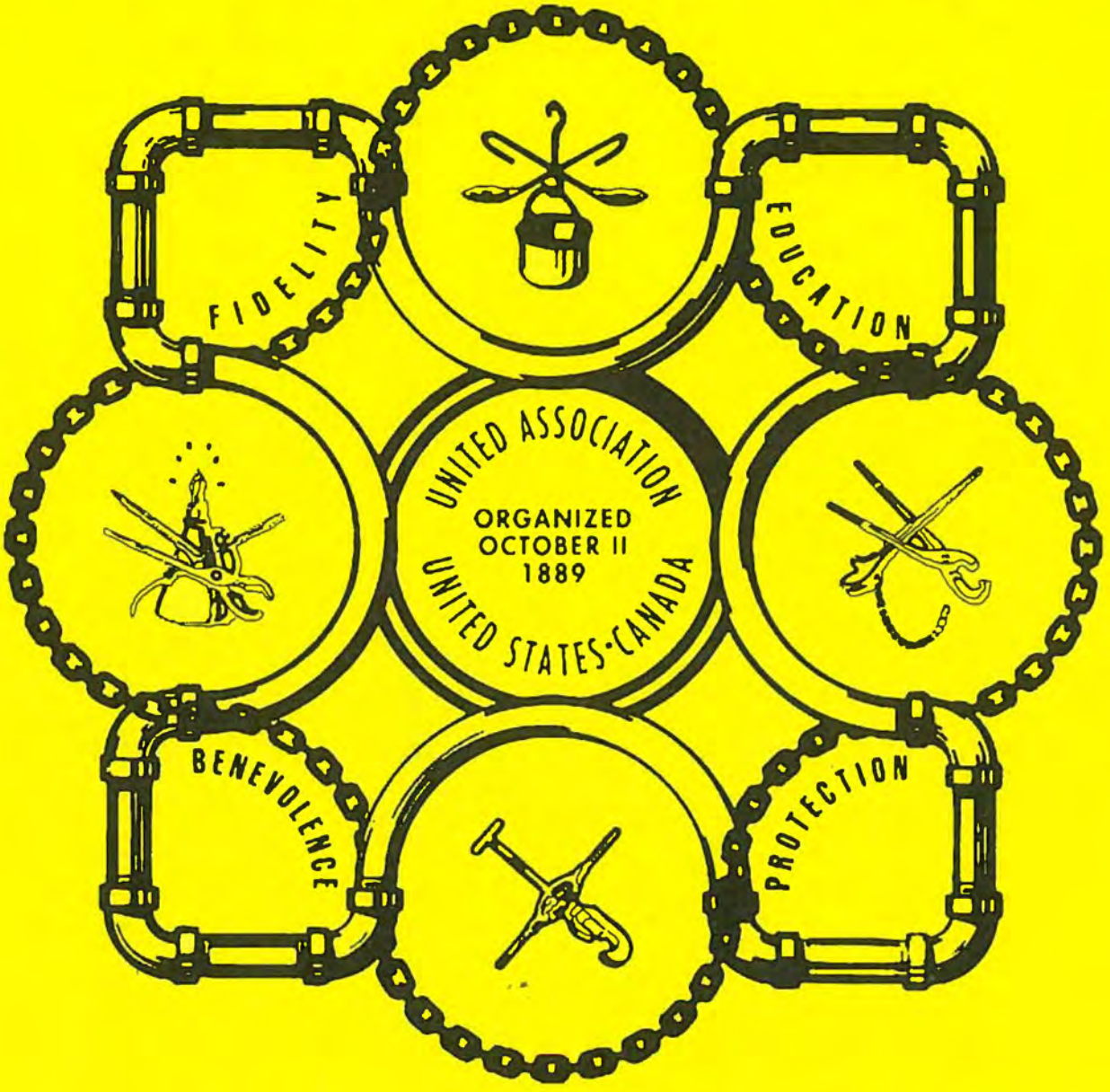
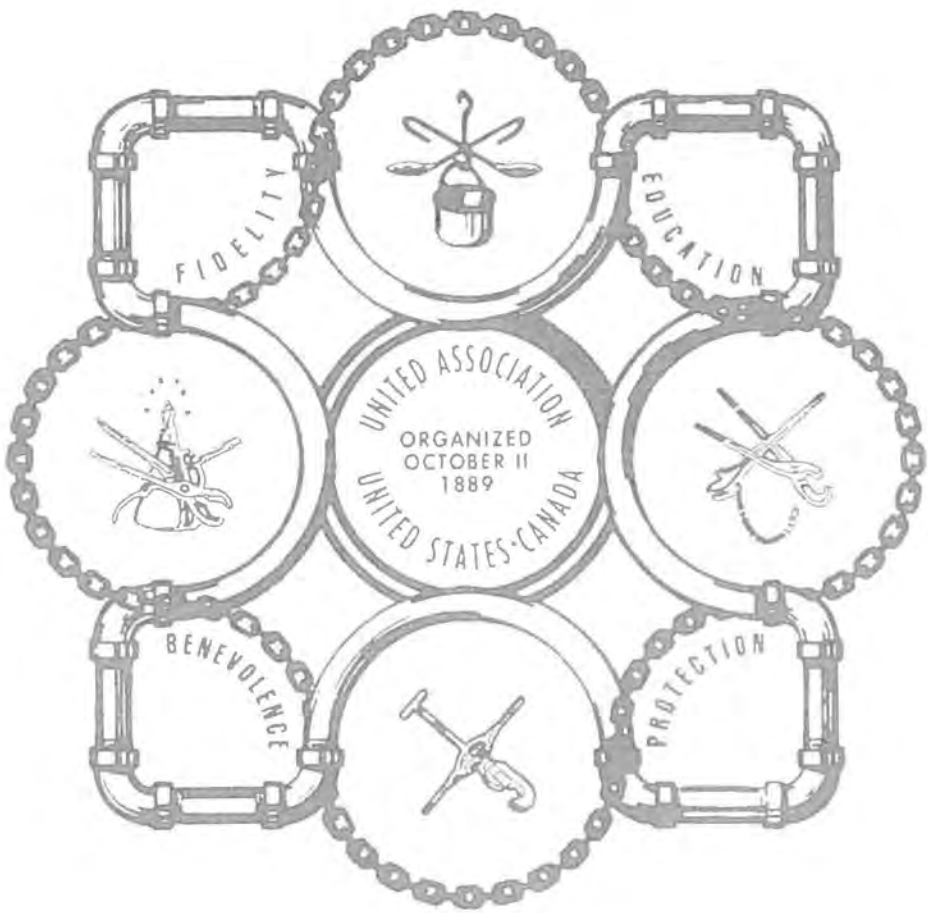
PIPE FITTERS LOCAL UNION 533
HEALTH AND WELFARE PLAN
KANSAS CITY, MISSOURI



SUMMARY PLAN DESCRIPTION

Effective July 1, 2009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INTRODUCTION

This document is your Summary Plan Description (SPD). It is a Summary of the benefits you are entitled to under the Pipe Fitters Local No. 533 Health and Welfare Plan pursuant to the Plan's governing documents. These documents include the Official Plan Document, the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health and Welfare Fund (the Trust), and the Collective Bargaining Agreement between Pipe Fitters Association Local Union No. 533 (the Union) and the Mechanical Contractors Association of Kansas City (the Association). Under these governing documents the Board of Trustees has the power and discretion to amend, change, add to, interpret, or terminate the Plan.

This SPD incorporates the most recent Plan of benefits as restated effective July 1, 2009 and incorporates any Plan Amendments made through that date. The SPD was written in a way to help you understand your benefits under the Plan. It contains general explanations only. If something is not clear, you should contact your Plan Administrator for more specific information.

Throughout this document, certain terms are used that have very specific meanings. They are capitalized wherever they are used in the SPD. These terms are defined at the beginning of this SPD on page 1.

You should remember that the Fund's money is <u>your</u> money. By saving the Plan money, we are able to provide better benefits, and it helps to lessen the need to add a higher contribution rate, which may ultimately decrease your paycheck. There are certain things that you can do to help in this effort, such as using in-network service providers, and using the mail-order prescription drug service or generic prescription drugs whenever possible. If you feel you are overcharged by a provider, please call the provider and ask for an itemized bill of your expenses. Being aware of your benefits under this Plan will help you to make good choices when making your healthcare decisions.

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

We hope you find this SPD useful, and we hope that you and your family will enjoy the protections of the Plan for years to come.

Sincerely,

Board of Trustees

IMPORTANT INFORMATION REGARDING YOUR BENEFITS

In-Network Providers: Please be aware of the following situations:

1) When you get a referral from your doctor you should ensure that the referral doctor is in-network.

2) Certain procedures can be performed at facilities other than your doctor's office or a hospital. Ensure that the facility where the procedure is being performed is an in-network provider.

3) Please be aware that certain hospitals use independent specialty contractor doctors rather than staff doctors. A hospital may be in-network; however certain providers in that hospital may not be in-network. For example, an anesthesiologist at a hospital may not be in-network although the hospital is in-network. In these instances you may get a separate bill from the independent contractor provider who will not necessarily be in-network.

Prior Authorization: Some services and benefits under the Plan require prior authorization from the Plan Administrator. Please carefully read each section of the Plan to determine whether a service or benefit requires prior authorization. Please contact the Plan Administrator if you have any questions regarding whether a particular service or benefit requires prior authorization.

Schedule of Benefits for Eligible Employees and Dependents
(All Benefit Amounts Listed are Per Covered Person, except the Family Deductible Maximum, as Shown Below)

