify the Plan's Mental Health Case Manager within 48-hours after the commencement of the emergency hospitalization or other emergency treatment and obtain approval for continuing treatment. If you fail to comply with these special rules regarding pre-certification of treatment of mental illness, and drug and alcohol problems, the Plan will not pay for treatment of these conditions.

b. Utilization Review and Case Management

In addition to providing pre-certification services, the medical network provider will monitor the length of any hospital stay. For a complex, lengthy, or expensive course of medical treatment, will monitor and manage your ongoing treatment and help insure you are receiving the most appropriate treatment at the most appropriate cost. The Plan's Mental Health Case Manager will provide review and approval of your ongoing treatment for any mental illness or drug or alcohol problems.

2. Medical Pre-Certification

a. Services for Which Provider is Required to Obtain Pre-certification

Under the terms of the Utilization Management Program, Network Providers must obtain pre-approval or pre-certification for non-emergency hospital admissions, certain surgical procedures, ambulatory services or ancillary services. Refer to the following website for a current list of services for which pre-certification is required: www.d9trusts.org.

b. How and When to Obtain Medical Pre-certification

(1) **Generally.** Generally, when you learn that you or one of your covered dependents will be receiving any of the services or supplies requiring pre-certification, you or your doctor should contact the medical network provider prior to commencement of the recommended treatment. You or your doctor may contact the medical network provider at the telephone number which is set forth on the Schedule of Benefits which is in the back of this Booklet and on your Plan identification card.

(2) **Emergency Hospital Admission or Treatment.** You or your covered dependent should contact the medical network provider within 48 hours after an emergency hospitalization or commencement of emergency treatment, including a pregnancy-related admission. For such admissions that occur on holidays or weekends, the medical network provider should be notified within 48 hours after the admission or on the next business day, if later.

c. Effect of Obtaining Medical Pre-certification

When your hospitalization or other treatment is approved by the medical network provider, that pre-approval does not guarantee that all expenses you incur will be paid by the Plan. It means only that the hospitalization or other treatment is appropriate for the illness or injury based on the facts as described. Charges submitted for pre-approval are subject to all other limitations, exclusions and conditions set forth in this Booklet.

If you or your provider fails to obtain pre-certification for one of the above listed procedures or services, there is no penalty for you. However, the benefit to you is that obtaining pre-certification makes it less likely that you will discover after you have already received a treatment or service that such treatment or service will not be covered by the Plan.

3. Medical Case Management

a. Concurrent Review of Hospital Stay or Course of Treatment

If you or one of your dependents is hospitalized or undergoing a course of medical treatment, the Medical Case Manager will monitor the hospitalization or course of treatment. If after consulting with the treating physician, the Medical Case Manager determines further hospitalization or other treatment is inappropriate, you or your doctor will be notified. The Plan will not cover continued hospitalization or treatment that has been determined to be unauthorized. Concurrent review is automatically undertaken when the pre-certification process has been initiated. (With respect to hospitalizations for childbirth, see Section 8G10 of this Booklet.)

b. Discharge Planning and Case Management

The Plan's Medical Case Manager will also monitor any hospitalization or course of treatment and will work with you or your dependent and the treating doctors to make sure you or your dependent are receiving the most appropriate care in the most appropriate setting at a reasonable cost. In most cases, the case manager's review will not affect the care you or your dependent receives. The case manager will simply report to the Plan that the care recommended for you or your dependent is appropriate. However, where the case manager determines there is a need for complex or extended treatment, the case manager will work with you and your medical providers to help insure that you or your dependent receives the care that is the most appropriate in the setting that is most appropriate for your circumstances and that is also economical for the Plan.

This can be of significant help to you and your family and can also save your Plan money. For example, if you or a dependent is hospitalized for a serious or incapacitating illness, the case manager will help identify and arrange for the services you or your dependent will need when discharged from the hospital. The Case Manager's helping to arrange for such services not only makes it easier for the patient when he leaves the hospital, it may also make it possible for the patient to leave the hospital sooner. This would be better for you and for the Plan.

In some limited circumstances, the Medical Case Manager may recommend alternative services or providers which would not normally be covered under the Plan if the Medical Case Manager determines such services or providers would be effective and would not cost the Plan more than services which would normally be covered. The Medical Case Manager may also provide you and your family with training and education regarding your illness.

If it is determined you or one of your dependents requires case management services, the Medical Case Manager will contact you.

c. Second Medical Opinion and Other Information

The Plan, through the Medical Case Manager, may require you to obtain, at the Plan's expense, a second medical opinion as to a recommended course of treatment or to provide other information so that the Plan can make appropriate decisions.

d. Voluntary Pre-Treatment Medical Review

When the Plan receives claims, it will make a determination about whether the services or supplies you received were medically necessary. If it determines they were not necessary, such services or supplies will not be covered. If your doctor prescribes an extended or expensive course of treatment, or what seems to you to be an unusual treatment, you may ask the Plan Office to have the proposed course of treatment reviewed before you undertake it to determine whether it will ultimately be covered.

There are a couple of treatments that are more likely than others to be determined to be unnecessary. The Plan will always review the necessity of these treatments when they are proposed if you request such a review. While the Plan cannot review every other proposed course of treatment, if your doctor prescribes or proposes a treatment that is extended, very expensive, or seems unusual, the Plan will most likely review it upon your request. The pre-treatment review may help you avoid undergoing a treatment that is not covered.

4. Mental Health Pre-Certification and Case Management

Anyone seeking treatment for any mental illness or any drug or alcohol problem must contact the Mental Health Case Manager (see Section 14H) to get pre-authorization and pre-approval of any such treatment. You must contact the Mental Health Case Manager prior to seeking treatment. The Mental Health Case Manager will direct you to the appropriate provider and will authorize appropriate care. (In case of emergency hospital admission or emergency treatment, you must contact the Mental Health Case Manager no later than 48-hours after the admission or commencement of treatment). Further, as your care continues, the Mental Health Case Manager will monitor your progress and will authorize continuing treatment at appropriate facilities and with appropriate professionals. **If you receive non-emergency treatment for a mental illness or drug or alcohol problem that has not been pre-approved by the Mental Health Case Manager, the Plan will not pay for such treatment.** *Further, if you fail to notify the Mental Health Case Manager within 48-hours of an emergency hospital admission or the commencement of emergency treatment, the Plan will not pay for the hospitalization or treatment.*

The Plan will cover mental, drug, or alcohol treatment that has been pre-authorized by the Mental Health Case Manager like any other major medical treatment you receive. In most cases, the Mental Health Case Manager will refer you to professionals and facilities who are members of the Mental Health Case Manager Network. Such services will be covered like any other in-network treatment, which means after the deductible is satisfied, the Plan pays 90% of covered charges. However, if the Mental Health Case Manager approves treatment by a professional or facility that is not a member of the Mental Health Case Manager network, the Plan will cover that treatment like any other non-network treatment you receive, which means after the deductible is satisfied, the Plan will pay only 60% of the covered charges and you will have to pay 40%.

B. Use of Network Providers

For medical treatment, the Plan participates in a medical network program which has agreements with a number of doctors, hospitals, and other providers of health care services to provide health care to you and your eligible dependents at rates that are often reduced. A current list of doctors, hospitals and other providers who are members of the network can be obtained online (see Section 14H for website address).

Under the medical network program, there are three levels of doctors, hospitals, and other providers:

Level 1 – HMO Providers;

Level 2 – PPO Providers; and

Level 3 – Non-Network Providers.

The Level 1 HMO Providers generally charge the Plan the least for your care, and the Level 2 PPO Providers generally charge less than Level 3 Non-Network Providers. The level of your benefits is determined by which level of provider you choose. If you choose an HMO Provider, the Plan will pay 90% of the covered charges after the deductible, and you will pay 10%. If you choose a Level 2 PPO Provider, the Plan will pay 80% of the covered charges after the deductible, and you will pay 20%. If you use a non-network provider, the Plan will pay 60% of the covered charges (non-network provider charges

are limited to the reasonable and customary charges as defined in Section 2B of this Summary Plan Description), after the deductible, and you will pay 40%.

The rates charged by non-network providers are often higher than those charged by network providers. So, you not only pay a higher percentage of charges, but often you pay a higher percentage of higher charges when you use non-network providers.

Please note: While the Level 1 Providers are referred to as HMO Providers, this is not a traditional HMO. You do not have to choose a primary care physician. You do not have to obtain referrals to see a specialist. This is truly an "open access" program. Each time you seek medical care, you can choose any provider you wish. However, as you can see, if you choose an HMO provider, both the charges and your share of those charges will be lower. Both you and the Plan will save money. Therefore, we urge you to use HMO providers whenever you can.

Network providers will normally obtain the necessary pre-certification, however, you may call the medical network provider to confirm pre-certification even when you use a network provider. The telephone number for pre-certification is set forth in the Schedule of Benefits in the back of this Booklet and on your Plan identification card.

See Section A4 above for information about the mental health network for mental illness and drug and alcohol problems.

C. Other Cost Saving Features of Plan

In addition to saving money by using preferred providers and by complying with the pre-certification and utilization review requirements, you may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described at Section 8G1 of this Booklet. Also, please see Section 8D3 with reference to pre-admission/pre-surgical testing and outpatient surgeries.

D. Deductibles and Co-Payments, Stop-Loss Amounts, and Maximum Benefits

1. Deductibles

a. Individual

The individual deductible is $250.00 per year.

b. Family

The family deductible is $750.00 per year.

c. Carry-Over

When any part of a year's deductible is applied against expenses incurred during the last three months of that calendar year, the deductible amount you must pay in the following calendar year will be reduced by the amount so applied.

d. Emergency Room Co-Pay

Each time you or a dependent visits an emergency room, you must pay the first $75.00 of covered charges. This $75.00 does not count toward the annual deductibles or the stop loss amounts. If the covered person is admitted to the hospital from the emergency room, the $75.00 emergency room co-pay will be waived.

2. Co-Insurance and Stop-Loss Amounts

Until you have satisfied the appropriate deductible and incurred additional covered expenses for covered services equal to the Stop-Loss Amounts set forth in the Schedule of Benefits contained in the back of this Booklet, you must pay part of the covered expenses of covered services. The portion of expenses you must pay is the co-insurance amount.

If you use an HMO provider, the Plan pays 90% of the covered expenses of covered services, and you pay 10%. If you use a PPO Provider, the Plan pays 80% of the covered expenses, and you pay 20%. If you use a non-network provider, you must pay 40% of the covered expenses of covered services, and the Plan will pay only 60%. See Section 8B for description of three levels of providers.

a. Individual. After you have or one of your eligible dependents has satisfied the deductible and has incurred additional covered expenses for covered services in an amount equal to the Individual Stop-Loss Amount set forth in the Schedule of Benefits contained in the back of this Booklet, the Plan will pay 100% of the covered expenses for covered services incurred by that same individual for the remainder of the calendar year.

b. Family. After three of your covered family members have incurred, in addition to the applicable deductibles, covered expenses for covered services in an amount equal to the Individual Stop-Loss Amount, the Plan will pay 100% of the covered expenses for covered services for you and all of your eligible dependents for the remainder of the calendar year.

You must satisfy the deductible plus the Stop-Loss Amount before the Plan pays 100% of covered expenses.

3. No Annual Deductibles or Co-Insurance for Out-Patient Surgeries, Pre-Admission/Pre-Surgical Testing, or Certain Treatment of Accidental Injuries

a. Outpatient Surgery

No deductible or co-insurance is applied to the following charges incurred in connection with surgery which results from an illness and which is performed other than while the individual is hospitalized or has been admitted to the hospital:

(1) Eligible charges by a legally qualified physician for such surgery, and

(2) Hospital charges and hospital-type charges.

The Plan uses internal guidelines to determine the reasonable and customary limit on charges from non-network surgery centers. Therefore, covered benefits for outpatient surgeries performed at non-network surgery centers are often significantly less than covered benefits for outpatient surgeries performed at network surgery centers.

Note: If you are confined to a hospital for more than 23 consecutive hours, the above charges will be considered charges incurred in connection with an inpatient surgery and the normal deductible and co-insurance <u>will</u> apply to those charges.

b. Pre-Admission/Pre-Surgical Testing

No deductible or co-insurance applies to charges for pre-admission/pre-surgical testing within seven days of an inpatient or outpatient surgery. Pre-admission/pre-surgical testing means x-ray and lab exams made in contemplation of and within seven days before a scheduled surgery which is performed in an inpatient or outpatient surgical setting.

c. Treatment of Accidental Injuries

No annual deductible or co-insurance applies to covered charges incurred for treatment of an accidental injury that is provided during the 48 hours following the accident. You will have to pay the $75.00 emergency room co-pay if you visit the emergency room. Any charges incurred for treatment occurring more than 48 hours after the accident <u>will</u> be subject to co-insurance and all deductibles.

4. Lifetime Maximum Benefit

The maximum lifetime comprehensive major medical benefit provided under the Plan is $1,500,000.00. <u>All</u> of the comprehensive major medical benefits paid out on behalf of an individual are added together to determine whether that individual has reached the lifetime maximum.

E. Covered Charges

Benefits are provided by the Plan for charges or expenses you or your covered dependents incur <u>only</u> for the medical treatments, services, or supplies set forth below and <u>only</u> <u>if</u> the treatment, service or supply is medically necessary for the care or treatment of an illness, (including pregnancy for you or your covered spouse), <u>and</u> the charges are reasonable and customary.

<u>Important Note</u>: Benefits for the treatments, services and supplies listed here are all subject to the limitations and exclusions set forth in Sections 8F and 8H of this Booklet, and some are subject to the

additional conditions and limitations set forth in Section 8G of this Booklet. Review those Sections carefully.

Charges For The Following Are Covered

1. Room and board and routine nursing services for confinement in a hospital, limited to the hospital's prevailing charge for a semi-private room. (For specific rules regarding hospitalizations for childbirth, see Sections 8G9 and 8G10 of this Booklet).