Description of Benefit	Emp'ee	Dep.	Co-Pay	Co-Ins.	Plan pays	Deductible	Annual Max.	Separate Program Max.
Death Bene.	X		n/a	n/a	$10,000	n/a	n/a	no
Loss of Time	X		n/a	n/a	$400/wk	n/a	n/a	26 wk/ disability
AD&D	X		n/a	n/a	$1,500*	n/a	n/a	no
Comp. Med.**								
all covered charges in-network	X	X	n/a	15% up to $20,000	85% up to $20,000, 100% of excess	$300, NTE $600 per family	n/a	n/a
all covered charges out of network	X	X	n/a	40% up to $20,000	60% up to $20,000, 100% of excess	$300, NTE $600 per family	n/a	n/a
emergency out of network	X	X	n/a	20% up to $20,000	80% up to $20,000, 100% of excess	$300, NTE $600 per family, comb. w/ in-network and out-of-network	n/a	n/a
WELLNESS	X	spouse only	$0.00	0%	100%	none	n/a	subj. to age-based sched.
ROUTINE/ PREVENTIVE CARE	X	spouse only	$0.00	0%	100% up to max.	none	$300	subj. to age-based sched.
WELL CHILD		child only	$0.00	0%	100%	same as Comp Med.	n/a	subj. to age-based sched.
MED. APPLIANCES & SUPPLIES	X	X	n/a	15%	85%	same as Comp Med.	$5,000	$5,000/yr.
Ambulance	X	X	n/a	15%	85%	same as Comp. Med.	n/a	n/a
Hospice care	X	X	$0.00	0%	100%	none	210 days	210 days
Organ Transplant	X	X	See Page 34 for explanation of benefits				n/a	$1,000,000/ lifetime
MENTAL HEALTH								
In-network inpatient	X	X	n/a	same as Comp. Med.	same as Comp. Med	none	30 days	n/a
inpatient out of network	X	X	n/a	40%	60%	none	30 days	n/a
outpatient in-network (no out-of-network benefits)	X	X	n/a	50%	50%	none	45 visits (all MH/SA outpt)	n/a
outpatient in-network following amputation	X	X	n/a	15% up to $20,000	85% up to $20,000, 100% of excess	none	45 visits (all MH/SA outpt)	n/a
SUBSTANCE ABUSE								
In-network inpatient	X	X	n/a	0%	100% up to $7,500	none	30 days or $7,500.00	$7,500/yr.
inpatient out of network	X	X	n/a	40%	60% up to $7,500	none	30 days or $7,500.00	$7,500/yr.
outpatient in-network (no out-of-network benefits)	X	X	n/a	50%	50%	none	45 visits (all MH/SA outpt)	n/a
outpatient with EAP referral	X		n/a	0%	100%	none	45 visits (all MH/SA outpt)	n/a
Case Management	X	X	Provided for any participant at the discretion of, and upon request of, the Board of Trustees					
Prescription Drug								
retail generic	X	X	$15.00	0%	100% above co-pay	$100, NTE $200 per family	n/a	n/a
retail preferred brand name	X	X	$30.00	0%***	100% above co-pay		n/a	n/a
retail non-preferred brand name	X	X	$50.00	0%***	100% above co-pay		n/a	n/a
mail order generic	X	X	$30/Rx up to 90d	0%	100% above co-pay		n/a	n/a
mail order preferred brand name	X	X	$60/Rx up to 90d	0%***	100% above co-pay		n/a	n/a
mail order brand name	X	X	$100/Rx up to 90d	0%***	100% above co-pay		n/a	n/a
Dental								
In-network	X	X	n/a	20%	80%	none	$1,500	$1,500/yr
out-network	X	X	n/a	40%	60%	none	$1,500	$1,500/yr
dental inplants	X	X	n/a	n/a	50% up to $1,500 dental max per year	none	$1,500	$1,500/yr
Hearing Aid	X	X	n/a	0%	100% up to max.	none	n/a	$2,000/ 5 consec. calendar years

*$1,500 principal amount; percentage paid for partial losses

**Comprehensive Medical benefits include reasonable, usual, and customary charge for medically necessary care and treatment of an injury or sickness.

***When a generic equivalent is available, the member must pay the difference in ingredient cost between the generic and the brand name.

Schedule of Benefits for Retirees and Dependents (Benefit Amounts Shown are Per Person, except for Family Deductibles where Listed)

Description of Benefit	Ret.	Dep.	Co-Pay	Co-Ins.	Plan pays	Deductible	Annual Max.	Separate Program Max.
Death Bene.	X		n/a	n/a	$10,000	n/a	n/a	no
Comp. Med.*								
all covered charges in-network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007	X	X	n/a	15% up to $10,000	85% up to $10,000, 100% of excess	$150, NTE $300 per family	n/a	n/a
all covered charges in-network for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007	X	X	n/a	15% up to $20,000	85% up to $20,000, 100% of excess	$300, NTE $600 per family, comb. w/ in-network	n/a	n/a
all covered charges out of network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007	X	X	n/a	40% up to $15,000	60% up to $15,000, 100% of excess	$400, NTE $800 per family	n/a	n/a
all covered charges out of network for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007	X	X	n/a	40% up to $20,000	60% up to $20,000, 100% of excess	$300, NTE $600 per family	n/a	n/a
emergency out of network for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007	X	X	n/a	20% up to $10,000	80% up to $10,000, 100% of excess	$150, NTE $300 per family, comb. w/ in-network	n/a	n/a
emergency out of network for Retiree w/application for pension after 12/29/2006 and effective date after 3/31/2007	X	X	n/a	20% up to $20,000	80% up to $20,000, 100% of excess	$300, NTE $600 per family, comb. w/ in-network and out-of-network	n/a	n/a
WELLNESS	X	Spouse Only	$0.00	0%	100%	none	n/a	subj. to age-based sched.
ROUTINE/ PREVENTIVE CARE	X	Spouse Only	$0.00	0%	100% up to max.	none	$300	subj. to age-based sched.
WELL CHILD			n/a	n/a	n/a	n/a	n/a	n/a
MED. APPLIANCES & SUPPLIES	X	X	n/a	20%	80%	same as Comp. Med.	$5,000	$5,000/yr.
Ambulance	X	X	n/a	20%	80%	same as Comp. Med.	n/a	n/a
Hospice care	X	X	$0.00	0%	100%	none	210 days	210 days
Organ Transplant	X	X	See pages		for explanation of benefits		n/a	$1,000,000/ lifetime
MENTAL HEALTH								
In-network inpatient	X	X	n/a	same as Comp. Med.	same as Comp. Med.	none	30 days	n/a
inpatient out of network	X	X	n/a	40%	60%	none	30 days	n/a
outpatient in-network (no out of network benefits)	X	X	n/a	50%	50%	none	45 visits (all MH/SA outpt)	n/a
outpatient in-network following amputation for Retiree w/application for pension on or before 12/29/2006 and effective date on or before 3/31/2007	X	X	n/a	15% up to $10,000	85% up to $10,000, 100% of excess	none	45 visits (all MH/SA outpt)	n/a
outpatient in-network following amputation for Retiree w/application for pension after 12/29/2006 or effective date after 3/31/2007	X	X	n/a	15% up to $20,000	85% up to $20,000, 100% of excess	none	45 visits (all MH/SA outpt)	n/a
SUBSTANCE ABUSE								
In-network inpatient	X	X	n/a	0%	100% up to $7,500	none	30 days or $7,500.00	$7,500/yr.
inpatient out of network	X	X	n/a	40%	60% up to $7,500	none	30 days or $7,500.00	$7,500/yr.
outpatient in-network (no out of network benefits)	X	X	n/a	50%	50%	none	45 visits (all MH/SA outpt)	n/a
Case Management	X	X	Provided for any participant at the discretion of, and upon request of, the Board of Trustees					
Prescription Drug								
retail generic	X	X	$15.00	0%	100% above co-pay	$100 per family	n/a	n/a
retail preferred brand name	X	X	$30.00	0%**	100% above co-pay		n/a	n/a
retail non-preferred brand name	X	X	$50.00	0%**	100% above co-pay		n/a	n/a
mail order generic	X	X	$30/Rx up to 90d	0%	100% above co-pay		n/a	n/a
mail order preferred brand name	X	X	$50/Rx up to 90d	0%**	100% above co-pay		n/a	n/a
mail order brand name	X	X	$100/Rx up to 90d	0%**	100% above co-pay		n/a	n/a
Dental								
In-network	X	X	n/a	20%	80%	none	$1,500	$1,500/yr
out-network	X	X	n/a	40%	60%	none	$1,500	$1,500/yr
dental implants	X	X	n/a	n/a	50% up to $1,500 dental max per year	none	$1,500	$1,500/yr
Vision	X	X	n/a	0% subj. to bene. max.	100% up to bene. max.	none	varies by item	yes
Hearing Aid	X	X	n/a	0%	100% up to max.	none	n/a	$2,000/ 5 consec. calendar years

*Comprehensive Medical benefits include reasonable, usual, and customary charge for medically necessary care and treatment of an injury or sickness

**When a generic equivalent is available, the member must pay the difference in ingredient cost between the generic and the brand name

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DEFINITIONS OF COMMON TERMS USED IN THIS SPD

The ***Allowable Charge*** is a reasonable charge for the covered service, product, or procedure that is the subject of the claim.

An ***Alternate Recipient*** is a person who is entitled to coverage under this Plan under a Qualified Medical Child Support Order.

Association means the Mechanical Contractors Association of Greater Kansas City.

A ***Beneficiary*** is any person who is eligible to receive benefits under this Plan based on a Participant's (i.e., an Eligible Employee's or a Retiree's) participation in this Plan.

Collective Bargaining Agreement means the Agreement and Contract by and between Members of Mechanical Contractors Association of Kansas City and Pipe Fitters Association Local Union No. 533 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada; as well as any other collective bargaining agreement between the Union and any other Participating Employer that sets forth benefits to be provided under this Plan or establishes any rights or obligations with respect to Participants, Beneficiaries, or contributing Employers.

Coverage Period means a specified period of time for which a Covered Person is eligible to receive benefits under the terms of this Plan.

Covered Person is any person who is eligible to receive benefits from this Plan, including Participants (Eligible Employees and Retirees), Dependents, and Designated Beneficiaries.

Dentist is a health care provider licensed to practice dentistry by the State in which he practices.

Dependent means a person who is (a) an Eligible Child or (b) the spouse (unless legally separated) of an Eligible Employee or Retiree.

Designated Beneficiary is the person designated by the Participant, or by the terms of this Plan, to receive such Participant's benefits under the Death Benefit and Accidental Death and Dismemberment Benefit Programs of this Plan.

Disability means an Eligible Employee will be considered to be disabled during any period when, as a result of an injury or sickness, he is unable to work at his occupation and is not performing any other work for wage or profit. A Dependent will be considered disabled during any period when, as a result of injury or sickness, (s)he is unable (because of a physical or mental condition) to engage in the normal activities of a person of the same age and gender.

Eligible Child means any Dependent child of an Eligible Employee or Retiree who meets the criteria for coverage under this Plan.

Eligible Employee means any Employee employed by a Participating Employer (an Employer signatory to a Collective Bargaining Agreement with the Union) who performs work covered by that Collective Bargaining Agreement, who has met the requirements to obtain coverage under this Plan, and on whose behalf contributions are made to the Plan pursuant to the Collective Bargaining Agreement. This term also refers to any regularly paid employee of the Union on whose behalf the Union makes contributions to the Plan, any regularly paid employee of the Fund, of the Pipe Fitters Local No. 533 Pension Fund, or of the Pipe Fitters Local No. 533 Training Center. See page 5 of this SPD for more in-depth eligibility rules.

An ***Emergency*** is any situation in which, due to an accident or Sickness, a person requires immediate medical care and delay could endanger the person's life, health, functioning, or could cause extreme pain that cannot be controlled without such medical care.

Employee means any person employed by an Employer to perform work covered by the Collective Bargaining Agreement between the Union and the Association (or any Collective Bargaining Agreement entered into between the Union and any other individual Employer), as well as any regularly paid employee of the Fund, the Pipe Fitters Local No. 533 Pension Fund, or the Pipe Fitters Local No. 533 Training Center.

Employer means any entity employing persons to perform work that is covered by the Collective Bargaining Agreement between the Union and the Association within the geographic area covered by such Collective Bargaining Agreement. (*See also* Participating Employer.)

Fund means the Pipe Fitters Local No. 533 Health and Welfare Fund. (*See also* Plan.)

Fund Office means any office or other physical location out of which the Fund is administered.

Hospice means palliative care provided to a person with a terminal illness and his family, to provide for the basic life functions and necessities of life during this time, including pain relief, in anticipation of the Covered Person's death, related services for the Covered Person's family to assist in the transition to the person's death, and to provide grief counseling.

Hospital means:

(1) an institution constituted, licensed, and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all facilities necessary to provide for the diagnosis and medical and surgical treatment of injury or sickness and which provides such treatment for compensation, by or under the supervision of Physicians on an inpatient basis with continuous 24-hour nursing service by Registered Nurses; or

(2) an institution which qualifies as a hospital, a psychiatric hospital, a tuberculosis hospital, or a provider of services under Medicare, and which is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

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

Medically Necessary (or ***Medical Necessity***) means medical care that is required to treat an injury or Sickness, and the absence of which could cause adverse consequences for the person in need of such medical care.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Care Condition means a physical or mental condition that causes cognitive or emotional effects, including any condition listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. (DSM-IV), published by the American Psychiatric Association, or subsequent revisions thereof.

Mental Health Care Provider means a person licensed by the State in which he practices to provide mental health counseling or therapy, and who has an appropriate educational degree or certificate in psychology, counseling, mental health care, or related field.

Nurse Practitioner is a primary treating health care provider, and the term refers to a person who is both:

(1) a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with state law, if any is applicable; and

(2) certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

Nurse Practitioner Retail Clinic is a health care facility located in either a retail store, supermarket or pharmacy that treats routine family illnesses and may provide limited preventative health care services. Such facilities are staffed primarily by licensed Nurse Practitioners or Physician Assistants.

Participant is any Eligible Employee or Eligible Retired Employee who has met all prerequisites to obtain coverage under this Plan and who is enrolled for coverage under this Plan.

Participating Employer is any Employer who is signatory to a Collective Bargaining Agreement with the Union, who employs persons to perform work covered by that Collective Bargaining Agreement, and who makes contributions to the Fund as required by the Collective Bargaining Agreement.

Physician means:

(1) an individual, other than a Dentist, who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery, or

(2) a Clinical Psychologist who holds a Ph.D. or Psy.D. in psychology, is duly licensed or certified, is working with the scope of such license or certification, and who is referred by, or working under the supervision of, a person described in clause (1) above.

Physician Assistant means a person who is both:

(1) a physician assistant who is authorized by the State in which the services are furnished to practice as a physician assistant in accordance with state law, if any is applicable, and

(2) certified as a physician assistant by a recognized national certifying body that has established standards for physician assistants.

Plan means the Pipe Fitters Local No. 533 Health and Welfare Plan, that is, the plan of benefits offered under the terms of the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health & Welfare Fund.

Plan Administrator means the Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund. The Board of Trustees retains ultimate authority as the Plan Administrator for this Plan, but this term also refers to any person or entity responsible for carrying out the regular administrative functions and activities on behalf of the Plan.

Plan Sponsor is the Board of Trustees of the Pipe Fitters Local No. 533 Health & Welfare Fund.

Qualified Beneficiary is a person who is entitled to continue coverage under this Plan pursuant to COBRA continuation coverage.

Qualifying Event is an event pursuant to which a Covered Person loses coverage under this Plan, and which allows the Covered Person to become a Qualified Beneficiary, and thus to continue coverage under the Plan pursuant to COBRA continuation coverage.

Qualifying Period is a certain four-month block of time during which you must work the required number of hours to become eligible for coverage under the Plan, and once you are eligible it is the block of time during which you must work the required number of hours to maintain your eligibility for coverage. Also see pages 5, 6, and 7 of this SPD.

Reasonable, Usual, and Customary Charges for medical services or supplies are the amount normally charged by the provider for similar services or supplies, and do not exceed the amount ordinarily charged by most providers of comparable services or supplies in the locality where the services or supplies are received.

Registered Nurse means a professional nurse who is licensed, registered, or certified in the State in which he is providing health care services, and who has the right to use the title "Registered Nurse" and the abbreviation "R.N."

Retired Employee (or ***"Retiree"***) means any person receiving benefits under the Pipe Fitters Local No. 533 Pension Plan who is eligible to receive benefits under this Plan.

Sickness means any abnormal physical or mental condition, including physical sickness, mental illness, or functional nervous disorder, that affects the person's ability to function normally. A recurrent sickness will be considered to be one sickness. Concurrent sicknesses will be considered one sickness unless the concurrent sicknesses are totally unrelated. The term "Sickness," as used in this Plan document, shall also include pregnancy, childbirth, or resulting complications, except in the case of an Eligible Child.

Surviving Spouse means the spouse of the Eligible Employee or Retiree to whom the Eligible Employee or Retiree is legally married on the date of the Eligible Employee's or Retiree's death, and only if the marriage is recognized in the State(s) of domicile of the Eligible Employee or Retiree and spouse, and only if the marriage has not been dissolved and the parties are not divorced, legally separated, subject to a decree of separate maintenance, or subject to any other legal provision separating or limiting the parties' marriage relationship.

Treatment Facility means, for purposes of the Plan's provisions concerning the treatment of mental health conditions and alcohol or other substance abuse or dependency, a facility offering a treatment program certified by the Missouri Department of Mental Health, the Kansas Department of Social and Rehabilitation Services, or like agency of another State.

Trust means the Agreement and Declaration of Trust made as of June 1, 1954, by and among the Union, the Association, and the Board of Trustees, as amended and restated on September 1, 2003, as the Restated Agreement and Declaration of Trust of the Pipe Fitters Local No. 533 Health and Welfare Fund, and as may be amended or restated from time to time in the future.

Union means the Pipe Fitters Association Local Union No. 533 of the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.

United Association means the United Association of Journeymen and Apprentices of the Plumbing, Pipefitting, and Sprinkler Fitting Industry of the United States and Canada.

ELIGIBILITY UNDER THE PLAN

To understand how coverage under this Plan works, there are two key types of eligibility you need to know about. You need to know (1) how you become eligible; and (2) how you stay eligible. Your eligibility hinges on the amount of hours you work during certain time frames. You must work a certain amount during a certain time frame in order to become eligible and after that you must continue to work a certain amount during certain time frames to keep that eligibility. The time frames that are used to determine eligibility are called "Qualifying Periods." Once you work enough during a Qualifying Period that will determine your coverage for a certain amount of time called a "Coverage Period." This information is explained in more detail below:

When Am I Covered?

You become an Eligible Employee under this Plan on the first day of the Coverage Period after you have completed at least 400 hours of covered work in the matching four-month Qualifying Period for which the Plan receives contributions for you. Once you become eligible you will automatically be enrolled for coverage under this Plan on the first day of the next Coverage Period.

How Do I Keep My Coverage?

Your coverage will continue as long as you work at least 250 hours in each Qualifying Period, or at least 500 hours in two consecutive Qualifying Periods immediately preceding the Coverage Period.

What Happens When I Lose My Coverage and How Do I Get Coverage Back?

If you do not work enough hours to maintain your coverage, and you do not qualify for "out-of-work" continuation coverage for three consecutive Coverage Periods, then you will have to meet the initial eligibility requirement of 400 hours within one Qualifying Period again to regain your coverage.

How Do Qualifying Periods and Coverage Periods Work?

Beginning on June 1, 2004, a Qualifying Period is a certain four-month block of time during which you must work the required number of hours to become eligible for coverage under the Plan.

Beginning on June 1, 2004, a Coverage Period is a certain four-month block of time during which you and your dependents are eligible to receive benefits under the Plan based on the work you performed during the corresponding Qualifying Period. The Coverage Period begins one month after the Qualifying Period. Below are some examples:

How Do I Become Eligible?

The work requirement Qualifying Periods, eligibility dates, and matching Coverage Periods to become eligible are as follows:

Work Requirement in Qualifying Period	***Initial Eligibility Date***	***Coverage Period***
400 hours worked from June 1 thru Sept 30	November 1	November 1 thru February 28
400 hours worked from Oct 1 thru Jan 31	March 1	March 1 thru June 30
400 hours worked from Feb 1 thru May 31	July 1	July 1 thru October 31

How Do I Keep My Eligibility?

The work requirement Qualifying Periods and matching Coverage Periods for keeping your eligibility are as follows:

Work Requirement in Qualifying Period	***Coverage Period***
250 hours worked from June 1 thru September 30 OR 500 hours worked from February 1 thru September 30	November 1 thru February 28
250 hours worked from October 1 thru January 31 OR 500 hours worked from June 1 thru January 31	March 1 thru June 30
250 hours worked from February 1 thru May 31 OR 500 hours worked from October 1 thru May 31	July 1 thru October 31

What Happens to My Eligibility While I am on Leave From Work?

FMLA leave: If you are on qualified leave under the Family and Medical Leave Act (FMLA), you will not lose your health benefits because of your leave. Your Employer will determine whether or not your leave qualifies as "FMLA" leave. Your Employer will also continue to make contributions to the Plan while you are on leave as if you were still working. The Plan will credit you with all hours for which it receives contributions as if you had actually worked all such hours.

Leave due to accident or Sickness: If you are unable to work due to an injury or Sickness you will be credited with sixteen hours per week for each week that you are absent from work because you are totally unable to work, and for which you are receiving benefits under Workers' Compensation or a similar law or program, or under the Plan's Accident and Sickness Weekly Disability Benefit. Benefits paid based on any type of partial Disability will not qualify you for the crediting of hours for eligibility purposes.

Only Eligible Employees and apprentices working toward initial eligibility are entitled to credit for hours not actually worked. You will not be credited for any additional hours beyond the date that you retire (as defined in the Pipefitters Local 533 Pension Plan), or the date that you are no longer an Eligible Employee, whichever is first to occur.

Uniformed Service leave: Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) or other applicable federal law, you and your Dependents may be entitled to continued coverage or COBRA benefits for certain periods that you are in the United States Uniformed Services. You should contact the Plan Administrator as soon as you are notified that you are being called to duty in the Uniformed Services. You should contact the Plan Administrator for more details about this issue, and to receive a copy of the Trustees' policies and procedures to be followed in the event that you are called to duty.

What Happens to My Eligibility When Work is Unavailable?

If you do not work enough hours to maintain your coverage as an Eligible Employee, you may continue coverage as an Eligible Employee if you pay an "Out-of-Work" premium for each month of coverage, and remain on the "out-of-work list" maintained under the Collective Bargaining Agreement between the Union and the Association. By doing this you are considered "ready, willing, and available for work."

If your out-of-work coverage terminates you are still eligible at the time of termination for COBRA continuation coverage. See page 13 of this SPD.