2. Medical services and supplies provided by hospital.

3. Anesthetics and their administration.

4. Professional services and medical treatment given by or in the presence of a licensed doctor of medicine or osteopathy or professional services rendered by one of the following providers of medical care, if such treatment is within the scope of the doctor's or other provider's license and the treatment is otherwise covered under this Plan.

   Licensed Chiropractor

   Licensed Dentist

   Licensed Optometrist

   Licensed Podiatrist

   Licensed Psychologist

   Licensed Speech Therapist or Licensed Speech Therapy Assistant

   Licensed Audiologist

   Licensed Registered Nurse

   Licensed Practical Nurse

   Licensed Physical Therapist or Licensed Physical Therapy Assistant

   Licensed Occupational Therapist or Licensed Occupational Therapy Assistant

   Licensed Nurse Practitioner

   Licensed Physician's Assistant

   Note: No charges for professional services of other providers of medical care are covered under the Plan unless you or your covered dependent is referred to such other provider by the Medical or Mental Health Case Manager organization and such other provider is a member of the appropriate Network.

5. X-ray exams (other than dental), lab tests and other diagnostic services including mammography and pregnancy exams.

6. X-ray and radiation therapy.

7. Speech therapy by a doctor or speech therapist to restore or rehabilitate speech lost or impaired by reason of an illness (other than a functional nervous disorder) or by reason of surgery due to an illness. If the speech loss or impairment is due to a congenital anomaly, any available surgery to correct the anomaly must have been performed prior to the speech therapy or the cost of the therapy will not be covered.

8. Physical therapy to restore or rehabilitate physical capabilities lost or impaired by reason of an illness or by reason of surgery due to an illness.

9. Occupational therapy charges for treatment or services rendered by a registered occupational therapist for conditions resulting from an injury or illness which will improve a body function through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in occupational therapy.

10. Repair or replacement of natural teeth and treatment of a fractured or dislocated jaw injured, damaged, or lost by reason of an accidental injury, but only if the treatment is initiated within 24 months of the accidental injury.

11. Transportation within the United States or Canada by professional ambulance service, railroad, or regularly scheduled airplane to, but not returning from the hospital or facility nearest to the covered individual which is equipped to furnish treatment for the covered individual's condition. If the nearest appropriate hospital or facility is not a Network facility, transportation to the nearest appropriate Network facility will be covered.

12. Room and board and routine nursing services for confinement in a skilled nursing facility, limited to one-half of the average semi-private hospital room and board rate prevailing in the area, but only if the confinement commences within 14 days following confinement in a hospital for at least three consecutive days for the same illness and only if the confinement in the skilled nursing facility is not for routine custodial care (see definition in Section 2 of this Booklet) and the individual is visited by his or her doctor at least once each 30 days.

13. Purchase of medical supplies or the rental of durable medical equipment up to the cost of purchase.

14. Home health care services and supplies.

15. Hospice services.

16. Surgical sterilization, but not its reversal.

17. Prescription drugs.

Important Note: Benefits for the above listed services and supplies are all subject to the exclusions and limitations set forth in Sections 8F and 8H of this Booklet, and some of them are subject to the additional terms, conditions, and limitations set forth in Section 8G of this Booklet. Review those Sections carefully.

F. Exclusions and Limitations Applicable to All Comprehensive Major Medical Benefits

No major medical benefits of any sort are payable for any of the following:

1. Charges for any care, treatment, services, supplies or materials which are not necessary to the care or treatment of an illness.

2. Charges for any care, treatment, services, supplies or materials undertaken without the recommendation of a legally qualified doctor.

3. Charges which would not have been made if the individual were not eligible for medical insurance or benefits.

4. Charges which the covered individual is not legally obliged to pay.

5. Charges which are in excess of the reasonable and customary charges for the services performed and the materials furnished. (See definition in Section 2 of this Booklet).

6. Charges for treatment by a doctor or other professional which is not within the scope of his or her license.

7. Charges for care, treatment, services or supplies that are experimental or investigative in nature with reference to the illness being treated. (See definition in Section 2 of this Booklet).

8. Charges for care, treatment, or surgery on the teeth, gums or alveolar process, or dentures, appliances or supplies used in such care or treatment, except the Plan will pay the hospital charges if the covered individual is admitted to a hospital while receiving such treatment, will pay dental charges arising out of an accidental injury as set forth above at Section 8E10 of this Booklet, and will pay all charges associated with the removal of impacted wisdom teeth.

9. Charges for the purchase of hearing aids.

10. Charges for the treatment of refractive errors, including but not limited to, eye exams, radial keratotomy procedures and other forms of surgery.

11. Charges for eyeglasses and contact lenses or the fitting of them, except that the Plan will treat charges for lenses made necessary by cataract surgery as covered charges.

12. Charges for any treatment for cosmetic purposes or for cosmetic surgery, (see definition in Section 2 of this Booklet) except the Plan will pay for cosmetic treatment or surgery due solely to an accidental injury or solely to a birth defect, provided such treatment is undertaken as soon as it is medically feasible. For specific information regarding reconstructive surgery following mastectomy, see Section 8G11 of this Booklet.

13. Charges for services of a person who usually lives in the same household as the covered individual, or who is a member of the covered individual's immediate family or the family of his or her spouse.

14. Charges for services or supplies furnished by an agency of the United States Government or a foreign government agency, unless:

    (a) excluding them is prohibited by law; or

    (b) the covered individual is legally required to pay in the absence of insurance or medical benefits.

15. Charges related to changing the sex of an individual.

16. Charges for cognitive therapy, by any name called (see definition in Section 2 of this Booklet).

17. Charges for vocational rehabilitation, by any name called (see definition in Section 2 of this Booklet).

18. Charges for behavior modification therapy, by any name called (see definition in Section 2 of this Booklet).

19. Charges for an abortion performed for any reason other than to prevent the death of the mother, except that the Plan will cover charges for treatment of the complications of an abortion and charges for treatment of spontaneous abortions.

20. Charges for in vitro fertilization, artificial insemination, or any other artificial means of conception.

21. Charges incurred in connection with the pregnancy of anyone other than a covered employee or the spouse of a covered employee.

22. Charges for the surrogate pregnancy of any person.

23. Charges for contraceptive injectables for contraceptive purposes, and charges for contraceptive implants and appliances, regardless of the purpose for which they are prescribed.

24. Charges for external devices, penile implant surgery, or vascular surgery to correct blockage of blood flow to the penis for the treatment of erectile dysfunction. Injections and insertions for erectile dysfunction are limited to four per month, only after unsuccessful use of oral medication for a 60-day period.

25. Charges for care or treatment due to any act of war, declared or undeclared.

26. Charges arising from or in connection with the covered individual’s service in the uniformed services of the United States or of any other country.

27. Charges for the treatment of any illness or injury that arises out of or in the course of any employment for any employer or any self-employment or for which the individual is entitled to benefits under any worker's compensation or occupational disease law or for which the individual receives any settlement from a worker's compensation carrier or a self-insured employer. Once a work-related injury is alleged, the Plan does not pay benefits until:

    a. an Administrative Law Judge (ALJ) determines the injury is not work-related, or

    b. until the worker’s compensation claim is dismissed and the Plan receives medical evidence that the injury is not work-related.

28. Charges for custodial care or general housekeeping services (see definition in Section 2 of this Booklet).

29. Charges for the treatment of any injury or illness that occurs during or as a result of the covered individual's engaging in conduct that constitutes a serious crime, as determined by the Plan and the Trustees.

30. Charges for personal comfort items, including but not limited to: television, newspaper, telephone, books, slippers, etc.

31. Charges incurred by your dependent spouse or child who has medical benefits provided by or through his or her own employer or union, or his or her parent's employer or union, unless the type and amount of benefits provided by or through that employer or union, when that plan of the other employer or union is primary under this Plan's coordination of benefits rules, are not affected by the fact the dependent is also covered under this Plan.

32. Charges which are not listed as covered by this Plan.

G. Additional Terms, Conditions and Limitations Applicable to Specific Benefits

In addition to the terms, conditions, limitations and exclusions set forth in Section 8F above and 8H that follows, the specific benefits described in this Section are subject to the additional terms, conditions and limitations set forth in this Section.

1. Prescription Drug Benefits

a. Prescription Drug Benefits

(1) Generally. The Trustees have retained the services of a pharmacy benefits manager (PBM) (see Section 14H). The PBM has an extensive network of pharmacies at which you will use your prescription card to obtain your prescription medication upon your payment of the appropriate co-payment. The PBM has contracted with these network pharmacies to provide drugs at a discount. It is to your benefit to use a network pharmacy.

If you use a non-network pharmacy, you must pay for your prescription and then file a claim for reimbursement. You may obtain a claim form from the Plan Office, from your shop steward, or in some cases, from your employer. The Welfare Plan will reimburse you for the "covered cost" of the covered prescription drugs you obtain at a non-network pharmacy minus your 20% co-payment. However, the "covered cost" is the lesser of the amount a network pharmacy would charge or the amount the non-network pharmacy actually charged you. If the non-network pharmacy charges more than a network pharmacy, you will have to pay the difference.

You will receive a prescription drug card that has all of the relevant telephone numbers on it. You will also be provided with a list of participating pharmacies and you can call the Plan Office or the pharmacy benefits manager to determine whether a particular pharmacy is in the network. You will also be able to obtain long-term maintenance drugs from the mail-order pharmacy.

(2) Retail Pharmacy Benefits. As indicated above, in order to receive your prescription at a network retail pharmacy, you will present your card and prescription to the pharmacist at a participating pharmacy. You will be required to pay the pharmacist a co-payment for each prescription. You may not obtain any more than a 30-day supply for a single co-payment.

The amount of your co-payment depends on whether you receive a generic drug, a preferred brand-name drug, or a brand-name drug that is not on the preferred list. You will be provided with a list of the preferred brand-name drugs.

As you will note, your co-payment is lower for generics than for brand-name drugs and is lower for preferred brand-name drugs than for other brand-name drugs. Thus, if you encourage your doctor to prescribe generic or preferred drugs, you will save money.

Co-Payments. Your co-payments for prescription drugs you obtain at a participating pharmacy will be as follows:

	You Pay:
Generic Drug	20% of the charge with a minimum co-payment of $8.00 and a maximum co-payment of $100.00
Preferred Brand Name Drug	20% of the charge with a minimum co-payment of $20.00 and a maximum co-payment of $100.00
Non-Preferred Brand Name Drug	20% of the charge with a minimum co-payment of $35.00 and a maximum co-payment of $100.00

Please Note: If you obtain prescription drugs at a non-network pharmacy, you will be required to pay for your prescription and submit a claim to the PBM for reimbursement. If your claim is otherwise payable, you will be reimbursed for the covered cost less the 20% co-payment. The covered cost is the lesser of the amount you actually paid or the amount that would have been charged by a network pharmacy. You may get a claim form from the Plan Office, from your shop steward, or in some circumstances, from your employer.

(3) Mail-Order Benefits. The new program contains a mail-order component for long-term maintenance drugs. After you have gotten two consecutive 30-day fills of a prescription at a retail pharmacy you may begin to take advantage of the mail-order program. Under this mail order program, you can obtain a 90-day supply of prescription drugs and your co-payments will be as follows:

	You Pay:
Generic Drug	13.33% of the charge with a minimum co-payment of $16.00 and a maximum co-payment of $200.00
Preferred Brand Name Drug	13.33% of the charge with a minimum co-payment of $40.00 and a maximum co-payment of $200.00
Non-Preferred Brand Name Drug	13.33% of the charge with a minimum co-payment of $70.00 and a maximum co-payment of $200.00

The phone number and other information you need to use the mail-order program is on your prescription card.

(4) **Special Rule for Certain Antihistamines (Often Used to Treat Allergies).** The Plan will treat all non-sedating antihistamines (such as Clarinex and Allegra) as non-preferred brand name drugs. Thus, you will have a minimum retail co-payment of $35 for each 30-day supply of such non-sedating antihistamines. The Plan will not pay any benefits at all for antihistamines that are over the counter.

(5) Policy Regarding Stolen Medications. The Plan will cover a refill of a non-narcotic prescription with a valid police report stating that the prescription was reported stolen. No refills of narcotic prescriptions will be provided under this policy. One stolen refill per calendar year will be allowed.

(6) Coordination of Drug Benefits. If a person covered under this Plan is also covered by another health plan which provides prescription drug benefits and which, under the coordination of benefits rules set out at Section 8I of this Booklet, pays its benefits before this Plan pays its benefits, that covered person will not be eligible for drug benefits as described here. Rather, that person should submit a claim to the other health plan or use the other health plan's benefits first, and if the other health plan does not pay the cost in full, may submit a paper claim to this Plan for the balance due. See Section 12C of this Booklet which describes the procedure for filing claims.

(7) Drug Co-Pays and Plan Deductibles and Maximums. The co-pay amounts do not count toward the regular major medical deductibles and co-insurance. However, the amounts the Plan reimburses or pays for prescription drugs are counted toward the maximum lifetime comprehensive major medical benefit.

b. Specialty/Injectable Drug Benefits

(1) Generally. The PBM is the preferred pharmacy provider for the Fund's specialty drug program and establishes the allowable cost for specialty drugs based on published standards. This means that your doctor or other medical provider should obtain specialty drugs needed for your treatment from the PBM, and even if your doctor obtains such drugs from another source, the allowable cost as established by the PBM will be the maximum amount covered by the Plan.

Specialty drugs shall encompass all drugs, and biological, human or animal derived products or biosynthetic agents, including preparations that are sterile and pyroxene free which are administered via injection or any type or alternative means of administration including infusion and implantation.

All injections, no matter where administered, including but not limited to, inpatient facilities, outpatient facilities, doctors' offices or the patient's home shall be subject to the Specialty Drug Program. The Specialty Drug Program does not apply to one-time routine injections of antibiotics or routine immunizations.

In a collaborative effort with the PBM, the Trustees have been able to affect recent cost reductions, which we are passing on to you, our valued participant.

Should you require specialty drugs, please inform your physician of these benefit provisions. Your physician will only be reimbursed at the allowable cost as determined by the PBM. In those rare cases where a bio-injectable or specialty drug is urgently needed, your physician can administer the first round of medication without contacting the PBM. Thereafter, you must contact a PBM case coordinator to make proper arrangements for future doses of specialty medications.

Contacting the PBM is critically important; because it will help you minimize your out-of-pocket costs and maximize your lifetime specialty drug and medical benefits.

(2) Co-Payment and Out-of-Pocket Amounts. There is a 20% co-payment, up to a $100 maximum per month, for each specialty drug. There is a separate annual $2,500.00 Out-of-Pocket for specialty drugs. This means after you have paid $2,500.00 in co-payments for specialty drugs, during a year, the Plan will, for the rest of the year, cover 100% of the allowable cost as established by the PBM. Please note, the amounts you pay for specialty drugs will not be included in determining whether you have reached the annual Stop-Loss that applied to other Major Medical Benefits under the Plan. The lifetime maximum for these specialty drugs is limited to $250,000.00, which is included in the Plan's overall $1,500,000.00 lifetime maximum benefit.

(3) Special Rules for Cancer Treatments. Specialty drugs used for the treatment of cancer or used to minimize the side effects of cancer treatment are no longer subject to deductibles or co-payments and are excluded from the specialty drug $250,000.00 lifetime maximum. However, they are still subject to the PBM's established maximum allowable cost.

(4) Special Rules for Migraine Therapies. Insulin and injectable migraine therapy are excluded from this Specialty Drug Program and can be purchased at your local retail pharmacy or through the PBM's mail service. There may also be other drugs excluded from this Program. If you have any questions about how your specialty drugs are covered, please contact the PBM.

(5) Centers of Excellence. The PBM has made arrangements with several Centers of Excellence, which will provide you with the highest quality specialty drug therapy in

the St. Louis metropolitan area. If your own doctor is unwilling to accept the allowable cost as established by the PBM, you should contact the Fund Office or the Case Manager for assistance in identifying these centers.

If you have any questions regarding your specialty drug benefits, please feel free to contact the PBM or the Fund Office for more information.

c. Exclusions from Prescription Drug Benefit

The following are <u>not</u> covered under the Prescription Drug Benefit:

(1) Any drugs or medicines that are excluded under the limitations and exclusions set forth at Section 8F of this Booklet that apply to all comprehensive major medical benefits;

(2) Drugs or medicines that are taken or administered while the covered individual is a patient in a hospital, skilled nursing facility, convalescent hospital, nursing home, rest home, sanitarium or similar institution. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(3) Drugs or medicines that are administered or dispensed by the doctor prescribing the drugs or medicines. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(4) Immunization agents, biological sera;

(5) Blood or blood plasma. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(6) Services or appliances. If otherwise covered, charges for such items will be covered as regular major medical expenses subject to the regular deductibles and co-insurance;

(7) Drugs or medicines prescribed for cosmetic or preventive purposes;

(8) Contraceptive injectables, for contraceptive purposes and contraceptive implants and appliances, regardless of the purposes for use;

(9) Drugs or medicines for which the covered individual is not required to pay;

(10) Experimental drugs and drugs labeled "Caution - Limited by Federal Law to Investigative Use," even if the covered individual is required to pay for them;

(11) Oral medication for erectile dysfunction, except for four pills each month, subject to your physician's letter of medical necessity. Injections and insertions for erectile dysfunction are limited to four per month, only after unsuccessful use of oral medication for a 60-day period;

(12) Smoking Cessation drugs, except for a maximum benefit of $100.00 per month, for a maximum of three months, one time in any three-year period;

(13) Drugs prescribed in connection with dental treatment, unless the treatment was covered under the major medical provisions of this Plan;

(14) Appetite suppressants or other drugs for the treatment of overweight or obesity; and

(15) Drugs which may be purchased without a prescription.

2. Temporomandibular Joint Dysfunction

Charges for any diagnosis or treatment of temporomandibular joint dysfunction are subject to deductibles and co-insurance.

3. Certain Wellness Care Benefits

The Plan does not normally pay benefits for any services or supplies unless they are necessary for the care and treatment of an illness. However, the Plan does treat the following services as covered charges.

a. Pap Smear

The Plan will pay the reasonable and customary cost of one routine pap smear and the necessary routine office visit for that pap smear once each calendar year for each covered female. No deductible or co-insurance will be applied to such charges.

b. Mammograms

The Plan will treat as a covered charge the reasonable and customary expenses of one routine mammogram each calendar year for each covered female. The normal deductible and co-insurance will be applied to such charges.

c. Newborn Well-Baby Care

The Plan will treat as covered the reasonable and customary charges, up to $200.00, for well-baby care provided by a legally qualified physician to a covered baby while the baby is hospital confined immediately following its birth. The Plan will also treat as covered the reasonable and customary charges, up to $40.00, for the newborn baby's first visit to the doctor. The normal deductible and co-insurance will apply to these charges.

d. Childhood Immunizations

The Plan will pay the reasonable and customary charges, including charges for necessary routine office visits, for the following childhood immunizations for covered children from birth through age 12. No deductible or co-insurance will be applied to such charges.

(1) Poliomyelitis

(2) Rubella

(3) Rubeola

(4) Mumps

(5) Tetanus

(6) Pertussis

(7) Diphtheria

(8) Hepatitis B

(9) Haemophilus Influenza type b (HIB)

(10) Varicella

(11) Pneumococcal

(12) Hepatitis A

(13) Rotavirus

(14) Influenza

(15) Meningococcal

e. Gardasil Immunization for Female Children Aged 9 to 26

The Plan will pay one-half (50%) of the reasonable and customary charges for immunizations with Gardasil for covered female children aged 9 through 26.

Gardasil is an immunization approved by the Federal Drug Administration (FDA) to reduce the risk of human papilloma virus (HPV) and HPV-linked cervical cancer later in life. Gardasil is given in three injections over six months.

As with other childhood immunizations, the Plan will also pay the reasonable and customary charges for routine office visits necessary to provide these immunizations, with no deductibles or co-insurance for these office visits.

If you have any questions concerning the coverage of Gardasil, please feel free to contact the Fund Office for more information.

f. Prostate Screening (PSA)

The Plan will pay the reasonable and customary charges, including charges for the necessary routine office visit, for one routine prostate screening (PSA) each calendar year for men age 50 and older. No deductible or co-insurance will be applied to such charges.

g. Bone Density Screening for Women

The Plan will cover the reasonable and customary charges for routine bone density scans for covered women once every three years for women at least 45 years of age and once every two years for women at least age 55. Normal co-insurance and deductibles will apply.

h. Colon Cancer Screening

The Plan will cover the reasonable and customary costs of the following routine cancer screening tests for covered individuals at least 50 years old:

(1) Yearly fecal blood test plus flexible sigmoidoscopy and digital rectal exam once every five years;

(2) Colonoscopy and digital rectal exam once every ten years; and

(3) Double contrast barium enema and digital rectal exam once every five years.

Normal co-insurance and deductibles will apply.

4. Chiropractic/Manual Manipulation of Spinal Skeletal System

The Plan covers medically necessary outpatient services for the manual manipulation (with or without the application of treatment modalities including but not limited to heat, cold, diathermy and ultrasound) of the spinal skeletal system and/or surrounding tissue rendered by or under the supervision of a Licensed Chiropractor within the scope of his license, or in the presence of a licensed doctor of medicine or osteopathy, physical therapist or occupational therapist. The covered therapy services include but are not limited to skeletal manipulations, x-rays, laboratory tests, ultrasound treatments, hot/cold packs and other medically necessary treatment modalities.

The Plan deductibles and co-insurance are applied to Chiropractic/Manual Manipulation of the Spinal Skeletal System. Chiropractic/Manual Manipulation services are further limited to:

a. One visit per day.

b. No more than 50 visits per year.

c. Up to a maximum of $2,000.00 paid per Calendar Year.

Normal co-insurance and deductible will apply.

5. Replacement of Organs or Tissue

a. Generally

The Plan will treat as covered the reasonable and customary charges incurred for the organ and tissue transplants and replacements listed in this Section 8G5 and the reasonable and customary charges incurred for the treatment of complications arising from the listed transplants or replacements. However, as with all treatments, an organ or tissue transplant or replacement will be covered only if it is medically necessary and it is not experimental or investigative in general or with reference to the illness for which the covered individual is being treated.

No organ or tissue replacements or transplants except those listed in subsections b. and c. of this Section 8G5 will be covered.

b. Transplants and Replacements Covered on a Regular Basis

The charges incurred for the following transplants and replacements are covered on the same basis as the charges incurred for any other covered treatments:

(1) cornea transplants;

(2) artery or vein transplants;

(3) kidney transplants;

(4) joint replacements;

(5) heart valve replacements;

(6) implantation of prosthetic lenses in connection with cataracts;

(7) prosthetic by-pass or replacement vessels; and

(8) bone marrow transplants, including charges for related and unrelated donor typing, work-up, harvesting and searching of National Marrow Donor Registry.

c. Transplants and Replacements Limited to $175,000.00

The charges incurred for the following transplants and replacements are covered on the same basis as the charges incurred for any other covered treatment, **except** the amount the Plan will pay for **any and all** charges related to these procedures (except for anti-rejection drugs), is limited to a lifetime maximum of $175,000.00 per type of procedure:

(1) heart transplant;

(2) lung transplant;

(3) heart and lung transplant; and

(4) liver transplant.

The maximum applies to each type of transplant and all charges incurred (except anti-rejection drugs) as a result of the transplant or replacement or complications arising from the transplant or replacements.

d. Special Rules for Transplant Donors

Under the Plan, the donation of an organ or tissue by a covered individual for transplanting into another person is considered to be an illness of the person receiving the donation. The donation of an organ or tissue by another person for transplanting into a covered individual will be considered to be an illness of the recipient (covered individual) up to a maximum of $25,000.00 per type of procedure. Such donor expenses are subject to all of the rules and limitations that apply to other expenses under the Plan. The Plan will treat as covered the reasonable and customary charges incurred in the donation and during the 31 days post donor transplantation up to a maximum of $25,000.00 per type of procedure.

6. Restorative Physical, Restorative Occupational, and Restorative Speech Therapies

The Plan will pay for Restorative Physical Therapy, Restorative Occupational Therapy and Restorative Speech Therapy service as follows:

a. Physical Therapy

The Plan will pay physical therapy charges for treatment or services rendered by a licensed physical therapist for conditions resulting from an injury or illness which are subject to significant improvement through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in physical therapy. Coverage for

physical therapy ordered by a chiropractor is subject to the chiropractic maximums at Section 8G4 of this Booklet.

b. Occupational Therapy

The Plan will pay occupational therapy charges for treatment or services rendered by a registered occupational therapist for conditions resulting from an injury or illness which will improve a body function through short-term therapy. The therapy must be in accord with a Physician's exact order as to type, frequency and duration of treatment. Covered expenses do not include therapy provided by a chiropractor, recreational programs, work hardening, maintenance therapy or supplies used in occupational therapy. Coverage for occupational therapy ordered by a chiropractor is subject to the chiropractic maximums at Section 8G4 of this Booklet.

c. Speech Therapy

The Plan will pay speech therapy charges for services rendered by a physician or licensed speech therapist to restore or rehabilitate speech lost or impaired by illness (other than a functional nervous disorder) or by surgery due to an illness. If the speech loss or impairment is due to a congenital anomaly, any available surgery to correct the anomaly must have been performed prior to the speech therapy in order for the therapy services to be covered.

d. Combined Annual Maximum

The benefits for Restorative Physical Therapy, Restorative Occupational Therapy and Restorative Speech Therapy shall be combined under one annual limit. The annual benefit for any or all of these therapy services will be limited to a maximum of $6,000.

7. Home Health Care Expenses

You may contact the medical network provider for pre-certification of home health care services. Further, you should contact the Plan Office so the Medical Case Manager can review the proposed home health care plan and help insure it is appropriate.

a. Generally

The reasonable and customary charges for medically necessary home health care services and supplies are covered to the extent they are listed below and meet all of the conditions set out below.

b. Conditions

(1) The charges are for services which are medically necessary for the treatment of a covered individual who is totally disabled and who, in the opinion of the attending physician, would otherwise have been admitted to or kept in a hospital or skilled nursing facility; provided:

(a) the covered individual is under the direct care of a legally qualified physician,

(b) the plan of treatment for the home health care is established in writing by the attending physician prior to commencement of such treatment,

(c) the plan of treatment for home health care is certified by the attending physician at least once every month, and

(d) the covered individual is examined by the attending physician at least once every 60 days.

(2) Further, such charges are covered only if they are for services which are provided by a home health agency which is an agency or organization meeting the following requirements:

(a) it is primarily engaged in and is federally certified, if required, as a Home Health Agency and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide nursing and other therapeutic services (as listed in c below);

(b) its professional service policies are established by a professional group associated with such agency or organization, including at least one legally qualified physician and at least one registered nurse, to govern the services it provides;

(c) it provides for full-time supervision of such services by a legally qualified physician or by a registered nurse;

(d) it maintains a complete medical record of each patient; and

(e) it has an administrator.

c. Covered Charges

Provided the above conditions are met, charges which are incurred for one or more of the following are covered as home health care expenses:

(1) part-time or intermittent nursing care, by a licensed practical nurse or registered nurse;

(2) part-time or intermittent home health aide services;

(3) occupational therapy, provided such therapy is performed by a licensed therapist, if licensing is required by the state in which the therapy is performed;

(4) social work, performed by a licensed social worker if licensing is required by the state in which the social work is performed (if licensing is not required by the state, the social worker must have at least a Master's degree in social work with at least one year of clinical social work experience);

(5) nutrition services performed by a licensed nutritionist, if licensing is required by the state in which the nutrition services are performed; and

(6) special meals.