RETIREE COVERAGE UNDER THE PLAN:

Generally:

You may obtain Retiree coverage under this Plan after your coverage would terminate (based on hours worked or "out-of-work" coverage) if you meet the following requirements:

a. you are at least 55 (or any age if you are retired due to Disability);
b. you receive benefits under the Pipe Fitters Local No. 533 Pension Plan;
c. you make an appropriate Retiree Health Coverage Election at the time you apply for retirement;
d. you pay the appropriate Retiree premium, as determined from time to time by the Board of Trustees; and
e. you meet one of the following:
    i. You were covered under the Plan as an Eligible Employee (not under COBRA continuation coverage) for at least three of the five years immediately preceding the year you retire; or
    ii. You met the "Retirement-Qualifying Work Period Rule". You meet this rule, if you retire on or after June 1, 2006, and you had three Retirement Work Qualifying Periods during the 24 month period immediately preceding your retirement, with a Retirement Qualifying Work Period (June 1 - September 30, October 1 - January 31, and February 1 - May 31) in which you worked at least 400 hours and the Fund received contributions for you for that work.

When is My Retiree Coverage Effective?

Retiree coverage begins the day after your coverage as an Eligible Employee ends, assuming you have paid the appropriate premium.

If you were not covered under the Plan on the date you retired, your coverage will be effective on the first day of the month following the month you retired, assuming you have paid the appropriate premium by that date.

How Do I Maintain My Retiree Coverage?

You must make self-payments in order to maintain your Retiree coverage under the Plan. The Board of Trustees will determine the amount. The Board of Trustees may set different Retiree premiums for Medicare-eligible and non-Medicare-eligible Retirees and may require an additional premium for your Dependents.

Your Retiree coverage does not include Accident and Sickness Loss of Time benefits or Accidental Death and Dismemberment benefits.

Can There Be Changes to My Retiree Coverage Under the Plan?

Yes. We reserve the right to change or eliminate Retiree coverage or to require you to make additional contributions to continue your Retiree coverage, even if you are already disabled or have already reached age 55 at the time we make changes. We also reserve the right to establish a set of benefits that are available to you as a Retiree that are different than the benefits available to other Eligible Employees, even if the change would reduce your current Retiree benefits.

When Will My Retiree Coverage Terminate?

Your Retiree coverage will terminate when you regain coverage as an Eligible Employee by returning to covered work. If you return to work after being covered by Retiree coverage you may maintain your coverage before you regain Eligible Employee coverage by paying the out-of-work premium rather than the Retiree premium.

Your Retiree coverage may also terminate if you do not pay the premiums, if you choose to terminate the coverage, or on the day following the date of your death.

DEPENDENT COVERAGE UNDER THE PLAN

Generally:

If you are an active Participant Employee, your spouse and Dependent children are automatically covered. Dependent coverage will become effective at the same time as your Eligible Employee coverage.

Newly acquired Dependents will be covered on the date of marriage, birth, adoption, placement for adoption, effective date of a court order establishing your or your spouse's financial responsibility for a child, or the effective date of a Qualified Medical Child Support Order ("QMCSO"), as applicable.

Even though your Dependents are automatically covered, we may require you to provide information regarding your Dependents in order to make claims processing and payment faster and easier.

Are My Dependents Automatically Covered if I Am a Retiree?

No. If you are a Retiree, your Dependents are not automatically covered. However, you may elect coverage for your current spouse and Dependent children. This means that if you elect coverage under the Plan when you retire, you must also make an affirmative election at that time or during a special enrollment period to cover your Dependent(s). However, if you get a new Dependent after you retire through marriage, birth, adoption, or placement for adoption, then that Dependent is entitled to a 30-day special enrollment period beginning on the date of the marriage, birth, adoption, or placement for adoption.

Your Dependents may not receive coverage if you have declined Retiree coverage for yourself. Once you have declined Retiree coverage, you may not later seek to enroll yourself or any Dependents. ***Except, that your spouse will be allowed a special enrollment period if at the time you retire you provide the Plan Administrator with proof of other coverage***

along with notice that you are declining coverage for your spouse under this Plan because (s)he has other coverage. Then when his/her other coverage terminates (s)he will be eligible to enroll in the Plan within a specified period of time. A spouse using other coverage shall not be treated as having a lapse in coverage under this Plan by reason of the other coverage.

You may have to pay a premium in addition to your Retiree premium for Dependent coverage.

Who Qualifies as an Eligible Dependent?

Spouse: Your spouse is only eligible for benefits if your marriage is recognized in the State where you live and intend to remain. You may not be legally separated or subject to a decree of separate maintenance in order for your spouse to be covered.

Children: Your child is eligible if (s)he meets the following:

(a) (s)he has one of the following relationships to you:
  (i) your son, daughter, stepson or stepdaughter;
  (ii) your eligible foster child;
  (iii) your legally adopted child or a child lawfully placed with you for legal adoption (so long as you adopt the child or the child is placed with you for adoption prior to his or her 18th birthday); or
  (iv) you have legal responsibility for the child by a court order for custody and support or maintenance (including a legal guardianship) or who is the subject of a Qualified Medical Child Support Order (QMSCO).

  *When the child is your Dependent due to guardianship or legal custody, you must provide legal documentation of the relationship before the child will be enrolled in the Plan.

  **When the child is not your natural child and the parents of the child may claim the child as a dependent on their federal income tax return, the Plan Administrator must verify that the child's natural parent is not claiming the child as a dependent and that you have a higher adjusted gross income than the highest adjusted gross income of any parent of the child.

(b) (s)he is actually financially dependent upon you (i.e. he or she has not provided over one-half of his or her own support for the calendar year);

(c) (s)he has the same principal place of abode as you for more than one-half of the year. The child is considered as having the same principal place of abode as you during periods of time when either you or the child or both are temporarily absent due to special circumstances including illness, education, business, or vacation. Additionally, if the child is your child (not step-child) and you and the child's other parent are divorced or separated and living apart, if your child does not have the same principal place of abode as you but instead has the same principal place of abode as his or her other parent, and the child receives over one half of his or her support from one or both parents then the child will be considered as having the same principal place of abode as you for purposes of this paragraph;

(d) (s)he is unmarried; and

(e) (s)he is under the age of 19, or 19-25 and a full-time student; or is permanently and totally disabled.

Student Children: If a child remains unmarried and financially dependent on you, (s)he will automatically remain covered through the end of the month in which (s)he turns 19; the child may continue to be covered until age 25 provided that (s)he is a full-time student at an accredited college, university, vocational-technical school, or trade school. Proof of enrollment, such as a letter from the school's registrar, is required to continue coverage past the age of 19. This student coverage will terminate at the end of the month of the last enrollment period that you have provided proof of enrollment for, or the end of the month in which the child turns 25, whichever is earlier.

A Dependent child who is covered past the age of 19 due to enrollment in school, will remain covered between enrollment periods as long as (s)he is enrolled for the next semester. (For example a college student whose Spring semester ends in May will remain covered during the Summer as long as (s)he enrolls for the Fall semester and provides proof of this enrollment to the Plan.)

Medically Necessary Leave of Absence: Notwithstanding the above paragraph, a Dependent child who is covered past the age of 19 due to enrollment in a post-secondary educational institution (i.e. college students between the ages of 19 - 25), will remain covered for up to a year, unless the child's coverage would end earlier for another reason (such as a parent's termination of employment or the child's age exceeding 25), during a Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is one which begins while a Dependent child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of the Plan (i.e. the child is unable to attend school on a full-time basis due to the serious illness or injury). In order to receive coverage during a Medically Necessary Leave of Absence, you must provide the Plan Administrator with written certification by a treating Physician of the child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. A Dependent child whose benefits are continued under this section will receive the same benefits as if the child continued to be a covered student at the institution of higher education and was not on a Medically Necessary Leave of Absence.

Disabled Children: A disabled Dependent child may remain eligible for coverage despite his/her age, provided the other criteria are met. A disabled Dependent child will be considered disabled for purposes of receiving continued eligibility for benefits under the Plan if (s)he is unable (because of a physical or mental condition) to support himself/herself financially, as long as the Disability began before the child's coverage would otherwise have terminated.

We may require proof of the Disability in order to continue coverage past the age of 19 or 25, and may continue to require this proof from time to time.

Adopted Children: An adopted child is eligible for coverage on the first date that (s)he is placed for adoption with you. This child is placed with you when you assume and retain a legal obligation for total or partial support of the child in anticipation of adopting him/her. Placement terminates when your legal support obligations terminate.

An adopted child will only be eligible for coverage under the Plan if (s)he is placed with you before (s)he turns 18.

Child Covered by a QMCSO: A child who does not meet the eligibility criteria under this Plan may still be covered as your Dependent if the Plan receives a Qualified Medical Child Support Order ("QMCSO") from the court ordering the Plan to provide coverage to the child (as the Alternate Recipient under the QMCSO). We will determine the Order to be a QMCSO under the Plan's procedures for handling medical child support orders. You can request a copy of these procedures from the Plan Administrator, at no charge

Will My Dependents Still Be Covered if I Die While I am Still an Active Employee?

Spouse: As long as you worked at least 1,500 hours for which the Plan received contributions before your death, and your Spouse was covered by the Plan as a Dependent on the date of your death, his/her coverage will continue under the Plan. In order to continue coverage under the Plan, your spouse must elect Surviving Spouse coverage within 90 days from the date of your death. Your spouse will continue coverage under the Plan until (s)he remarries.

The Surviving Spouse will have to pay a premium in order to continue coverage under the Plan. The Plan must receive the premium within 15 days of the due date or coverage will be terminated.

The Surviving Spouse will be required to submit a sworn statement at least once per year certifying that (s)he is not remarried.

Once a Surviving Spouse has lost coverage because of failure to pay on time or remarriage, (s)he cannot again be covered under the Plan.

Neither your Surviving Spouse nor any of his/her dependents will be entitled to death benefits, accident and sickness weekly disability/loss of time benefits, or accidental death and dismemberment (AD&D) benefits.

For COBRA purposes, the Surviving Spouse suffers a "Qualifying Event" whenever his/her Surviving Spouse coverage terminates.

Spouse's Dependents: If the Surviving Spouse has dependents who were also your Dependents, and they were covered under this Plan on the date of your death, then they may remain covered as long as your Surviving Spouse remains covered under this section. If your Spouse is pregnant at the time of your death, the child will be treated as your Dependent and may be covered under the Plan as well.

Will My Dependents Still Be Covered if I Die After I Retire?

Spouse: As long as your Surviving Spouse was covered as a Dependent on the date of your death, his/her coverage under this Plan continues until the end of the month in which (s)he gets remarried. If your Surviving Spouse is using other coverage on the date of your death in accordance with the special enrollment period rules described above, (s)he will be treated as a Dependent so long as all other requirements are met. ***In order to continue coverage under the Plan your spouse must elect Surviving Spouse coverage within 90 days from the date of your death.***

The Surviving Spouse will have to pay a premium in order to continue coverage under the Plan. The Plan must receive the premium within 15 days of the due date or coverage will be terminated.

The Surviving Spouse will be required to submit a sworn statement at least once per year certifying that (s)he is not remarried.

Once a Surviving Spouse has lost coverage because of failure to pay on time or remarriage, (s)he cannot again be covered under the Plan.

For COBRA purposes, the Surviving Spouse suffers a "Qualifying Event" whenever his/her Surviving Spouse coverage terminates.

Spouse's Dependents: If the Surviving Spouse has dependents who were also your Dependents, and they were covered under this Plan on the date of your death, then they may remain covered as long as your Spouse remains covered under this section. If your Spouse is pregnant at the time of your death, the child will be treated as your Dependent and may be covered under the Plan as well.

Neither your Surviving Spouse nor any of his/her dependents will be entitled to death benefits, accident and sickness weekly disability/loss of time benefits, or accidental death and dismemberment (AD&D) benefits.

TERMINATION OF COVERAGE UNDER THIS PLAN

Generally:

The Plan is intended to exist and provide benefits to Covered Persons indefinitely. However, under certain circumstances coverage may terminate for certain individuals, for all Covered Persons, or any group of Covered Persons. If we find it appropriate to terminate the Plan, then all Covered Persons will lose coverage under the Plan. We reserve the right to amend the Plan at any time, and these amendments may eliminate certain benefits for all Covered Persons or terminate all benefits for Certain Covered Persons, such as Retirees and Dependents.

Are There Other Reasons Coverage Will Terminate?

Except as otherwise stated in this Plan, any person who loses eligibility under the Plan will lose coverage. In addition, you may lose coverage for the following reasons

You and your covered Dependents will lose coverage the first day that you perform work in the plumbing and pipefitting industry in the Kansas City metropolitan area (the area covered by your Collective Bargaining Agreement) for an employer who does not contribute to the Plan.

You and your covered Dependents will lose coverage the date that you enter the Armed Forces on active duty, except that you have the right to extend your coverage under USERRA or other applicable law. See page 6 of this SPD.

Any person covered under this Plan who is required to make self-payments as well as all Dependents of such Covered Person, will lose coverage on the first day of the month that the Covered Person does not make the monthly payment by the due date or grace period.

A spouse covered under this Plan will lose coverage on the first day of the month following the month in which a decree of divorce, dissolution of marriage, legal separation, or separate maintenance (regardless of the terms used to describe the divorce or legal separation) is entered, or the month in which the Eligible Employee or Retiree dies, subject to the spouse's right to continue coverage as a Surviving Spouse.

How Do I Get Certificates of Creditable Coverage From the Plan When My Coverage Terminates?

We will issue Certificates of Creditable Group Coverage to each person who loses coverage. These Certificates provide the necessary documentation that you and your Dependents will need to reduce pre-existing condition exclusions when you enroll in a new health benefit plan.

We provide the Certificates free of charge and will give them out automatically when you or your Dependents lose coverage under this Plan, or exhaust COBRA continuation coverage. You may also request the Certificates from the Plan Administrator before you lose coverage or within 24 months after losing coverage.

CONTINUATION OF COVERAGE WHEN YOU ARE NO LONGER ELIGIBLE UNDER THE PLAN

NOTICE OF EMPLOYEE'S RIGHTS TO CONTINUE GROUP HEALTH COVERAGE UNDER COBRA

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

The Plan Administrator of this Plan is the Board of Trustees of the Pipe Fitters Local 533 Health and Welfare Plan, 3100 Broadway, Suite 805, Kansas City, MO 64111. The phone number where you may contact the Plan Administrator is (816)756-3313 or toll free at (866)756-3313. The Board of Trustees has delegated the responsibility for carrying out the day-to-day functions of the Plan to a third party administrator listed on page 49 of this SPD. The Board of Trustees, as Plan Administrator, is responsible for administering COBRA continuation coverage, but the third party administrator's staff members can answer most of your questions and will handle the processing and administration of COBRA continuation coverage.

COBRA Continuation Coverage: COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The coverage provided under COBRA continuation coverage is identical to the medical coverage provided under the Plan to similarly situated beneficiaries with respect to whom a qualifying event has not occurred. Ancillary welfare benefits, such as the death benefit, AD&D, and accident and sickness loss of time benefits may not be continued under COBRA.

If you lose coverage under the Plan due to an involuntary termination of employment between September 1, 2008 and February 28, 2010, you may be eligible to have part of your COBRA premium paid under the American Recovery and Reinvestment Act of 2009. If you are eligible to receive this benefit, you will receive additional information about how to apply with your COBRA Continuation Coverage Notice.

Qualifying Events: If you will lose coverage because one of the following happens, you are considered a "qualified beneficiary" who has suffered a "qualifying event" and will be eligible for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

A. Your hours of employment are reduced (such as, you do not work sufficient hours to maintain eligibility), or
B. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee or Retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

A. Your spouse (i.e. the Eligible Employee or Retiree) dies;
B. Your spouse's hours of employment are reduced (that is, if the Eligible Employee does not work sufficient hours to maintain eligibility);
C. Your spouse's employment ends for any reason other than his or her gross misconduct;
D. Your spouse becomes entitled to Medicare (Part A, Part B, or both);
E. You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

A. The parent-employee dies;
B. The parent-employee's hours of employment are reduced (that is, if the parent-employee does not work sufficient hours to maintain eligibility);
C. The parent-employee's employment ends for any reason other than his or her gross misconduct;
D. The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
E. The parents become divorced or legally separated; or
F. The child stops being eligible for coverage under the Plan as a "Dependent child".

We will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are responsible for determining that you are eligible for COBRA continuation coverage when the qualifying event is the end of employment, reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare (Part A, Part B, or both).

For any other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child losing eligibility for coverage as a Dependent child), ***you must notify the Plan Administrator within 60 days after the qualifying event occurs. Send this notice in writing, along with appropriate documentation, to the Fund Office. See the chart below for appropriate documentation.***

Procedures for Covered Employees and Qualified Beneficiaries to Furnish Notices of Qualifying Events

It is the responsibility of an Eligible Employee or a qualified beneficiary to notify the Fund Office in writing (or by fax) of any of the following qualifying events, whether they occur while you are still working or while you are already receiving COBRA continuation coverage. The following chart describes the type of documentation you must provide as well as the time limits for notifying the Fund Office:

Qualifying Event	***Documentation Required***	***Time Limits***
Divorce	Divorce Decree	Within sixty (60) days after the qualified beneficiary would lose coverage as a result of the divorce
Legal Separation	Legal separation decree or equivalent State court document	Within sixty (60) days after the qualified beneficiary would lose coverage as a result of the legal separation
Dependent child ceasing to qualify as a Dependent under the Plan	Proof of age if turning age 19, or failure to provide proof of continuing eligibility past age 19	Within sixty (60) days after the qualified beneficiary would lose coverage as a result of no longer qualifying as a Dependent child
Disability Determination	Copy of Social Security Administration disability determination letter	Within sixty (60) days after: the date of the disability determination letter or the date the qualified beneficiary receives notice of this policy (receives a copy of the SPD), whichever is later
Change in Disability Status	Copy of Social Security determination letter	Within thirty (30) days after: the date of Social Security Administration's final determination that the individual is no longer disability or the date the qualified beneficiary receives notice of this policy (receives a copy of the SPD), whichever is later

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days after receiving such notice. If you submit a notice of a qualifying event, and the Plan Administrator determines that you are not eligible for COBRA continuation coverage, the Plan Administrator will send you written notice of the unavailability of such coverage. For each qualified beneficiary who

elects it, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. ***Disability extension of 18-month period of continuation coverage:*** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must provide the notice to the Plan Administrator within the first 60 days of COBRA continuation coverage, or if later, within 60 days from the Social Security Administration's determination of disability and before the end of the 18-month period of COBRA continuation coverage. Additionally, such notice must be accompanied with a copy of the Social Security Administration's determination letter. This notice must be sent to the Fund Office.

2. ***Second qualifying event extension of 18-month period of continuation coverage:*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, If notice of the second qualifying event is properly given to the Plan. This extension is available to the spouse and Dependent children if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, Or if the Dependent child stops being eligible under the Plan as a Dependent child, But only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Office and must be accompanied by any appropriate documentation.

Applicable Premium for COBRA Continuation Coverage

COBRA premiums are payable monthly, and are due on the first day of the month for the month of coverage. You will have 60 days in which to elect COBRA continuation coverage, and you have 45 days from the date you elect COBRA continuation coverage to submit your initial premium payment. Payments must be submitted to the Fund Office, as explained more fully in the notice you will receive when you become eligible for COBRA continuation coverage.

The applicable premium is an amount determined by the Board of Trustees to be a fair and appropriate amount to cover the cost of the coverage provided to you, but will never exceed 102% of the total cost to the Plan for your coverage, except as provided for in this paragraph regarding Disability. The total cost to the Plan for your coverage is calculated on an actuarial basis by making a reasonable estimate of the cost of providing coverage for similarly situated Participants and beneficiaries. This amount may be recalculated annually. The Plan reserves the right to charge an additional premium for qualified beneficiaries who take advantage of the 11 month extension of COBRA continuation coverage for totally disabled qualified beneficiaries and family members of such qualified beneficiaries described on page 16 of your SPD. If you are eligible for the 11 month extension (to a maximum 29 months of continuation coverage), the maximum applicable premium for those additional 11 months is 150% of the total plan cost of your coverage.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its staff members, or you may contact the nearest Regional or District Office of the Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

Termination of COBRA Continuation Coverage

Your COBRA continuation coverage will terminate on the earliest of the following events:

1. The end of the 18, 29, or 36-month maximum period as described above in this section. Since this Plan does not provide for a conversion option from group coverage under the Plan to an individual policy, you will not receive any notice prior to the termination of your COBRA continuation coverage due to exhaustion of the maximum period;
2. The date on which the Pipe Fitters Local 533 Health and Welfare Fund no longer provides any group health coverage to any members or employees;
3. The first day of the month for which you do not pay your applicable premium on time;
4. The date on which you become covered by another group health plan (after the date of your election of COBRA continuation coverage) that does not contain any exclusion or limitation with respect to any pre-existing condition which you may have;
5. The date on which you become entitled to Medicare after your election of COBRA continuation coverage; or
6. If your coverage was extended up to 29 months due to a disability, the first date of the month following the month in which the Social Security Administration determines that the qualified beneficiary is not disabled.

If your continuation coverage terminates earlier than the maximum coverage period (18, 29, or 36 months, as described above), the Plan Administrator will send you a notice of such termination.

You do not have to show that you are insurable to receive continuation coverage. Eligibility for COBRA continuation coverage is subject only to the general eligibility rules stated in this notice. If the Plan Administrator or its designee determines that you were not eligible for coverage, your coverage may be terminated retroactively.

COBRA Continuation Coverage Procedures

General

A participant or beneficiary with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

Notice of Qualifying Events

Participating Employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator shall determine whether a qualifying event has occurred due to the Employee's termination of employment or reduction in hours of employment, the Employee's becoming entitled to Medicare (Part A, Part B, or both), or the Employee's death.

In order to make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator shall review the monthly Employer contribution reports to determine the number of hours to be credited to the Employee based on the number of hours worked and whether full contributions are received for all hours worked. If Employer contributions reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether an employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the qualification period in which the employee does not have sufficient hours or contributions credited to maintain coverage. The Plan Administrator shall send notice of the qualifying event and the qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after having determined that a qualifying event has occurred.

If the qualifying event is the Employee's death, the Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after determining that a qualifying event has occurred.