The normal co-insurance and deductibles will be applied to covered charges for covered home health care services.

Note: The maximum payment per visit is $40.00. A maximum of 100 visits per year are covered. (Each time a representative of a home health care agency comes to your home is a visit. In addition, each four hours of service rendered by a home health care agency representative will be treated as a separate visit.) Covered charges are subject to the normal deductible and co-insurance.

Note: If services are performed by a registered nurse and those services performed can only be performed by a registered nurse, the covered charges will be the reasonable and customary charges for such services.

8. Hospice Care Expenses

You may contact the medical network provider for pre-certification of hospice services.

a. Definition of Hospice

A "Hospice" is an agency that provides counseling and medical services and may provide room and board to terminally ill patients and which meets the following tests:

(1) It has obtained any required state or governmental certificate of need approval and any required licenses;

(2) It provides service 24 hours each day, seven days each week;

(3) It is under direct supervision of a doctor, has a nurse coordinator who is a registered nurse, has a social service coordinator who is licensed, and has a full-time administrator;

(4) It has as its primary purpose the provision of hospice services; and

(5) It maintains written records of services provided to patients.

b. Covered Charges

The reasonable and customary charges for the Hospice services listed below will be covered if the covered individual's doctor certifies the individual is terminally ill and expected to live no longer than six months, and if the services are rendered in a Hospice or in the covered individual's home.

(1) Room and board for confinement in a hospice;

(2) Services and supplies furnished by the hospice while the individual is covered;

(3) Part-time nursing care by or under the supervision of a registered nurse;

(4) Home health aide services;

(5) Nutrition services and special meals.

The normal co-insurance and deductibles will apply to the covered charges for covered hospice services.

In addition, 50% of the cost of up to 15 visits per family for counseling services by a licensed social worker or licensed pastoral counselor for the covered individual's spouse and children and the covered individual's parents, if the covered individual is a child, will be covered provided such services are furnished within six months after the covered individual's death.

9. Pregnancy-Related Expenses

Medical expenses arising in connection with pregnancy are covered as for any other illness but only with respect to the covered employee or the covered wife of a covered employee. Pregnancy is not treated as a pre-existing condition. No pregnancy-related expenses are covered for your dependent children.

10. Statement of Rights Under The Newborns' And Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or child to less than 48 hours in connection with a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Plan Office.

11. Reconstructive Surgery Following Mastectomy

Pursuant to federal law, if you or a dependent is receiving benefits for a mastectomy and elect to have reconstruction, the Plan will treat as covered the reasonable and customary charges of medical and surgical treatment in connection with that reconstruction. The Plan will provide coverage for:

- Reconstruction of the removed breast;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- A prosthesis;
- All physical complications, including lymphedemas, at all stages of mastectomy.

The appropriate treatment will be determined in consultation with the covered person and her doctor.

12. Treatment of Mental Illness and Substance Abuse Problems

The following limitations apply to the Plan's coverage of the treatment of mental illness and drug and alcohol problems:

a. The Plan will cover a maximum of 30 days of inpatient care in a calendar year for the treatment of mental illness or substance abuse problems, or any combination of the two.

b. The Plan will cover a maximum of 15 days of residential care in a calendar year for the treatment of mental illness or substance abuse problems or any combination of the two. A residential treatment facility is a facility other than a hospital at which the patient must reside around the clock.

c. The Plan will cover a maximum of 50 outpatient visits in a calendar year for the treatment of mental illness or substance abuse problems, or any combination of the two.

d. The Plan will cover a maximum of three inpatient admissions and three residential treatment admissions in a covered person's lifetime for the treatment of substance abuse problems.

As with most covered services, only medically necessary treatments of mental or substance abuse problems are covered. Further, benefits for treatment of mental illness or substance abuse problems are subject to the Plan's co-insurance and deductible provisions.

13. Bariatric Surgery Benefit

Bariatric surgery is a surgical procedure for treatment of morbidly obese patients. Morbid Obesity is defined as being 100 pounds over your ideal body weight which would be equivalent to a body mass index of 40 or greater. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.

a. Conditions Required for the Procedure to Be Eligible as a Covered Expense

In order for bariatric surgery to be determined as an eligible expense, the following conditions must be met.

If your bariatric surgeon recommends bariatric surgery, he or she will prepare a letter to obtain preauthorization from the Plan. The goal of this letter is to establish the medical necessity of bariatric surgery and gain approval for the procedure. The Plan has adopted the following minimum requirements to be met before authorizing bariatric surgery:

(1) The specific type of bariatric surgery procedure has been determined to be appropriate for the treatment of morbid obesity by the Centers for Medicare and Medicaid Services; and

(2) The patient is greater than 100 pounds overweight or 100% over his or her ideal body weight; and

(3) The patient is at least 18 years of age and has completed bone growth; and

(4) The patient has a body-mass index (BMI) of at least 40; and

(5) The patient is being treated by his or her Physician for at least one of the following complicating conditions: Diabetes, Hypertension, Cardiovascular Disease, Pulmonary/Respiratory Disease or Degenerative Joint Disease; and

(6) The patient has been on a documented medically supervised diet and exercise program for at least one year immediately preceding the request for the procedure without successful weight loss; and

(7) No surgical procedure will be authorized without the evaluation and approval of the Plan's Medical Case Manager; and

(8) The type of bariatric procedure must be performed by a Medicare-approved facility.

b. Recommendations for Patients Seeking Pre-authorization of Bariatric Surgery

Keep track of every visit you make to a healthcare professional for obesity-related issues or visits to supervised weight loss programs. Make note of other weight loss attempts made through diet centers and fitness club memberships. Keep good records, including receipts.

c. Payment of Charges

If all of the above conditions are met, the Plan will pay for 60% of the charges at an approved facility and In-Network provider. These charges are excluded from the annual out-of-pocket maximum and are subject to a lifetime maximum of $50,000, including any charges incurred as a result of complications from the procedure. The Plan will not pay any charges incurred at an unapproved facility or Out-of-Network provider.

14. Treatment of Erectile Dysfunction

Prior to receiving benefits for Erectile Dysfunction, you must meet the following medical necessity criteria:

a. Conditions Required for the Treatment to Be Covered

(1) Be under current treatment for at least one of the following medical conditions: diabetes, metabolic syndrome, neurological disease, kidney disease, multiple sclerosis, Parkinson's disease, hormonal disorder, atherosclerosis, heart or vascular disease, depression, morbid obesity, or

(2) Have sustained a traumatic pelvic or spinal cord injury, or

(3) Have undergone surgery or treatment for prostate, bladder or certain other cancers, or

(4) Be taking certain prescription medications with side effects or interactions that cause Erectile Dysfunction.

b. Treatment Options

(1) Oral Medications – maximum of four doses per month in accordance with the Plan's formulary.

(2) Injected or Inserted Medications – a maximum of four injections or insertions per month, only after unsuccessful use of oral medication for a 60-day period.

The Plan will <u>not</u> provide coverage for external devices, penile implant surgery, or vascular surgery to correct blockage of blood flow to the penis.

15. Ambulance Benefit

Effective with date of service August 18, 2009 and after, all non-PPO ambulance charges are to be reimbursed at the PPO level. Charges prior to this date are to be reimbursed at the appropriate non-PPO level. There is a $15,000 benefit maximum per day. Reasonable and Customary apply to the charges.

H. Pre-Existing Condition Limitation and Health Insurance Portability and Accountability Act (HIPAA)

Under certain circumstances, this Plan limits benefits for pre-existing conditions. The Health Insurance Portability and Accountability Act (HIPAA), which governs a plan's use of a pre-existing condition limitation, will be applied.

1. Definitions

For purposes of the Plan's pre-existing condition limitations, the following definitions apply.

a. Pre-existing condition is an illness, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the three-month period ending on the affected individual's enrollment date.

b. Enrollment date is, for the employee and any then existing dependents, the earlier of the date the affected person became covered under the Plan or the first day the employee

worked in covered employment. For later-acquired dependents, the enrollment date is the first date the person became an eligible dependent. The enrollment date constitutes the following:

(1) the end of a break in coverage;

(2) the beginning of the three-month "look-back" period for determining whether a condition is pre-existing; and

(3) the beginning of the 12-month exclusion period for pre-existing conditions.

c. Creditable coverage is prior coverage the affected person had under any of the following:

- a group health plan;
- health insurance coverage;
- Medicare;
- Medicaid (other than the program for distribution of pediatric vaccines);
- health care benefits provided for members and dependents of the uniformed services of the United States;
- Indian Health Service or tribal plan;
- state health benefits risk pool;
- Federal Employees Health Benefit Plan;
- public health plan; or
- a health benefit plan provided under the Peace Corps Act.

Creditable coverage does not include accident or disability income insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit insurance, coverage for on-site medical clinics, limited scope dental or vision benefits, long-term care insurance, coverage or insurance for only specified illnesses, hospital indemnity or other fixed indemnity insurance, or supplemental insurance policies, such as Medicare supplement policies.

d. Certificate of Creditable Coverage is a certificate provided by a health plan or health insurer showing the period of creditable coverage and the length of any waiting period for such coverage.

2. Pre-Existing Condition Limitation

a. Generally

The Plan will pay out no more than $5,000 for the covered care and treatment of a covered person's pre-existing illness until the earlier of:

(1) the completion of three consecutive months, ending on or after the effective date of coverage, during which no medical care, treatment, advice or diagnosis is received or recommended for the individual's pre-existing condition; or

(2) the completion of 12 months after the enrollment date

b. Reduction of 12-month period

The 12-month maximum period during which the Plan applies its $5,000 limit to pre-existing conditions is reduced by the aggregate periods of creditable coverage the affected individual had as of the enrollment date. If the affected person had a continuous 63-day break in creditable coverage, any creditable coverage the person had prior to that 63-day break will not be counted to reduce the 12-month maximum period.

3. Exceptions to Pre-Existing Condition Exclusion

a. Pregnancy

Pregnancy is never treated as a pre-existing condition.

b. Children

No pre-existing condition limitation will apply to a child you adopt or a child who is first placed with you for adoption while you are covered under the Plan.

Further, no pre-existing condition limitation will apply to a child who is covered under any creditable coverage within 30 days after birth or adoption or placement for adoption (prior to age 18) unless such child subsequently has a 63-day gap in creditable coverage.

I. Coordination of Benefits Under this Plan with Other Coverage

1. Medicare Benefits

This Plan will pay as the Primary Plan (as defined below) for all active employees of contributing employers and the eligible dependents of such active employees regardless of the age of such active employees and their dependents.

For all other individuals entitled to Medicare, this Plan will be the Secondary Plan (as defined below) and Medicare will be primary. **Further, to the extent you or your dependent is eligible to enroll in Medicare, this Plan will adjudicate its claims as if you are covered by both Medicare Parts A and B.** This means that even if you choose not to enroll in Medicare A or choose not to pay for Medicare Part B, the Plan will pay only what it would pay if you had chosen both parts of Medicare.

There are special coordination rules for individuals who have end stage renal disease. Generally, if an individual first becomes eligible for Medicare by virtue of having end stage renal disease, this Plan will be primary for the first 30 months of the individual's Medicare eligibility. Thereafter, Medicare becomes primary.

2. Coordination of Benefits Generally

a. Benefits Subject to this Provision

All comprehensive major medical benefits and dental benefits provided under this Plan are subject to this provision.

b. Effect on Benefits

Coordination of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other Plans covering the individual for whom claim is made. If this Plan is a Secondary Plan, the benefits payable under this Plan may be reduced, so that a covered individual's total payment from all plans will not exceed 100% of the total Eligible Expenses. This Plan will pay the individual's out-of-pocket costs, not to exceed this Plan's regular benefits if greater.

c. Primary and Secondary Plan

"Primary Plan" means the Plan which pays benefits or provides services first under the Order of Benefit Determination Rules below. The Primary Plan does not reduce its benefits because of duplicate coverage.

"Secondary Plan" means any Plan which provides coverage for the individual for whom claim is made and which is not a Primary Plan.

d. Eligible Expense

"Eligible Expense" means any necessary, reasonable and customary item of expense which is covered, in whole or in part, under one or more Plans covering the individual for whom claim is made.

If benefits under the Primary Plan are reduced because the covered individual does not comply with the Primary Plan's rules regarding pre-certification or second surgical opinions

or because the covered person did not use a preferred provider under the Primary Plan, the amount by which the benefits are reduced is not an eligible expense under any of the plans. If the primary plan is a closed panel plan (meaning only services provided by specified providers are covered) and the covered person uses a non-panel provider, the secondary plan will pay as primary, unless use of a non-panel provider is paid for or provided for under the closed panel plan.

If a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Eligible Expense and a benefit paid.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Eligible Expense under the above definition unless the private room is medically necessary.

e. Claim Determination Period

"Claim Determination Period" is the period of time during which Eligible Expenses are compared with total benefits payable to determine how much each Plan will pay. The Claim Determination Period is a calendar year.

f. Plans Considered for COB

A "plan" is any arrangement which provides medical coverage for the individual for whom a claim is made and with which coordination is allowed. The definition of plan in a contract or description of benefits must state the types of coverage that will be considered in applying the COB provisions of that contract or plan of benefits. The right to include a type of coverage is limited by the rest of this definition. Separate parts of the plan for members of a group that are provided through separate contracts or arrangements that are intended to be part of a coordinated package of benefits are considered one plan, and there is no coordination with the separate parts of the plan. For example, if an employer-provided plan of medical benefits is made up of a base plan or contract and a major medical plan or contract, this Plan will treat those two components as a single coordinated plan for purposes of these COB rules.