The Plan Administrator shall determine whether an Employee has become entitled to Medicare and whether such entitlement constitutes a qualifying event within 30 days following the qualifying event. If the Plan Administrator determines that a qualifying event has occurred, the Plan Administrator shall send notice of the qualifying event to all qualified beneficiaries within 14 days of the determination.

An Employee must give written notice to the Plan Administrator within 60 days after the occurrence of a qualifying event that is a divorce or legal separation of the Employee (or Retiree) and spouse or a Dependent child's ceasing to meet the Plan requirements for an eligible Dependent. The notice shall be provided in writing, mailed, faxed, or delivered to the Fund Office.

The Plan will provide forms to participants and beneficiaries which may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Plan Administrator will then send notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage, within fourteen (14) days after receiving such notice.

Second Qualifying Event and Disability

If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Plan Administrator within sixty (60) days of the second qualifying event in order to extend the maximum COBRA continuation coverage period to thirty-six (36) months.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first sixty (60) days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within thirty (30) days after the Social Security Administration's determination.

The Plan Administrator shall send notice of right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation coverage, within fourteen (14) days after receiving notice from the qualified beneficiary.

Unavailability of COBRA Continuation Coverage

When the Plan Administrator receives a notice from an Employee or beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered Employee, qualified beneficiary, or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice shall be sent within fourteen (14) days from receipt of the notice from the employee or other individual.

Early Termination of COBRA Continuation Coverage

Whenever COBRA continuation coverage is terminated prior to the latest date shown on the Election Notice (that is, prior to the end of the 18, 29, or 36-month maximum period), notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the Plan or under applicable

law to elect an alternative group or individual coverage. The termination notice will be provided as soon as practicable following the Plan Administrator's determination that continuation coverage shall terminate.

Change of Premium Rate

In the event COBRA premiums change, the Plan Administrator shall send notice of such change to all qualified beneficiaries at least one month prior to the effective date of the change.

Deficient Premium Payment

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50.00 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50.00), the Plan Administrator shall provide notice of deficiency to the qualified beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30 day period. If the Plan Administrator fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50.00 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30 day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

BENEFITS UNDER THIS PLAN

Generally

You will pay a deductible every year. It must be paid before we start paying for your benefits. Once you have paid your deductible, we use a cost sharing mechanism called a "co-pay" so that you and the Plan each pay for part of the benefits. There is a separate co-pay for prescription drug benefits that you will always pay and that does not count towards your deductible. This is all explained in more detail below:

What is My Yearly Deductible?

The amount of your deductible (both in-network and out-of-network) depends on whether you are an Eligible Employee or a Retiree as described in detail below:

In-Network:

a. If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, you will pay the first $300 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $600 in deductibles for the year [Any amounts credited towards your out-of-network deductible will also count for the in-network deductible].

b. If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, you will pay the first $150 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $300 in deductibles for the year. [Any amounts credited towards your out-of-network deductible will also count for the in-network deductible.]

Out-of-Network:

a. If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, you will pay the first $300 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $600 for in-network and out-of-network deductibles combined for the year [Any amounts credited towards your in-network deductible will also count towards your out-of-network deductibles.]

b. If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, you will pay the first $400 of Allowable Charges per year. This applies to every Covered Person. However, your family will not pay more than a total of $800 for in-network and out-of-network deductibles combined for the year. [Any amounts credited towards your in-network deductible will also count towards your out-of-network deductibles.]

Common Accident: If more than one person in your family is injured in the same accident, all the Allowable Charges will be combined, and only one deductible amount will be required to pay benefits for that accident.

How Does Cost-sharing for the Comprehensive Medical Benefits Program Work?

Once you have met your deductible, there is cost-sharing between you and the Plan. How costs are divided between you and the Plan is based on the Plan's total Allowable Charge for the service or treatment you receive.

What is the Plan's total Allowable Charge?

The Plan's total Allowable Charge is the amount the Plan has determined is generally charged for any given service or treatment.

What happens if the bill for my treatment is more than the total Allowable Charge?

The percentage that the Plan pays for your treatment is always a percentage of the total Allowable Charge, even if the total amount billed for your service or treatment is more than the total Allowable Charge. The Plan will never pay expenses which exceed the total Allowable Charge.

I thought the Plan had agreements with the providers. How could a bill ever be for more than the total Allowable Charge?

The Plan does have agreements with the providers in the Plan's network. So, when you receive treatment or services from an in-network provider, you will not be billed for more than the total Allowable Charge. However, if you use an out-of-network provider, that provider will not have an agreement with the Plan and could bill for more than the total Allowable Charge.

Does the Plan pay a portion of every treatment or service expense I incur?

No. Your cost-sharing arrangement with the Plan applies only to covered treatments and services. If you receive a treatment or service which is not covered by the Plan, the Plan will not pay any portion of that expense.

How Does the Cost-sharing Work For In-Network Services After I Have Paid My Deductible for the Year?

If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, we will pay 85% of the total Allowable Charge for in-network (services, and you will pay the other 15%. Once you have incurred $20,000 in in-network Allowable Charges for a year, we will pay 100% of your in-network Allowable Charges for the rest of the year.

If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, we will pay 85% of the total Allowable Charge for in-network services, and you will pay the other 15%. Once you have incurred $10,000 in in-network Allowable Charges for a year, we will pay 100% of your in-network Allowable Charges for the rest of the year.

How Does the Cost-sharing Work For Out-of-Network Services After I have Paid My Deductible for the Year?

If you are an Eligible Employee or a Retiree who submitted an application for benefits after December 29, 2006 or whose pension effective date was after March 31, 2007, we will pay 60% of the total Allowable Charges for out-of-network charges for covered medical care, and you will pay the other 40%, plus any additional amount charged over the total Allowable Charge. Once you have incurred $20,000 in out-of-network charges for covered medical care, we will pay 100% of all Allowable Charges.

If you are a Retiree who submitted an application for pension benefits that was received by the Fund Office before December 30, 2006, the pension effective date was before April 1, 2007, and the application was approved by the Board of Trustees, we will pay 60% of the total Allowable Charges for out-of-network charges for covered medical care, and you will pay the other 40%, plus any additional amount charged over the total Allowable Charge. Once you have incurred $15,000 in out-of-network charges for covered medical care, we will pay 100% of all Allowable Charges.

What if I Need medical care and There is No In-Network Provider Nearby?

We will pay an out-of-network claim the same as an in-network claim in the event that you need medical care and the nearest in-network provider of like specialty is more than 25 miles away.

What if I Get Emergency Treatment From an Out-of-Network Provider?

In an Emergency situation where the circumstances of treatment are beyond your control or so serious that you do not have time to obtain treatment from a participating provider because it would endanger your life or health, and as a result you go to an out-of-network provider, we will pay 80% of the Allowable Charges for covered Emergency services.

However, you should note that beginning on the date that you could be transferred to an in-network facility or provider without risk to your health, the standard out-of-network rules will apply.

Are Any Medical Benefits Provided at a Flat Fee Instead of Cost-Sharing?

Yes, cost-sharing does not apply to covered services provided at Nurse Practitioner Retail Clinics. You will be charged a flat $10 co-pay per visit for all covered services provided at an in-network Nurse Practitioner Retail Clinic. Please note that most clinics will not be able to accept the $10 co-pay at the time of service and will require you to pay 100% of the expense. When this occurs, please obtain an itemized statement from the in-network provider and submit the claim to the Fund Office for reimbursement of all covered expenses over $10.

Is There a Maximum Lifetime Amount That the Plan Will Pay?

Yes. We will pay a lifetime maximum amount of two million dollars ($2,000,000) for benefits under this Plan. After we have paid out $2,000,000 on your behalf, you will no longer be eligible for any benefits.

Is There Ever Case Management Under This Plan?

Yes. When you are receiving (or reasonably anticipate that you will receive) prolonged medical care for a serious Sickness or injury, we may employ a case manager to consult with you, your Physician, and your family to help design a treatment plan that will provide the most appropriate and cost-effective medical care in the least restrictive setting. We will pay for all case management costs. The decision to employ a case manager is at our discretion.

Three Situations You Should Be Aware Of:

1. When you get a referral from your doctor you should ensure that the referral doctor is in-network.
2. Certain procedures can be performed at facilities other than your doctor's office or a Hospital. Ensure that the facility where the procedure is being performed is a Blue Cross and Blue Shield of Kansas City provider.
3. Please be aware that certain Hospitals use independent specialty contractor doctors rather than staff doctors. A Hospital may be in-network, however certain providers in that Hospital may not be in-network. In these instances you may get a separate bill from the independent contractor provider who will not necessarily be in-network.

COMPREHENSIVE MEDICAL BENEFITS

Generally:

We will pay for Medically Necessary covered medical care based on the total Allowable Charge for the service. We will pay a percentage of the total Allowable Charge, and you will pay the rest.

You are covered for Medically Necessary diagnosis and treatment (including both medical and surgical treatment, but not including chiropractic or alternative treatment) provided by a Physician, Physician Assistant, or Nurse practitioner for treatment of an injury or Sickness. This includes diagnostic services such as X-ray and lab services, as well as inpatient drugs (including oxygen and blood or blood products) that you may be given while being treated in a Hospital. This also includes charges for a professional anesthetist or anesthesiologist. Other types of treatments (both medical and surgical treatment and the supplies necessary for such treatment) may also be covered if deemed Medically Necessary and prescribed by a Physician in appropriate circumstances. The other treatments covered include but are not limited to; physical therapy, occupational therapy, radiation therapy, physical rehabilitation, cardiac rehabilitation, respiratory therapy or rehabilitation, and prosthetics and orthotics (other than foot orthotics)** Coverage for prosthetic and orthotics is limited to the initial purchase and fitting of the prosthetic or orthotic device as well as repairs or replacement when they are Medically Necessary because of a change in the physiological condition of the patient, an irreparable change in the condition of the device, or the condition of the device requires repairs and the cost of the repairs would be more than 60% of the cost of a replacement device. Additionally, you must receive prior authorization from the Plan Administrator for a prosthetic or orthotic device. If you receive authorization from the Plan Administrator, the device is Medically Necessary, and an appropriate prosthetic or orthotic device is not available in-network, then an 80% cost-sharing rate will be substituted for the 60% rate. ***Please contact your Plan Administrator prior to purchasing a prosthetic or orthotic device.***

**Foot orthotics are covered under medical supplies and durable medical equipment provided the criteria on pages 25 and 26 of this SPD are met, and subject to the limitations regarding durable supplies and medical equipment on pages 25 and 26 of this SPD.

What If I Become Pregnant While Covered Under This Plan?

You or your Spouse is covered for Medically Necessary expenses related to pregnancy and childbirth and follow-up Hospital care for mother and newborn for up to 48 hours after a vaginal birth, and up to 96 hours after a cesarean section. We do <u>not</u> cover pregnancy related expenses for your Dependent children.

Pregnancy is treated the same as any other Sickness under the Plan. This includes coverage for pre-natal care, post-natal care, and pregnancy complications.

What is Covered if I Have a Mastectomy?