COB applies to the following plans:

(1) Group insurance or individually purchased health insurance or other medical benefits plans;

(2) Other arrangements, whether insured or uninsured, covering medical expenses of individuals in a group;

(3) Plans designed to pay a fixed-dollar benefit per day while the individual is hospital confined, but which, at the time of claim, allow the individual to elect an alternate benefit. COB will be applied only to the portion of the daily benefit which exceeds $100.00 per day;

(4) Blue Cross and Blue Shield plans;

(5) Plans of other hospital or medical service organizations;

(6) Group practice plans;

(7) Pre-payment plans;

(8) Coverage under Federal Government plans or programs, including Medicare;

(9) Coverage required or provided by law. COB will not apply to state programs which provide benefits for individuals unable to pay for their care;

(10) Individual no-fault auto insurance, by whatever name called.

(11) Medical payments coverage under any auto or property insurance policy.

(12) HRA, FSA, or HSA as defined in Section 2 Definitions.

Note: This Plan is always a Secondary Plan to benefits provided under any mandatory No-Fault Auto Insurance Act in the state in which the Covered Individual resides.

g. Order of Benefit Determination

Any plan which does not have a COB or similar provision and any plan that provides it is always secondary will pay its benefits first.

When all plans involved contain COB or similar provisions, the first of the following rules that describes the situation determines the order in which the plans pay their benefits.

(1) Non-Dependent or Dependent

The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary, and the plan that covers the person as a dependent is secondary.

However, when a person is covered as the dependent of his or her spouse who is actively employed and is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is primary to the plan that covers the person as other than a dependent and secondary to the plan that covers the person as a dependent. In such circumstances, the plan that covers the person as a dependent pays first, Medicare pays second, and the plan that covers the person as other than a dependent pays last.

(2) Child Covered Under More Than One Plan

(a) The primary plan is the plan of the parent whose birthday is earlier in the calendar year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the non-custodial parent; and then

(iv) The plan of the spouse of the non-custodial parent.

(3) Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection g(1).

(4) Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(b) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

h. Operation of COB

In order to make this COB provision work properly:

(1) Upon request, the covered individual is required to furnish to the Plan complete information concerning all plans which cover the individual for whom claim is made.

(2) As permitted by law, the Plan may, without the covered individual's consent:

(a) Obtain information from all plans which may cover the individual; and

(b) Release to such other plans any information it has with respect to any individual.

(3) If payments which should have been made by this Plan have been made under any other plans, this Plan may reimburse such other plans to the extent necessary to make this provision work. Any such payment will be a benefit paid under this Plan.

(4) If this Plan has paid benefits which result in payment in excess of the amount necessary under this Plan to make this provision work, this Plan has the right to recover such excess payment from:

(a) any person;

(b) any insurance company; or

(c) any other organization

to or for or with respect to whom such payments were made.

i. Prescription Drug COB

If with respect to a covered individual, another health plan pays first under these COB rules, that person may not obtain prescription drugs under this Plan's drug card program or mail order program. Rather, that person should claim benefits for prescription drugs or obtain prescription drugs under the other plan first, and then submit a claim to this Plan for any amounts not paid by the other plan. See Section 12C of this Booklet for information on how to file a claim when another Plan pays first.

j. Coordination of Major Medical Benefits with District No. 9, I.A.M.A.W. Welfare Plan Dental Benefits

To the extent that a treatment, service, or supply is covered under both the major medical provisions of this Plan and the dental provisions of the District No. 9, I.A.M.A.W. Welfare Plan, a claim for such treatment, service or supply, will be considered first under the major medical provisions of the Plan and then under the dental provisions.

k. Special Rules for Plans that Attempt to Shift Liability

(1) When a Primary Plan is a group health plan containing a sub plan/no loss provision, this Plan will not pay as the Secondary Plan until the Primary Plan has exhausted its benefits under any no loss or similar provisions.

(2) If another plan is primary under this Plan's rules, and it contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other plan provides its customary benefits as the Primary Plan without regard to such cap.

(3) As indicated above in f. "Plans Considered for COB," the definition of plan includes one with separate contracts or arrangements that are intended to be part of a package of benefits. If more than one carrier or entity provides benefits under such a plan with component parts, this Plan will not deal separately with multiple carriers or entities; rather, those multiple carriers or entities will be required to select one of their number to comply with these coordination of benefits rules on behalf of all of the carriers or entities that provide any part of the benefits that has separate components.

SECTION 9. DENTAL BENEFITS

A. Introduction

A person eligible for dental benefits may receive covered dental services and appliances from any licensed dentist, medical doctor, doctor of osteopathy, or licensed dental hygienist under the direction of a licensed dentist, and the Plan will pay the portion of the charges indicated below up to the maximums indicated below. There is no longer a network of preferred dental providers. Further, there is no longer a requirement that any covered treatment be pre-certified. Claims should be submitted directly to the Plan at:

District No. 9, I.A.M.A.W.
ATTENTION: Dental Claims
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

B. Annual Deductible

Each person must pay the first $25 of covered dental expenses before the Plan pays any dental benefits (except preventive treatment as described below). There is no maximum family deductible. Each eligible family member must satisfy the $25 annual deductible.

C. Maximum Annual Benefit

The Plan will pay a maximum of $1,500 for covered dental expenses on behalf of each covered person each calendar year.

D. Description of Benefits

The Plan will provide the following dental benefits:

1. Preventive Services Paid at 100%

   For each covered individual, the Plan will pay 100% of the cost and will not apply the deductible to the cost of the following:

   - Two regular exams, two cleanings, and two bitewings per calendar year;
   - Two periodontal cleanings per calendar year;
   - One full mouth x-rays (not periapical x-rays) per calendar year;
   - One panoramic x-ray every 36 months; and
   - Two fluoride treatments per calendar year for children under the age of 18.

2. Other Services Are Subject to Deductible and Paid at 80%

   For all other covered dental services and appliances the Plan will pay 80% of the charges, unless such services or appliances are excluded.

   Sealants are covered once per lifetime for each tooth on permanent teeth for children under the age of 18.

E. Exclusions

The Plan will <u>not</u> pay benefits for the following:

1. Any orthodontic services or appliances of any kind;
2. Dental services or appliances that are not reasonably necessary or customarily performed or supplied;
3. General anesthesia for simple tooth extractions for individuals 18 years of age or older;
4. Nitrous Oxide for individuals 18 years or older;

5. Fluoride treatments for individuals 18 years of age or older;

6. Charges you are not required to pay in the absence of dental insurance or benefits;

7. Services or appliances for treatment or correction of any illness or injury that arises out of or in the course of employment for any employer or any self-employment or for which the individual is entitled to benefits under any worker's compensation or occupational disease law or for which the individual receives any settlement or award from a worker's compensation carrier or employer;

8. Dental services or appliances rendered or provided by anyone other than a licensed dentist, medical doctor, doctor of osteopathy, or licensed dental hygienist under the direction of a licensed dentist;

9. Cosmetic dental services or appliances (facings on molar crowns or pontics are always considered cosmetic);

10. Replacement of lost or stolen appliances;

11. Dental services provided and supplies received before the person becomes eligible for dental benefits under this Plan or after that eligibility ends;

12. Charges for missed appointments;

13. Experimental or investigative dental services or appliances;

14. Charges for services of a person who usually lives in the household of the covered individual, or who is a member of the covered individual's immediate family or the immediate family of his or her spouse;

15. Any prescription drugs that are not administered in the doctor's office;

16. Treatment of illnesses or injuries arising out of service in the uniformed or military service of any country;

17. Any services or appliances of any kind for the treatment of TMJ (temporomandibular joint) disorder; or

18. Charges incurred by your dependent spouse or child who has dental benefits provided by or through his or her own employer or union, or his or her parent's employer or union, unless the type and amount of benefits provided by or through that employer or union, when the plan of the other employer or union is primary under this Plan's coordination of benefits rules, are not affected by the fact the dependent is also covered under this Plan.

F. Coordination of Dental Benefits With District No. 9, I.A.M.A.W. Welfare Plan Major Medical Benefits

If a treatment, service or supply is covered under both the dental provisions of this Plan and the Major Medical provisions of the District No. 9, I.A.M.A.W. Welfare Plan, a claim for such treatment, service or supply will be considered first under the Major Medical provisions of the Plan and then under these dental provisions. This paragraph applies only to individuals who have both dental and Major Medical benefits under the District No. 9 Plan.

SECTION 10. VISION BENEFITS

A. Generally

The vision benefits provided by the Plan are paid for out of the assets of the Plan, but the Plan has retained a vision administrator to design the benefits and handle the claims and other administrative duties with respect to the vision benefits.

Check your collective bargaining agreement or call the Fund Office (314-739-6442 or 888-739-6442) to determine whether you and your dependents are eligible for vision benefits.

B. Vision Network Doctors

The vision network provider maintains an extensive network of highly qualified private practice doctors. If you use vision network doctors, the doctor will take care of filing any required paperwork. In many cases, you will not have to pay anything, and in other cases, you will pay only the difference between the covered amount and the total charge.

C. Benefits

Type of Service	Plan Pays In Network	Plan Pays Out of Network
Vision Examination (once each 12 months)	Full Cost	Up to $36.00
Lenses (once each 12 months)		
Single Vision	Full Cost	Up to $28.00
Lined Bifocal	Full Cost	Up to $45.00
Lined Trifocal	Full Cost	Up to $56.00
Lenticular	Full Cost	Up to $80.00
Progressive Multifocals	Full Cost	$0
Photochromic	Full Cost	$0
Anti-Reflective Coating	Full Cost	$0
Polycarbonate	Full Cost	$0
Scratch Resistant Coating	Full Cost	$0
High Index	Full Cost	$0
Frame (once each 24 months)	Full Cost up to $120.00	Up to $45.00
Contact Lenses (once each 12 months)	Up to $120 for Professional Fees and Contact Lenses	Up to $105 for Professional Fees and Contact Lenses
Medically Necessary Contacts (usually required after cataract surgery)	Full Cost *Requires prior approval from vision administrator.	Up to $210

Contact lenses are provided in place of eyeglasses. NOTE: If you or a dependent obtains contact lenses, that person will not be eligible for eyeglass lenses for 12 months and will not be eligible for eyeglass frames for 24 months.

1. Low Vision Benefit

The low vision benefit is available to covered individuals who have severe visual problems that are not correctable with regular lenses and is subject to pre-approval by the vision administrator's consultants.

	Plan Pays In Network	Plan Pays Out of Network
Supplementary Testing	Full Cost	Up to $125.00
Supplemental Care Aids that are visually necessary or appropriate	75% of Cost	75% of Cost
Benefit Maximum	$1000 every 24 months	$1000 every 24 months

2. Additional Discounts

Each Covered Person shall be entitled to receive a discount of 30% toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) including lens options, from the same network doctor on the same day as your exam, or a discount of 20% from any network doctor within 12 months of your last exam. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under this Plan.

Additionally, Covered Persons shall be entitled to receive a discount of 15% off a Network Doctor's professional fees for contact lens evaluations and fittings. Discounts are applied to the Network doctor's usual and customary fees for such services and are available within 12 months of the covered eye examination from the Network Doctor who provided the covered eye examination. Contact lenses are provided at the doctors' usual and customary charges.

Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at the vision network's member preferred pricing. Ask your network doctor for details. On average, you will save 35-40% on all non-covered lens options.

If you choose a frame valued at more than your allowance, you will save 20% on your out-of-pocket costs for frames from a network doctor.

These additional discounts are subject to change as deemed appropriate by the vision network.

D. Exclusions

The Plan will <u>not</u> pay vision benefits for professional services or eyewear connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.38 diopter power); or two pair of glasses in lieu of bifocals;

2. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

3. Medical or surgical treatment of the eyes;

4. Experimental treatment;

5. Costs for services and/or eyewear above Plan benefit allowances;

6. Services and/or eyewear not specifically indicated as covered; or

7. Patient Options. This Plan is designed to cover visual needs rather than Cosmetic eyewear. When a covered person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

   a. Contact lenses (except as noted elsewhere herein).

   b. Oversize lenses.

   c. Tinted lenses except Pink #1 and Pink #2.

   d. The coating of the lens or lenses.

   e. The laminating of the lens or lenses.

   f. A frame that costs more than the Plan allowance.

   g. Certain limitations on low vision care.

   h. Cosmetic lenses.

   i. Optional cosmetic processes.

   j. UV (ultraviolet) protected lenses, except polycarbonate lenses.

SECTION 11. PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT*

A. Generally

If this Plan pays out major medical, weekly disability benefits or dental benefits to or on behalf of a covered person in connection with an illness or an injury for which a third party may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's injury or illness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, by medical malpractice, or by some defective condition of a third party's property.

B. Definitions

1. For purposes of these reimbursement and subrogation provisions, a "covered person" is a person to or on whose behalf this Plan pays out benefits. The term "covered person" also includes such individual's guardian, estate, heirs, or other representatives.

2. For purposes of these reimbursement and subrogation provisions, a "third party" is a person who caused the covered person's injury or illness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that injury or illness. For example, both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of "third party" to the extent such insurers are obliged to compensate the covered person as a result of the injury or illness. Thus, to the extent the injured person's own insurer is obliged to compensate him under his uninsured or underinsured motorist coverages, the injured person's own insurer will be a "third party."

C. Plan's Right to Reimbursement

If this Plan pays out any benefits to or on behalf of a covered person in connection with an illness or injury for which a third-party may be responsible, such benefits are paid on the express condition that the covered person (and his or her spouse, to the extent the spouse recovers damages in connection with the injury or illness to the covered person) must reimburse the Plan for the benefits it paid out from any amount the covered person (or his or her spouse) recovers from any third party or parties.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and his or her spouse acknowledge the Plan's right to reimbursement and agree to make such reimbursement and agree to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that injury or illness. The covered person and his or her spouse must reimburse the Plan in full from any recovery from any third party or parties for benefits the Plan paid in connection with the injury or illness before any other amounts are deducted from the recovery paid by the third party or parties. However, the Plan's reimbursement may be reduced by its proportionate share of the attorney's fees and costs incurred by the covered person (or his or her spouse) in connection with the recovery, but in no event will the Plan's reimbursement be reduced by more than one-third for fees and costs.

D. Plan's Right to Subrogation

"Subrogation" means the substitution of one person in the place of another with respect to a claim, demand or right.

To the extent of benefits it pays out, the Plan will be subrogated to all claims, demands, actions and rights of the action the covered person may have against any third party or parties. This means that to the extent the covered person has a claim against anyone as a result of an injury or illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person's claim. In effect, the Plan "stands in the place" of the covered person with respect to such claim or claims. For example, if you are injured in an auto accident caused by another person and the Plan pays out benefits for the treatment

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* **Please Note:** This section does not apply to work-related injuries. The Plan simply does not cover work-related injuries.

of your injury, the Plan could, on its own, sue the person who caused the accident or, if you sued that person, the Plan could join in your lawsuit.

The amount of the Plan's subrogation interest is equal to the amount it paid out in connection with the injury or illness, plus the attorney's fees and costs it incurs in pursuing the claim against the third party or parties.

The Plan may assert its claim against any third party even if the covered person does not, or the Plan may join in any action the covered person brings against any third party or parties. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any injury or illness for which a third party may be responsible, the covered person expressly acknowledges the Plan's rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

E. Covered Person's Responsibilities

In order to receive benefits from this Plan in connection with an injury or illness for which a third party may be responsible to compensate the covered person, that covered person (and, if applicable, his or her spouse) must do all of the following:

1. Notify the Plan when he or she suffers an injury or illness for which a third party may be required to compensate the covered person;
2. Provide the Plan with any and all documents and information regarding the injury or illness the Plan may request;
3. Execute an agreement setting forth the Plan's rights and the covered person's obligations and the obligations of his or her spouse under these subrogation and reimbursement provisions. If the covered person is represented by an attorney, that attorney must also sign the subrogation agreement;
4. Provide the Plan with notice if the covered person asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;
5. Obtain the written consent of the Plan or its designee prior to settling any claim to which this Plan is subrogated;
6. Notify the Plan of any compensation the covered person or his or her spouse receives from any third party in connection with the injury or illness and immediately reimburse the Plan for the benefits it paid out from such compensation from the third party or parties upon the receipt of such compensation;
7. Cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and
8. Take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or his or her spouse fails to comply with these obligations, the Plan will not pay out benefits in connection with that injury or illness. If the covered person or his or her spouse fails to reimburse the Plan for the benefits it paid out from any recovery they receive from the third party or parties as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

F. Rejection of "Make-Whole" Doctrine

This Plan specifically rejects the "make-whole" doctrine. The Plan's rights to reimbursement and subrogation do not depend on whether the covered person or his or her spouse recovers from third parties monies sufficient to fully compensate the covered person or his or her spouse, or both, for their losses.

G. Plan's Enforcement of These Provisions

In the event the covered person or his or her spouse fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary

to enforce the Plan's rights under these provisions. The Plan may refuse to pay benefits in connection with the injury or illness if the covered person or his or her spouse fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person or his or her spouse later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and his or her family members, may bring an action against the covered person and his or her spouse, or may recoup amounts it paid out from the providers to whom such amounts were paid or any other sources. Should the Trustees bring legal action to enforce the Plan's rights under these reimbursement and subrogation provisions, and succeed in whole or in part in such action, the covered person or his or her spouse shall pay the legal fees and costs the Trustees incur in that action.

H. Future Claims Relating to the Same Injury or Illness

Once the covered person's claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the injury or illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and his or her spouse by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

SECTION 12. ENROLLMENT, BENEFICIARY DESIGNATIONS, AND CLAIMS REQUIREMENTS

A. Enrollment and Updates

You must complete an individual enrollment form in order to activate your eligibility for benefits. You may obtain the enrollment form from the Welfare Plan Office, your employer or shop steward. Return the completed form to your employer who will forward it to the Welfare Plan Office.

As indicated above in Section 3 of this Booklet, in order to enroll your dependents, you may be required to furnish proof of their status as eligible dependents. If you have any questions about your dependents' eligibility, please contact the Welfare Plan Office.

You will also be required to complete a Member Information Update Form updating information about yourself and your eligible dependents. The Plan Office will send you this form. Benefits will not be paid until the Plan Office has received the Member Information Update Form.

Your failure to complete the original enrollment form for yourself or any dependent or your failure to complete a Member Information Update Form can cause the delay of benefits. Further, if you fail to provide the enrollment form or Member Information Update Form within the time limit for filing a particular claim, that claim will not be covered.

Children will also be enrolled as required by any qualified medical child support order. (See definition in Section 2 of this Booklet), on the date the Welfare Plan Office receives such an order. If you would like information about the Plan's procedures for processing a QMCSO, call the Welfare Plan Office.

B. Designation of Beneficiaries

You will designate in writing the beneficiary to whom benefits for the loss of your life are payable. You may change your beneficiary at any time. However, to be effective, any change of beneficiary must be made upon appropriate forms supplied by the Welfare Plan Office and must be in writing signed by you and received by the Welfare Plan office before life benefits are paid out to any beneficiary. Benefits payable on account of the death of a covered dependent will be paid to you. If you have named more than one beneficiary, and have not designated the share for each, the benefits will be paid in equal shares to those beneficiaries who survive you. If you have named no beneficiary or if you die before the life insurance carrier makes payment on the dismemberment benefits, payment will be made to your estate or at the life insurance carrier's option, to your widow or widower, if living, otherwise to your living children, if any, otherwise to your parents, if living, or up to $500 may be paid to any person equitably entitled to payment because of expenses from your burial.

C. Filing of Claims and Supporting Documentation

1. Generally

a. Member Information Update Form

You may obtain any necessary Member Information Update forms from the Welfare Plan Office, your employer, or your shop steward.

b. Time for Submission of Claims

You must submit a claim for life insurance or AD&D insurance within 90 days after the death or other loss. However, the life insurance carrier will not deny a claim if it is submitted as soon as reasonably possible.

You must submit a claim for any other benefits within one year after the loss for which benefits are claimed or within one year after you incur the expense for which benefits are claimed. The claim should be accompanied by all supporting documentation. No claim for any benefits will be considered if it is received by the Welfare Plan Office more than one year after the loss for which benefits are claimed.

2. Claims for Death and Accidental Death and Dismemberment Benefits and Loss of Sight

If you or your beneficiary has a claim for death benefits or accidental death and dismemberment benefits, contact the Welfare Plan Office. The Plan Office will prepare and submit the appropriate claim forms to the life insurance company or its designated claims administrator and will tell you or your beneficiary what documentation you must supply in support of the claim. When the claim is

for death benefits, you or your beneficiary must submit a certified copy of the death certificate of the deceased individual, but additional information or documentation may also be needed.

3. Weekly Disability Benefits

You may obtain the claim form for weekly income benefits from the Welfare Plan Office, your employer or your shop steward or from the website www.d9trusts.org. **The form must be completed by you, your employer, and your physician and must be returned to the Welfare Plan Office. The completed claim form must be submitted no later than one year after the disability commences. The completed claim form should be accompanied by all supporting documentation.**

4. Comprehensive Major Medical Benefits

a. Medical Benefits

Generally, you will not be required to submit a claim for medical benefits. Your doctor, hospital or other provider will forward the bills to the medical network provider or to the Welfare Plan Office. Receipt of such bills will be regarded as receipt of a claim. In some circumstances, the Plan Office will contact you for additional information. You should provide any such information as soon as possible after requested.

b. Prescription Drug Benefits

In order to file a claim for reimbursement for amounts you have paid for prescription drugs, you should obtain a prescription drug claim form from the Plan Office, your employer, or your shop steward. You must complete the prescription drug claim form and send it, along with the pharmacy prescription receipt or the itemized pharmacy billing statement, to the Welfare Plan Office. You should use this procedure when for any reason you have not used the drug card or mail order service or when you believe the amount you were required to pay when using the drug card or mail order service was in excess of the amounts set out in this booklet, or if you are denied a drug by a network pharmacy or the mail-order service. You may obtain Prescription Drug Claim Forms on our website www.d9trusts.org.

In order to take advantage of the mail-in drug program for maintenance drugs, you must obtain an order form from the Welfare Plan Office, your employer or your shop steward and send the completed order form, along with your doctor's prescription and the appropriate co-payment, to the address indicated on the order form. You may obtain mail-order prescription drug claim forms on our website www.d9trusts.org.

All claims for comprehensive major medical benefits must be submitted within one year from the date you received the service or supply for which claim is being made. The claim should be accompanied by all completed documentation. If the Plan Office does not receive the claim and all documentation necessary for the Plan to decide the claim within this one-year period, the claim will be denied as untimely. The required documentation includes: itemized bills; paid receipts if you are seeking reimbursement; the original enrollment forms and annual updates reflecting the individual in question is covered; EOB's from primary plan, if any; subrogation and reimbursement questionnaire and agreement; and any other documents and information requested by the Plan Office.

5. Additional Information or Examination May be Required

The Welfare Plan Trustees and Life Insurance carrier reserve the right and opportunity to require the submission of additional information regarding a claim for benefits and reserve the right to examine the person whose illness is the basis of a claim as often as necessary during the duration of the condition for which a claim is made.

D. Payment of Claims

1. Generally

The benefits payable on account of your death will be paid to your beneficiary. Accidental death benefits will be paid to the beneficiary you designate, and dismemberment benefits will be paid to you. Benefits payable on account of the death of a dependent will be paid to you. Weekly disability benefits will be paid directly to you. Medical benefits will be paid directly to the

doctor, hospital, or other provider who provided the services unless you prove you paid the provider, in which case reimbursement will be made to you or to the person indicated in a QMCSO or applicable law governing the payment of benefits.

The Trustees reserve the right to allocate the deductible amounts to any eligible charges and to apportion the benefits to you and any assignees.

2. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for you or one of your dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Trustees of the Welfare Trust may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for you or your dependents to offset the overpaid or mistakenly paid amounts or bringing a legal action against you to collect the overpayment. If it is necessary for the Trustees to institute legal proceedings to collect an overpayment and they prevail, you will be responsible for paying the reasonable attorney's fees and costs they incur in connection with such action.

3. Return of Erroneously Paid Life Insurance Benefit

To the extent that the life insurance carrier pays any benefit in error or makes an overpayment, the erroneously paid benefit or overpayment must be returned to the life insurance company.

SECTION 13. CLAIMS REVIEW AND APPEAL PROCEDURES

A. Death and Accidental Death and Dismemberment Benefits

1. Initial Decision

The life insurance company will evaluate the claim and make a decision as to payment within 90 days (45 days for benefits requiring a determination of disability) of the date the claim is received by the life insurance company or its designated claims administrator. If the claim is payable, a benefit check or draft will be issued payable to you or your beneficiary and forwarded through the Welfare Plan Office. In the event that a claim is not eligible under the group policy, the life insurance company will notify you or your beneficiary of the denial. Such notification will be made in writing, within 90 days (45 days for benefits requiring a determination of disability) of the date the claim is received, and will be transmitted through the Welfare Plan Office. The notification will include the specific reason or reasons for denial, as well as specific reference to the group policy certificate provisions or Plan provisions upon which the denial is based. You or your beneficiary will also be informed as to the steps which may be taken to have the claim denial reviewed.

A decision as to the validity of a claim will ordinarily be made within 10 working days of the date the claim is received by the life insurance company. Occasionally, however, certain questions may arise (for example, whether the group policy was in force at the time of the claim; whether a particular employee met all the eligibility requirements; whether death was accidental, as defined by the policy; etc.), and these questions may prevent the life insurance company from rendering a decision on the validity of the claim within the 90-day (45-day for benefits requiring a determination of disability) period. If this occurs, you or your beneficiary will be notified in writing through the Welfare Plan Office of the reason for the delay and the anticipated length of the delay. If further information or other material is required, you or your beneficiary will be so informed.

2. Appeal

If you or your beneficiary is dissatisfied with the denial of a claim or the amount paid, you or your beneficiary have 60 days (180 days for a claim for benefits which required a determination of disability) from the date of receipt of the notice of a claim denial to object to the action taken by the life insurance company or its designated claims administrator. If you or your beneficiary wishes to contest a claim denial, you or he should notify the Welfare Plan Office, which will assist in making inquiry to the life insurance company. You or your beneficiary should have access to the group policy and insurance certificate at the Welfare Plan Office; however, if these documents are not available, they may be obtained from the life insurance company along with any other documents pertinent to the claim denial. All objections to the life insurance company's action should be in writing and submitted to the Welfare Plan Office for transmittal to the life insurance company. The life insurance company will review the claim denial and render a decision on the claim. You or your beneficiary will be informed in writing of the decision of the life insurance company within 60 days (45 days on an appeal of a claim for benefits which required a determination of disability) after the claim review request is received by the life insurance company. In some circumstances, additional time, up to an additional 60 days (45 days on an appeal of a claim for benefits which required a determination of disability), may be required to render a decision. In such circumstances, you or your beneficiary will be notified in writing of the reason for the delay and the anticipated length of the delay.

B. Weekly Disability Benefits

1. Initial Decision

The Plan will evaluate and make a decision with respect to a claim for weekly disability benefits within 45 days after you submit such a claim. This 45-day limit may be extended twice by up to 30 days each time. The Plan will, prior to the expiration of the original 45-day period, or first 30-day extension, notify you of the reason for the delay and the date by which a decision can be expected. The Plan will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the claim. You will be given 45 days to provide such additional information. (The Plan's time limits are tolled while the Plan is waiting for you to provide additional information.)

If your claim is denied, you will be notified in a writing which sets forth the specific reason for the denial, the specific Plan provisions upon which the denial is based, a description of additional material or information necessary for you to perfect a claim, and a description of the Plan's appeal procedures.

2. Appeal

You may appeal from the denial of a claim for disability benefits within 180 days after you are notified of the denial. To appeal, you should write to:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

You may include any comments, documents, or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records, and other information relevant to your claim.

The Board of Trustees will review all comments, documents, records and other information you submit with your original claim or with your appeal. If the original denial was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant field of medicine and who is not the same expert or the subordinate of any expert the Plan consulted in connection with the original denial.