The Women's Health and Cancer Rights Act of (1998) (WHCRA) is a federal law that requires coverage for mastectomies and other related services. We cover mastectomies, including all stages of reconstruction on the breast on which the mastectomy was performed, as well as surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment

of physical complications related to mastectomies including lymphedema. All of these services are considered Medically Necessary under the Plan.

Hospital Care and Other Facilities Generally:

We will pay for inpatient Hospital charges when it is Medically Necessary for covered medical care and no other more cost-effective arrangement is appropriate. This also applies to intensive care, confinement in a private room, and a semi-private room, wherever such is Medically Necessary. The Allowable Charge will be based on the reasonable, usual, and customary charge for that service.

Home health care services are covered when:

- They are provided in accordance with a home health care plan established by your Physician;
- They are Medically Necessary; and
- You would have to be hospitalized if the services were not available in your home.

Is There Hospice Care for Terminal Illness Under This Plan?

Yes. We cover the reasonable, usual, and customary charges of Hospice care for management of a terminal illness or palliative care for up to 210 days for the following services:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Physical, occupational, and speech therapy;
3. Medical social services if they are under the direction of a Physician;
4. Personal care services and household services that are needed to maintain a safe and sanitary environment and that are not performed by a person who lives with the covered person or who is related to the covered person;
5. Drugs, medical supplies, and the use of medical appliances or durable medical equipment;
6. Physician services;
7. Occasional short-term (5 consecutive days or less) inpatient care in an inpatient facility ("crisis care");
8. Counseling for members of the covered person's family with respect to the care of the terminally ill individual and the adjustment of his or her death.

You are eligible for Hospice care if:

1. You have a life expectancy of six months or less;
2. The Hospice care charges are certified as a Hospice Care Program under Medicare or by the Joint Commission on Accreditation of Healthcare Organizations;
3. Your Physician approves and agrees to follow a Hospice care plan that was drafted by the Hospice program;
4. The written Hospice care plan provides that your care will be provided at home; and
5. Your Hospice care program agrees to accept the benefits under the Plan as payment in full for the services and supplies provided to you.

What Medical Supplies and Equipment Are Covered?

We cover some medical supplies and durable medical equipment when prescribed by a Physician. However, you should note that we will only pay up to $5,000 per person in a calendar year for

covered medical supplies or equipment that is/are Medically Necessary for the treatment of Sickness or injury. If a Medically Necessary appliance is not available through the Plan's PPO, then you will pay an 80% co-insurance rate instead of the regular 60% rate.

We will not cover any supplies that are solely for your convenience or comfort.

We will pay for whichever costs less between renting and purchasing equipment or supplies, and any charge in excess of that will not be considered part of the Allowable Charge.

What if My Infant Needs Phenyl-Free Formula?

We will pay for 80% of the reasonable, usual, and customary charges for the infant formula, if your Physician recommends it to treat phenylketonuria ("PKU"), or any inherited disease of amino and organic acids, up to $5,000 per person in a calendar year, after you have paid your deductible.

Are There Special Rules for Using an Ambulance Service?

Yes. In a non-emergency situation you should always check to see if there is an "in-network" ambulance service provider that serves your area, because if you use an ambulance service that is not in-network, you will pay for it as an out-of-network claim. If no ambulance or other appropriate medical transportation service is available "in-network", we will pay 80% of the allowable charge. In an Emergency situation, the rules that apply to all Emergency situations on page 23 of the SPD apply to ambulance services.

Ambulance services are provided to a covered person for:

1. Transport to the nearest facility for appropriate care for an Emergency medical condition;
2. Transfer of a covered person who has received Emergency care or who is an inpatient at an acute care facility to the nearest facility where appropriate care can be provided; or for transporting a covered person who is bedridden to a facility for treatment or to his or her home;
3. Transporting a respirator-dependent person; and
4. Transporting a Covered Person to and from the nearest appropriate facility for testing and/or procedures that cannot be performed at the present facility.

Are Any Dental Services Covered Separately From the Dental Benefits Program?

Yes. We cover treatment of your natural teeth if they are accidentally injured, or if you require cutting procedures to treat a disease of the teeth, jaw or gums. We also cover treatment of a fractured or dislocated jaw, or surgery to remove impacted teeth. We only cover tooth implantation if it is necessary because of an accident and you need bone replacement in the same area as the implant.

Effective January 1, 2009, we cover general anesthesia materials, their administration, and medical care facility charges when they are provided to the following covered persons:

1. Children age 7 and under; and
2. Individuals with medical or behavioral conditions that require hospitalization or general anesthesia when dental care is provided and who have received prior authorization from the Plan Administrator.

Any other dental services not specifically discussed here may be covered under the Dental Benefits Program (page 33 of this SPD), but are excluded from coverage under the Comprehensive Medical Benefits section.

Are Immunizations Covered?

We cover the Allowable Charge for immunizations that your Physician recommends, like "flu shots." We do not cover immunizations that you may get for purposes of employment or international travel. This section applies to Covered Persons age seven or over under the same cost-sharing provisions as apply to other benefits under this Comprehensive Medical Benefits Program. The Allowable Charge for these immunizations includes the charge for the immunization itself, but not the office visit to get the immunization.

Some immunizations for your Dependent child are covered under the Well Child Benefit Program (page 28 of this SPD).

WELLNESS BENEFITS UNDER THIS PLAN:

If you are an Eligible Employee or Retiree, then we will pay 100% of the cost for you and your spouse to get a Wellness Physical Exam from Concentra only. We have contracted with Concentra to perform this service. The following schedule applies to this benefit:

Wellness Benefits:

Provided through Concentra only.

Co-Payment ***(We pay)***.....100%
Co-Payment ***(You pay)*** 0%

Frequency of Exam
Eligible Employee or Retiree and Spouse ages 18 to 30 ..... 1 exam every 5 years
Eligible Employee or Retiree and Spouse ages 31 to 35 ..... 1 exam every 3 years
Eligible Employee or Retiree and Spouse ages 36 to 40 ..... 1 exam every 2 years
Eligible Employee or Retiree and Spouse age 41 and over..... 1 exam per year

ORGAN OR TISSUE TRANSPLANT

Human organ and tissue transplant benefits are provided according to the terms and conditions set forth in a separate Organ & Tissue Transplant Policy (Transplant Policy) that has been issued to the Plan. Transplant related benefits will be provided to each covered person during the transplant benefit period specified in the Transplant Policy. Once the transplant benefit period has elapsed, all transplant-related benefits will revert back to this Plan, subject to its terms and conditions.

Transplant related benefits are only available to individuals that:

A. Are eligible for medical benefits under this Plan;
B. Meet all the terms and conditions outlined in the Transplant Policy; and
C. Have fulfilled the waiting period (if applicable) as defined in the Transplant Policy.

For further information about the Organ & Tissue Transplant benefit, including steps to obtain a specialist referral and a complete copy of the Transplant Policy, please contact the Plan Administrator.

ROUTINE CARE BENEFITS:

Routine Care Benefit
Employee Co-Payment does not apply to Deductible or Out of Pocket Limits.
Co-Payment ***(We pay)***
In Network or Out of Network.....100%
Co-Payment ***(You pay)***
In Network or Out of Network.....0%
Covered Exams
Thyroid Stimulating Hormone (TSH) Test
Pap smear
Mammogram
Prostate Specific Antigen (PSA) Test
Colonoscopy
Maximum Benefit (Calendar Year) ..... $300 per person

These Routine Care benefits are available to Retirees and their Spouses.

WELL CHILD BENEFITS:

After you have paid your child's annual deductible, we pay for 100% of the Allowable Charge for services provided or supervised by a Physician including routine well baby care, pediatric preventive services, developmental assessment, appropriate immunizations and laboratory tests. We will also provide full coverage for most routine immunizations required to place your Dependent children in a child care facility, school or similar program.

These benefits are listed below:

Well Child Benefit (Eligible Dependents of Eligible Employees only)
The Co-Payment percentages apply only after your deductible has been met.

Co-Payment ***(We pay)***
In Network or Out of Network.....100%
Co-Payment ***(You pay)***
In Network or Out of Network.....0%
Maximum Well Child Benefit
Eligible Dependent children age birth through 1 year ..... All visits per year
Eligible Dependent children ages 1 and 2 years ..... 5 visits per year
Eligible Dependent children age 3 years through 6 years.....1 visit per year
Eligible Dependent children age 7 or over .....0 visits per year

These Well Child benefits are not available to Retirees and their Dependents.

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT:

Generally:

No benefits for mental health care or substance abuse treatment are available under other sections of this Plan except that you may receive Loss of Time Benefits while you are getting inpatient treatment, see page 37.

What if I Receive Inpatient Treatment for Mental Health Care?

If your inpatient treatment is Medically Necessary to treat a Mental Health Care Condition, it will be covered the same as a Hospital stay under the Comprehensive Medical Benefits Section (see page 25) as long as you get treatment from an accredited and licensed Hospital or Treatment Facility that participates in the Plan's PPO. If you receive Medically Necessary inpatient treatment for a Mental Health Care Condition at an out-of-network facility, we will pay 60% of the treatment as long as the facility is an accredited and licensed Hospital and Treatment Facility. We will only cover up to thirty days of inpatient treatment for a Mental Health Care Condition.

What if I Receive Inpatient Treatment for Substance Abuse?

If your inpatient treatment is Medically Necessary to treat a substance abuse problem, then we will pay for 100% of the treatment up to a $7,500 maximum per covered person, per calendar year, as long as you get treatment from an accredited and licensed Hospital or Treatment Facility that participates in the Plan's PPO. If you receive Medically Necessary inpatient treatment for a substance abuse problem at an out-of-network Hospital or Treatment Facility then we will pay for 60% of the treatment up to a $7,500 maximum per covered person, per calendar year, as long as the out-of-network facility is an accredited and licensed Hospital and Treatment Facility.

We will only cover up to thirty (30) days of inpatient care per calendar year, regardless of whether you have reached the $7,500 maximum limit for treatment.

What if I Need Treatment for Substance Abuse and a Mental Health Condition at the Same Time?

If you require treatment for a dual diagnosis of substance abuse and another mental health condition, then benefits will be paid under the substance abuse benefit rules. This means that there are two separate thirty day limitations, there is one thirty day maximum limitation for inpatient treatment for mental health care per calendar year and there is one thirty day maximum limitation per calendar year for treatment of substance abuse or of a dual diagnosis. The thirty day maximum limitation for a Mental Health Care Condition is not combined with the thirty day maximum limitation for substance abuse or for a dual diagnosis of substance abuse and a Mental Health Care Condition.

What if I Need Outpatient Treatment for Mental Health Care or Substance Abuse?

We will pay 50% of the Allowable Charges for up to 45 outpatient visits per calendar year for the treatment of substance abuse or dependency and/or other Mental Health Care Conditions (including "after care" following inpatient substance abuse treatment, when that care is not included in the charge for the inpatient treatment), as long as you get treatment from a duly-licensed Physician, Nurse Practitioner, Mental Health Care Provider, or alcohol or drug

dependency counselor, who participates in the Plan's PPO. There are no out-of-network benefits available for outpatient Mental Health Care or substance abuse treatment.