The Trustees will review and decide your appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees following their receipt of your appeal, unless your appeal is received within 30 days of that meeting. In such case, the Trustees will decide no later than the date of the second meeting following receipt of your appeal. If special circumstances require further time, the Trustees will notify you prior to the commencement of the extension of the need for such extension, the reasons for the extension and the date as of which a decision will be made. In such case, the Trustees will decide no later than the third meeting following the Trustees' receipt of the appeal.

You will be notified, in writing, of the Trustees' decision not later than five days after they make it. If the decision is adverse to you, the notice will identify the specific reason(s) for the decision and the Plan provisions relied upon.

C. Medical and Other Benefits Generally

1. Initial Decision

The Plan will evaluate and make a decision with respect to a claim for benefits within 30 days after you submit such a claim. This 30-day limit may be extended by up to 15 days. The Plan will, prior to the expiration of the original 30-day period, notify you of the reason for the delay and the date by which a decision can be expected. If the extension of time is necessary due to your failure to submit all information necessary to decide your claim, you will be notified of the additional information needed and you will be given 45 days to provide such additional information. (The Plan's time limits are tolled while the Plan is waiting for you to provide additional information.)

If your claim is denied, you will be notified in writing which sets forth the specific reason for the denial, the specific Plan provisions upon which the denial is based, a description of additional material or information necessary for you to perfect a claim, and a description of the Plan's appeal procedures.

2. Appeal

You may appeal from the denial of a claim within 180 days after you are notified of the denial. To appeal, you should write to:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

You may include any comments, documents, or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records, and other information relevant to your claim.

The Board of Trustees will review all comments, documents, records and other information you submit with your original claim or with your appeal. If the original denial was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant field of medicine and who is not the same expert or the subordinate of any expert the Plan consulted in connection with the original denial.

The Trustees will review and decide your appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees following their receipt of your appeal, unless your appeal is received within 30 days of that meeting. In such case, the Trustees will decide no later than the date of the second meeting following receipt of your appeal. If special circumstances require further time, the Trustees will notify you prior to the commencement of the extension of the need for such extension, the reasons for the extension and the date as of which a decision will be made. In such case, the Trustees will decide no later than the third meeting following the Trustees' receipt of the appeal.

You will be notified, in writing of the Trustees' decision not later than five days after they make it. If the decision is adverse to you, the notice will identify the specific reason(s) for the decision and the Plan provisions relied upon.

D. Decisions Concerning Pre-Approval of Treatment for Mental Illness or Drug or Alcohol Problems

With respect to treatment or care for mental illness or a drug or alcohol problem requiring prior approval by the Mental Health Case Manager (i.e., all situations except emergencies), if the care or treatment which is the subject of the claim has not been provided as of the time the claim is filed or under consideration, an initial decision on the claim shall be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the claim by the Plan. If the claim is denied, and if the care or treatment subject of the claim has not been provided when an appeal is filed or under consideration, then any such appeal from a denial of the claim shall be decided within 30 days of the Plan's receipt of the appeal. If the care or treatment which is the subject of the claim has been provided at the time the claim or appeal is filed or under consideration, then the time frames generally applicable to medical claims shall apply. (See Section 13C above).

E. Concurrent Care

If a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved, the request must be made in writing and the request will be treated as a claim for benefits. The claim will be processed consistent with the rules generally applicable to medical claims except that if at the time of the submission of the claim the course of treatment has not been extended, the time for deciding the claim will be a reasonable period of time appropriate to the medical circumstances but not later than 15 days and the time for deciding any appeal from a denial of such a claim will be 30 days.

If the Plan determines to reduce or terminate a course of treatment which the Plan has previously approved, then the Plan will notify you of this decision in writing before the end of such period of time or number of treatments previously approved. The contents of this notice will comply with the rules generally applicable to claim denials and will be provided to you sufficiently in advance of the reduction or termination of treatment to enable you to appeal and obtain a determination from the Plan before the treatment is terminated or reduced. In the event you receive a notice of the Plan's intention to terminate or reduce previously approved treatment you will be notified of the date by which you must submit an appeal.

F. Dental Benefits

1. Filing of Dental Claims and Supporting Documentation

a. Dental Claim Forms

Generally, you will not be required to submit a "claim form". Your dentist will forward bills to the Fund Office. Such bills will be regarded as the claim. However, if your provider does

not submit your claim, you must submit it. To do so, you should send an itemized bill for any services and supplies to:

District No. 9, I.A.M.A.W. Welfare Plan
ATTENTION: Dental Claims
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

b. Time for Submission of Dental Claims

You or your dentist must submit a claim for dental benefits within one year after you received the service or appliance for which benefits are claimed. The claim should be accompanied by all supporting documentation. No claim for benefits will be considered if it and/or the supporting documentation is received by the Welfare Plan Office more than one year after the service or supply for which benefits are claimed.

c. Additional Information or Examination May be Required

The Welfare Plan Trustees reserve the right and opportunity to require the submission of additional information regarding a claim for benefits and reserve the right to examine the person whose treatment is the basis of a claim as often as necessary during the duration of the condition for which a claim is made.

2. Payment of Dental Claims

a. Generally

Dental benefits will be paid directly to the provider who provided the services unless you prove you paid the provider, in which case reimbursement will be made to you or to the person indicated in a QMCSO or in applicable law governing the payment of benefits.

The Trustees reserve the right to allocate the deductible amounts to any eligible charges and to apportion the benefits to you and any assignees.

b. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for you or one of your dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous amounts may be requested. If a requested refund is not paid or if none is requested, the Trustees of the Welfare Trust may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for you or your dependents to offset the overpaid or mistakenly paid amounts or bringing a legal action against you or your dependent to collect the overpayment. If it is necessary for the Trustees to institute legal proceedings to collect an overpayment and they prevail, you or your dependent will be responsible for paying prejudgment interest and the reasonable attorney's fees and costs they incur in connection with such action.

3. Initial Decision on Dental Claim

The Plan will evaluate and make a decision with respect to a claim for benefits within 30 days after you submit such a claim. This 30-day limit may be extended by up to 15 days. The Plan will, prior to the expiration of the original 30-day period, notify you of the reason for the delay and the date by which a decision can be expected. If the extension of time is necessary due to your failure to submit all information necessary to decide your claim, you will be notified of the additional information needed and you will be given 45 days to provide such additional information. (The Plan's time limits are tolled while the Plan is waiting for you to provide additional information.)

If your claim is denied, you will be notified in writing which sets forth the specific reason for the denial, the specific Plan provisions upon which the denial is based, a description of additional material or information necessary for you to perfect a claim, and a description of the Plan's appeal procedures.

4. Appeal from Denial of Dental Claim

You may appeal from the denial of a claim for dental benefits within 180 days after you are notified of the denial. To appeal, you should write to:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

You may include any comments, documents, or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records, and other information relevant to your claim.

The Board of Trustees will review all comments, documents, records and other information you submit with your original claim or with your appeal. If the original denial was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant field of medicine and who is not the same expert or the subordinate of any expert the Plan consulted in connection with the original denial.

The Trustees will review and decide your appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees following their receipt of your appeal, unless your appeal is received within 30 days of that meeting. In such case, the Trustees will decide no later than the date of the second meeting following receipt of your appeal. If special circumstances require further time, the Trustees will notify you prior to the commencement of the extension of the need for such extension, the reasons for the extension and the date as of which a decision will be made. In such case, the Trustees will decide no later than the third meeting following the Trustees' receipt of the appeal.

You will be notified, in writing of the Trustees' decision not later than five days after they make it. If the decision is adverse to you, the notice will identify the specific reason(s) for the decision and the Plan provisions relied upon.

G. Vision Benefits

1. To Obtain Benefits From and File a Claim With a Network Doctor

When you obtain services from a network doctor, you get the most value from your vision benefit. Make an appointment with a Network Doctor and the doctor will confirm your eligibility prior to your appointment. Your Network Doctor will perform the covered services and provide the covered eyewear at no cost. If the services or eyewear you receive are not covered or cost in excess of what is covered, you will pay the doctor for the non-covered portion of services or eyewear. The vision administrator will reimburse the doctor directly. You do not need to file a claim. However, if you believe your Network Doctor has charged you too much or your Network Doctor has refused to provide you with services or eyewear, you may submit a claim by calling the vision administrator.

The customer service department will help you file a claim in this circumstance.

2. To Obtain Benefits From and File a Claim With a Non-Network Provider

If you use a Non-Network provider, you get the services and eyewear and pay the entire bill at the time of service. Be aware that out-of-network benefits do not guarantee full payment. Services obtained through out-of-network providers are subject to the same time frames and co-payments as services obtained through network doctors. To ensure a timely reimbursement, log on to the vision network's website and access the claim form.

If you do not have Internet access, send the following to the vision administrator:

- An itemized receipt listing the services received
- The name, address and phone number of the out-of-network provider
- The covered member's ID number, name, address and phone number
- The name of the organization that offers your vision network coverage

- The patient's name, date of birth, address and phone number
- The patient's relationship to the covered member, such as "self," "spouse," "child".

Keep a copy of the claim information and send the originals to:

Vision Service Plan
ATTENTION: Out-of-Network Claims
P. O. Box 997100
Sacramento, California 95899-7100

3. Initial Decision on Vision Claim

The vision administrator will evaluate and make a decision with respect to a claim for benefits within 30 days after you submit such a claim. This 30-day limit may be extended by up to 15 days. The vision administrator will, prior to the expiration of the original 30-day period, notify you of the reason for the delay and the date by which a decision can be expected. If the extension of time is necessary due to your failure to submit all information necessary to decide your claim, you will be notified of the additional information needed and your claim will be finalized. When you return the claim to VSP with the additional information, it will be processed as a new claim. As long as the claim, along with the corrections, are submitted within the Welfare Trust's allowed time frame for claim submission, the vision administrator will process the claim accordingly.

If your claim is denied, you will be notified in writing which sets forth the specific reason for the denial, the specific Plan provisions upon which the denial is based, a description of additional material or information necessary for you to perfect a claim, and a description of the Plan's appeal procedures.

4. Appeal from Denial of Vision Claim

You may appeal from the denial of a claim for vision benefits within 180 days after you are notified of the denial. To appeal, you should write to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, California 95670
(800) 877-7195

You may include any comments, documents, or information you wish. The Plan will provide to you, free of charge, upon your request, copies of all documents, records, and other information relevant to your claim.

The vision administrator will review all comments, documents, records and other information you submit with your original claim or with your appeal. If the original denial was based in whole or in part on a medical judgment, the vision administrator will consult with a health care professional who has appropriate training and experience in the relevant field of medicine and who is not the same expert or the subordinate of any expert the vision administrator consulted in connection with the original denial.

The vision administrator's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within 30 calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If the Covered Person disagrees with the vision administrator's determination, he/she may request a second level appeal within 60 calendar days from the date of the determination. The vision administrator shall resolve any second level appeal within 30 calendar days.

H. Miscellaneous Provisions Pertaining to Claims and Appeals

You may designate another person to act as your authorized representative for purposes of the Plan's claims and appeals procedures. To designate an authorized representative you will need to fill out a form which may be obtained from the Plan Office.

Under federal law you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if you are dissatisfied with the decision of the Trustees on

appeal. Before bringing such an action you must exhaust the Plan's claims and appeals procedure. Any such action under ERISA must be filed within two years of the date on which your appeal was denied.

With respect to any claim or appeal involving medical or disability benefits which has been denied, you have a right to receive free of charge upon written request:

1. a copy of any rule, guideline, protocol or other similar criterion which was relied upon;

2. if a medical judgment was involved in the denial of your claim on appeal, an explanation of the scientific or clinical judgment upon which the decision on your claim or appeal was based; and

3. the identity of any medical or vocational experts who were consulted with respect to your claim.

You further have the right to receive free of charge upon written request all documents, records and other information relevant to your claim. Any written request encompassed by this paragraph should be sent to the Administrative Manager at the Plan Office.

Decisions on claims and appeals (with respect to benefits other than life and accidental death and dismemberment benefits) are uniformly made in accordance with the terms and conditions of the Plan Benefits and cannot be paid unless authorized by the Plan. The decisions with respect to life and accidental death and dismemberment benefits are made uniformly in accordance with the insurance policy and cannot be paid unless authorized by that policy.

SECTION 14. ERISA INFORMATION

A. Plan Name

District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan.

B. Plan Number

501

C. Employer Identification Number

43-0648504

D. Plan Sponsor and Administrator

Joint Board of Trustees of the
District No. 9, International
Association of Machinists and
Aerospace Workers Welfare Trust Fund
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
Phone: (314) 739-6442
Toll Free: 888-739-6442

As of January 1, 2011, the Trustees are:

Union Trustees

Tony Rippeto
Directing Business Representative
District No. 9, I.A. of M. & A.W.
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

Mark Conner
Assistant Directing Business Representative
District No. 9, I.A. of M. & A.W.
12365 St. Charles Rock Road
Bridgeton, Missouri 63044

Management Trustees

Chris Adelmann
St. Louis Automobile Dealers Association
13616 Manchester Road
St. Louis, Missouri 63131

James J. Jost
South Side Machine Works, Inc.
3761 Eiler Street
P. O. Box 22199
St. Louis, Missouri 63116

E. Type of Plan

The Plan is a welfare benefit plan that currently provides life, accidental death and dismemberment, weekly income, comprehensive major medical, dental and vision benefits. Not all participants are eligible for all benefits.

The life insurance and accidental death and dismemberment insurance benefits are furnished in accordance with group insurance policies issued by a life insurance carrier selected by the Trustees. As of October 1, 2009, the life insurance carrier is Hartford Life and Accident Insurance Company, P.O. Box 2999, Hartford, Connecticut 06104-2999. Under this policy, the insurance company insures your life insurance and AD&D benefits.

All of the other benefits are paid directly out of the assets of the Welfare Plan.

The vision benefits are also provided from the assets of the Plan. However, the benefits are administered by:

Vision Service Plan (VSP)
3333 Quality Drive
Rancho Cordova, California 95670

F. Plan Year Ends

The Plan's financial records are maintained on a plan year basis ending each June 30. However, benefit records are maintained on a calendar year basis. Thus, deductibles, annual maximums, etc., apply during each calendar year.

G. Plan Cost

The Plan Sponsor pays the cost of the Plan out of the District No. 9, I.A.M.A.W. Welfare Trust, which is funded by contributions from contributing employers. In certain instances, contributions may also be made by Plan participants directly.

H. Type of Administration

The Board of Trustees administers the overall operation of this Plan.

As indicated above, the Trustees have purchased a policy of insurance from the Hartford Life and Accident Insurance Company to provide the life and accidental death and dismemberment benefits. As of October 1, 2009, Hartford insures these benefits. The address of the insurance company is as follows:

Hartford Life and Accident Insurance Company
P.O. Box 2999
Hartford, Connecticut 06104-2999

All other benefits are provided directly by the Plan from its assets.

The Trustees have entered into an agreement with a medical network provider, HealthLink, which permits covered individuals to have access to HealthLink's Open Access III network. A current list of doctors, hospitals and other providers who are members of the network can be obtained at www.healthlink.com. Further, HealthLink performs the medical pre-certification and concurrent review services/medical case management.

HealthLink
1831 Chestnut Street
St. Louis, Missouri 63103

HealthLink is not financially responsible for any of the benefits provided by this Plan.

The Trustees have entered into a pharmacy benefit management agreement pursuant to which covered individuals have access to a network of pharmacies. This pharmacy benefit manager (PBM) will also process claims for reimbursement for drugs obtained outside the network. The PBM is:

LDI Pharmacy Benefit Management
680 Craig Road, Suite 200
Creve Coeur, Missouri 63141

LDI is not financially responsible for any of the benefits provided by the Plan.

The Trustees have entered into an agreement with St. John's Managed Behavioral Health Service which permits covered individuals to have access to St. John's Network. Further, St. John's provides pre-certification and case management services with respect to mental illness, drug and alcohol problems.

St. John's Managed Behavioral Health Service
314-729-4600
1-800-413-8008

I. Agent for Service of Legal Process

Legal process may be served upon the Managing Trustee, Tony Rippeto, at the above address. Additionally, service of legal process may be made upon any Trustee at the above address.

J. Collective Bargaining Agreements

The Plan is established and maintained pursuant to collective bargaining agreements, a copy of which may be obtained by written request to the Board of Trustees. Such collective bargaining agreements are also available for examination by Plan participants and beneficiaries at the office of the Plan. If for

any reason, you wish to review a collective bargaining agreement, please contact the Plan Office to make an appointment.

You may receive from the Plan Administrator, upon written request, information as to whether a particular employer or labor organization sponsors the Plan and, if so, you can receive the address of the employer or employee organization.

K. Board of Trustees to Interpret, Construe, and Apply Terms of Plan Documents

The Trustees of this Plan have the discretionary authority to determine, pursuant to the terms of this Summary Plan Description, the Plan Document, the Trust Agreement, and other relevant documents, questions concerning eligibility for benefits, questions concerning whether the expense of any given treatment or service is a covered expense, and any other questions which may arise in the administration of this Plan. The Trustees also have the discretionary authority to interpret, construe, and apply the terms of the plan documents, including any ambiguous terms. Any interpretation, construction, or application shall be binding on all parties. The Trustees intend that the most deferential standard of judicial review shall apply to their decisions.

L. Termination or Amendment of the Plan or Trust

The Plan may be amended or terminated by a majority vote of the Trustees at any regular or special meeting of the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this Booklet are those currently provided by the Plan. Those benefits can be altered, modified, reduced, or terminated at any time the Trustees determine, in their discretion, such action is necessary.

Should it occur that no employers are obligated to contribute to the Trust or should the Trustees determine to terminate the Trust, any assets remaining in the Trust shall be used consistently with the purposes of this Trust. No assets of the Trust shall revert to any employer.

M. Trustees Are Fiduciaries

The Trustees are fiduciaries with respect to the Plan. The Trustees in exercising their powers and duties are doing so at all times in their fiduciary capacity.

N. Participating Employers

A participant or beneficiary may receive from the Plan Administrator, upon written request, a statement as to whether a particular employer is a participating employer and the address of that participating employer.

O. Statement of ERISA Rights Required by Federal Law and Regulations

As a participant in the District No. 9, I.A. of M. & A.W. Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan description;

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;

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

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents will have to pay for this coverage. (See Section 5 of this Booklet).

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. (See Section 8H of this Booklet). You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation

coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Welfare Plan. The people who operate your Plan, called "fiduciaries" of the Plan have a duty to do so prudently and in your interest and in the interest of other Plan participants and beneficiaries. No one, including your employer 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial and may obtain copies relating to the decision without charge. You have the right to have the insurance company or the Trustees review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If 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. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees, for example, if it finds your claim is frivolous.

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

P. Trust Fund

The assets used to provide benefits are held in trust by the Board of Trustees of the District No. 9, I.A.M.A.W. Welfare Trust. Those assets can only be used to provide benefits to the employees and former employees of contributing employers, and the dependents of such employees, and to defray the reasonable administrative expenses of operating the Plan.

Q. Grandfather Status

Federal regulations require us to advise you that this group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (314) 739-6442. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SECTION 15. NOTICE OF PRIVACY AND SECURITY PRACTICES FOR DISTRICT NO. 9, I.A.M.A.W. WELFARE PLAN

Effective April 14, 2003, the District No. 9, I.A.M.A.W. Welfare Plan was required to comply with the Privacy Rule set out by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act (HIPAA). While the Welfare Plan has always protected your confidential health information, the Plan was required as of April 14, 2003, to formalize its procedures in this regard.

Effective April 20, 2005, the District No. 9, I.A.M.A.W. Welfare Plan was required to comply with the Security Rule set out by the United States Department of Health and Human Services pursuant to HIPAA. While the Welfare Plan has always secured your confidential health information, the Plan was required as of April 20, 2005, to formulate its procedures in this regard. Effective September 23, 2009, the Welfare Plan was subject to the breach notification rules under HITECH.

The notice was effective on April 14, 2003, and was revised in 2005 and 2010.

This notice describes how medical information about you may be used and disclosed, how you can get access to this information, and informs you of your rights related to your health information. Review it carefully.

We are required by law to:

- Maintain the privacy of your health information;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

A. How We May Use and Disclose Medical Information About You

We may use your health information, as described in each category below, for treatment purposes, for payment purposes, and for our health care operations. We have set out for each of these categories an example of how your health information might be used.

1. Treatment

We may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist the provider in making a determination on a course of treatment for you or we may disclose your health information to a case manager retained by the Plan.

2. Payment

We may use and disclose health information about you for purposes related to payment. For example, we may use your health information to obtain premiums or to determine our responsibility under the Plan. As another example, we may use your health information to coordinate benefits with another health plan.

3. Health Care Operations

We may use and disclose health information about you in order to carry-out the day-to-day health care operations of our health plan. For example, we may use health information in connection with:

legal services;

audit services;

business planning and development; and

business management of the Plan.

4. Other Potential Uses and Disclosures

In addition to the general uses and disclosure of your information discussed above, there may be other special situations where it is necessary, and permissible, for us to use or disclose your health information. These situations are discussed below:

a. Public Health Activities

For example, we may disclose information to a public health authority for the purposes of preventing or controlling disease.

b. Reporting Abuse, Neglect or Domestic Violence

For example, circumstances may arise where we need to disclose to appropriate authorities suspected abuse or domestic violence.

c. Health Oversight Activities

We may disclose health information to a health oversight agency for health oversight activities, including audits, health care fraud investigations, inspections, and other oversight activities authorized by law. For example, it may be necessary for us to disclose information pursuant to a Medicare audit.

d. Judicial or Administrative Proceedings

For example, we may disclose information pursuant to a court or agency order in a legal proceeding.

e. Law Enforcement Purposes

For example, it may be necessary for us to disclose information to law enforcement officials regarding the identification or location of suspects, fugitives, or missing persons.

f. Medical Directors, Coroners, and Funeral Directors

In the event of your death, we may disclose your health information to medical directors, coroners, or funeral directors. For example, disclosure may be necessary for determining a cause of death.

g. Organ and Tissue Donation

We may disclose your information to organizations handling organ and tissue donation.

h. Disclosures to Avert a Serious Threat to Health or Safety

For example, we may disclose information to appropriate authorities in order to protect the safety of an individual.

i. For Specialized Government Functions

We may disclose health information pursuant to certain governmental functions, for example, for military, veteran, or national security activities.

j. Workers' Compensation

We may release information in accordance with applicable Workers' Compensation laws.

k. Disclosures to the Plan Sponsor

The Plan may disclose health information to the Trustees of the Plan in order to carry out plan administration functions.

5. All Other Uses or Disclosures

We may not use or disclose your health information for any purpose other than as described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

B. Your Rights Regarding Health Information

Federal law provides you with several rights regarding your health information:

1. Right to Inspect and Copy Your Health Information

You have the right to inspect and copy the health information that we maintain about you. You must submit any request to inspect or copy your health information in writing. All such written requests should be forwarded to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

If you request a copy of your information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

2. Right to Amend Your Health Information

You have the right to request an amendment to your health information maintained by our Plan, for as long as the information is kept by our Plan. You may wish to request an amendment to your information if you feel that the information is inaccurate or incomplete.

You must make any request for amendment in writing. Your request should be submitted to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

A request must state the reason you feel the amendment is necessary.

3. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures of your health information made by the Plan. This accounting does not include disclosures made pursuant to treatment, payment, healthcare operations, or pursuant to your individual authorization.

You must submit a request for an accounting of disclosures in writing to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

Your request should state the time period for which you would like an accounting, which cannot extend beyond the six-years prior to the date of your request. You are not entitled to an accounting of disclosures made prior to April 14, 2003.

You are entitled to one free accounting within any 12-month period. We may charge you a reasonable fee for any other accounting made within this same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

4. Right to Request Restrictions

You have the right to request specific restrictions on our uses and disclosures of your health information. For example, you have the right to request that we not disclose any of your health information for treatment purposes. We do not have to agree to a requested restriction. Agreeing to a restriction is within our sole discretion.

5. Right to Request Confidential Communications

You have the right to request that we communicate specific information to you in a certain manner or at a certain location, if you feel that the communication might otherwise place you in danger. For example, you may request that an explanation of benefits be sent to your work rather than to your home if you feel that this information may put you in danger if sent to your home.

Any request for a confidential communication must be made in writing and be accompanied by a statement that the confidential communication is necessary to avoid your personal endangerment. All requests should be submitted to:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

6. Right to a Paper Copy of This Notice

You have the right to receive a paper copy of this notice at any time. To request a paper copy of this notice, please contact:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

C. Revisions to This Notice

We reserve the right to change the terms of this notice. Any changes to this notice will be effective for health information that we maintain about you. Should we revise this notice, we will promptly provide you with a new Notice by mailing you a written copy of the new notice or including it in the newsletter that is sent to you periodically from the Welfare and Pension Plans.

D. Complaints Regarding Privacy Rights

If you believe your privacy rights have been violated, you have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact:

District No. 9, I.A.M.A.W. Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
ATTENTION: Privacy Officer

Your privacy rights will not be affected by filing a complaint. Further, you will not be retaliated against in any manner for filing a complaint.

E. Security Measures

We will reasonably and appropriately safeguard electronic protected health information (ePHI) created, received, maintained, or transmitted to or by us. Accordingly, the Plan has:

1. Implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI it creates, receives, maintains, or transmits;

2. Ensured that there is adequate separation (or firewall) between the information that is received from the Plan and other employment information and decisions, and this separation is supported by reasonable and appropriate security measures; and

Ensured that any agent, including any subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

F. Breach Notification

Effective September 23, 2009, the Plan was subject to the new HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under the new HITECH law, we will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information:

1. a brief description of what happened, the date of the breach if known, and the date of discovery;

2. the type of PHI involved in the breach;

3. any precautionary steps you should take;

4. what we are doing to mitigate the breach and prevent future breaches; and

5. how you may contact us to discuss the breach.

We will also report the breach to the U.S. Department of Health and Human Services.

DISTRICT NO. 9, I.A.M.A.W. WELFARE PLAN
SCHEDULE OF BENEFITS
C-3-G

Annual Deductible
- Individual $250
- Family $750

Emergency Room Co-Payment ..... $75 per visit
..... (waived if admitted)

Percentage Paid of Covered Charges
..... 90% HMO
..... 80% Network
..... 60% Non-Network

Annual Stop-Loss

After covered medical expenses subject to coinsurance reach this amount per calendar year, the plan pays 100%
- Individual $2,500
- Family $7,500

Specialty Drugs Out-of-Pocket per Individual (Not included in Major Medical Stop-Loss)

After the member pays this amount per calendar year, the plan pays 100% $2,500

Major Medical Benefits
- Lifetime Maximum $1,500,000

Weekly Income Benefit – Employee Only
- Amount – 70% of weekly pre-disability earnings
- From Covered Employment to a maximum of ..... $400 per week
- For a maximum of ..... 26 weeks
- Benefits begin
  - Accident ..... 1st day
  - Other illness or injury ..... 8th day

Life Insurance
- Employee $20,000
- Dependent Spouse $5,000
- Dependent Child (from live birth) $2,000

Accidental Death and Dismemberment (AD&D) – Employee Only $20,000

Important Note: **Additional conditions apply to many of these Benefits. Please read the appropriate portions of the Booklet with regard to specific benefits.**

For medical pre-certification, call HealthLink at
877-284-0102 (Toll-Free)

For all mental, drug or alcohol,
Call St. John's Mercy Managed Behavioral Health at
314-729-4600 (Local)
800-413-8008 (Toll-Free)