Is Outpatient Mental Health Care Treatment After an Amputation, Including a Mastectomy Covered?

Yes. The cost sharing for this type of treatment will be treated like outpatient treatment for medical and surgical benefits. This means that we will pay 85% and you will pay 15% for "in network" treatment. No out-of-network benefits are available, and the forty-five visit maximum applies.

Are Any Counseling Services Covered?

Yes. We offer you and your family comprehensive Employee Assistance Program ("EAP") services. The EAP offers short-term counseling (up to 4 visits) and/or referral and follow-up services for support in areas including family or relationship difficulties, emotional stress, alcohol or drug problems, smoking cessation, and financial or legal concerns. Services provided by the EAP are available at no cost to you or your family; however situations that require outside referral or continued counseling (beyond the 4 visits) may or may not be covered by the Plan. Please contact the Plan Administrator to determine what benefits, if any, may be available for your situation.

Is There a Different Cost-Sharing Rule When Outpatient Treatment is Referred By the Medical Review Office of the Employee Assistance Program?

Yes. We will pay 100% of the cost for your outpatient treatment if it is provided as the result of a referral from the Medical Review Office of the Employee Assistance Program.

Combined Forty-five (45) Day Visit Maximum For Outpatient Treatment:
There is a forty-five visit maximum per calendar year combined for all out-patient visits for the treatment of substance abuse or dependency and other mental health conditions, regardless of the cost-sharing rule that applies.

PRESCRIPTION DRUG BENEFIT

We now use a drug 'Formulary.' A Formulary is a list of *preferred* brand name drugs that is carefully designed to best serve your interests by providing quality drugs at a reasonable cost.

The type of drug prescribed by your doctor will determine how much you pay for your prescription (your co-payment). You should share the Formulary with your doctor.

Prior Authorization and Quantity Control Program: The following two paragraphs are currently suspended, meaning the prior authorization requirements and the quantity control limits do not apply. If the suspension is lifted you will receive a Benefit Alert. Please contact the Plan Administrator if you have any questions.

[You must receive prior authorization for a specific list of medications. If a medication is subject to prior authorization it must be reviewed by the Plan's Pharmacy Benefit Manager prior to being covered. Medications that may be subject to prior authorization include: antihypertensive drugs, biotech agents, dermatological drugs, injectable agents, proton pump inhibitors (coverage only in connection with throat, tongue, stomach, esophageal, or larynx cancer, scleroderma, and in suspended form for children up to age 7), Xolair (asthma), Zelnorm, and Lotronex.

If your prescription exceeds the quantity limit, coverage will be denied with a message to the pharmacy indicating the approved quantity allowed. The prescription can then be resubmitted for the approved quantity. Medications that may be subject to the quantity control include: pain management drugs, diabetic supplies, anti-emetics drugs, migraine therapy drugs, sedative/hypnotic drugs, and erectile dysfunction drugs.]

Here is the schedule for co-payments that you will pay to the pharmacy when you buy drugs from a retail pharmacy:

If your prescription is for a:	***Your co-payment:***
Generic drug	$15
Brand name drug listed on the Formulary	$30 *
Brand name drug NOT listed on the Formulary	$50 *

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available

Important: Your purchase at a retail pharmacy is limited to a 34-day supply for each co-payment. You may purchase a 102-day supply if you pay 3 co-payments, if your doctor prescribes a 102-day supply.

Mail Order Prescriptions:

The Formulary also applies to purchases made through the mail order program. The co-payments schedule for mail order purchases is as follows: ***Important: You will be permitted to purchase as much as a 90-day supply with one co-payment.***

If your prescription is for a:	***Your co-payment:***
Generic drug	$30
Brand name drug listed on the Formulary	$60*
Brand name drug NOT listed on the Formulary	$100*

* plus the difference in the ingredient cost if your prescription is for a brand name drug when a generic is available

Remember, this Prescription Drug Benefit does not cover the cost of medications that have recently become available 'over-the-counter'. ***However, coverage of legend drugs includes vitamins that are treated as legend drugs under federal law, so prescription vitamins are covered.***

Your Benefits and Co-Payments are also listed on the chart at the beginning of this SPD.

High-Risk Patient Support Services:

If you are at a higher-risk, you may be contacted by a HealthReach Care Manager. HealthReach is a specialized health education and support program that provides personal assistance to help higher-risk covered persons understand and manage specific medical conditions and minimize potential side effects of prescription drugs. HealthReach is provided at no charge to covered persons, is completely voluntary, and is confidential. HealthReach Care Managers will provide you with information and clarification to help you make informed health care decisions, but they will not make decisions for you.

Deductible and Cost-Sharing:

A separate deductible applies every year for expenses for Prescription Drug Program benefits. The deductible is satisfied only by prescription drug expenses.

If you are an Eligible Employee you will pay the first $100 a year. This applies to every Covered Person. However, no family will pay more than a total of $200 in deductibles for the year.

If you are a Retiree, you will pay the first $100 per year. This applies to your ***entire family*** (i.e. your family will not pay more than a total of $100 in deductibles for the year).

Covered Expenses:

Prescription drug expenses are expenses for legend drugs, insulin, and diabetic supplies other than those that are excluded below, that are purchased through either the Plan's direct mail prescription provider or a participating preferred retail pharmacy. Legend drugs are those that may only be obtained with a valid prescription.

Exclusions: No benefits are payable under the Prescription Drug Program for:

a. drugs obtained without a valid prescription;
b. non-legend or over-the-counter (OTC) drugs (that is, drugs which may be obtained without a prescription);
c. contraceptive drugs for non-spouse Dependents;
d. any expense for a prescription drug to the extent the billed charge exceeds a reasonable, usual and customary charge for such drug;
e. non-legend or over-the-counter (OTC) vitamins (that is vitamins which may be obtained without a prescription);
f. drugs provided without charge to you, or paid for, under any government program or law;
g. drugs or other pharmaceutical products for which no charge is incurred, or for which you incur no legal obligation to pay;
h. drugs or other pharmaceutical products provided to you while confined in a Hospital or other facility, or that are covered under any other section of this Plan;
i. devices (including biotechnology devices) of any type even though such devices may require a prescription order;
j. expenses incurred for more than six dosages (i.e., pills or injections) per calendar month for treatment of sexual dysfunction;

k. charges payable under Worker's Compensation, occupational disease, or similar law;

l. Non-Sedating Antihistamines, including but not limited to: Allegra, Allegra D, Clarinex, or Clarinex D; or

m. Proton Pump Inhibitors (except in connection with throat, tongue, stomach, larynx or esophageal cancer, and in suspended form for children up to age 7. Additionally, the Plan will cover Proton Pump inhibitors in connection with limited scleroderma (CREST syndrome) but only after the covered person completes a 30-day trial of an over-the-counter Proton Pump Inhibitor drug) including but not limited to: Prilosec, Nexium, Aciphex, Prevacid, and Protonix

DENTAL SERVICES

Your Dental Services Generally:

We pay for 80% of the Allowable Charges for covered dental care provided by a licensed participating Dentist up to $1,500 per person per year. There is no set deductible that you have to pay for dental care, but you will pay the other 20% of the Allowable Charge for the services. (If you use an out-of-network provider then we only pay 60% of the Allowable Charge and you will pay the other 40%.)

What is Included in Covered Dental Care?

Diagnostic and preventive dental care including:

- Routine exams and cleanings not more than twice a year;
- Bitewing and periapical X-rays as required;
- Full mouth X-rays once in any 36 consecutive months;
- Dental prophylaxis not more than twice a year including cleaning, scaling, and polishing (treatment for diseases of the gums is not included in this benefit);
- Topical fluoride applications for Covered Persons under age 19 once in a calendar year;
- Palliative emergency treatment as needed;
- Certain space maintainers for prematurely lost teeth for your Dependent children;
- Preparation of a treatment plan;
- Diagnosis of mouth, teeth, gum and jaw disorders;

Basic dental care, including:

- Restorative services including amalgam, synthetic porcelain, and plastic restorations;
- Periodontics including treatments for diseases of the gums and surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth and periodontal splitting;
- Endodontics including pulpal therapy and root canal filling; and
- Extractions, including simple and surgical extractions and pre and post-operative care related to such surgical extractions.

Major dental care, including:

- Prosthetics including bridges, partial dentures, and complete dentures (including replacement of dentures when Medically Necessary if it has been five years since you originally got dentures or since your most recent replacement);

- Crowns and jackets when your teeth cannot be restored without a filling;
- Oral Surgery; and
- Occlusal mouth guards prescribed in connection with the treatment of Bruxism, but only when it has been five years since you originally got an occlusal mouth guard or since your most recent replacement.

Orthodontia, including all medically necessary orthodontic services (including adult orthodontia and appliances) subject to your annual $1,500 benefit maximum for all dental benefits combined. Benefits include treatment for correction of malposed teeth, the establishment of proper occlusion through the movement of teeth or their maintenance in position, and an occlusal mouthpiece in connection with the treatment of Bruxism up to one time every five years.

Dental Implants: We will pay 50% of Allowable Charges for dental implants up to a maximum of $1,500 per person per calendar year. You are responsible for the remaining 50% of Allowable Charges for dental implants as well as any charges that exceed $1,500. The charges incurred for dental implants count towards your $1,500 maximum per year. (For example, if the allowable charges for your dental implants are $3,000 we will pay $1,500 and you will pay $1,500 and you will not be entitled to any other dental benefits for the year. If the allowable charges for your dental implants are $2,000, we will pay $1,000 and you will pay $1,000 and you will still be allowed $500 more of covered dental care for the year).

When is an "Expense Incurred" for My Dental Benefits?

For an appliance or modification of an appliance, at the time the impression is made.
For a crown or bridge, at the time the teeth are prepared.
For a root canal, at the time the pulp chamber is opened.
For all other expenses, at the time the service or supply is provided.

Is Oral Surgery Covered By This Plan?

When you need oral surgery, it is covered the same as the Comprehensive Medical Benefits Program as long as the surgery is performed by a Dentist who is a member of the Plan's PPO, or a Physician who is properly certified in oral surgery.

The benefits for oral surgery do not count towards your annual dental maximum.

VISION BENEFITS

Generally:

We will pay for 100% of your covered vision care up to the following maximums:

Maximum amount paid for exams:

a. $50 for one examination by a licensed optometrist or ophthalmologist per calendar year;

Maximum amount paid for lenses:

a. $50 per pair for single vision lenses;
b. $85 per pair for bifocal lenses;
c. $95 per pair for trifocal lenses;

d. $10 per pair for color tint, if Medically Necessary;
e. $100 per set of contact lenses (or the total cost if Medically Necessary)

An Eligible Employee is covered for up to two pairs of prescribed lenses (whether spectacle or contact) per calendar year; and Retirees and Dependents are covered for one pair of prescribed lenses (whether spectacle or contact) per calendar year. A package of disposable contacts is treated as a pair of prescribed lenses.

Maximum amount paid for frames:

a. $75 for a pair of frames once per calendar year for Eligible Employee; and
b. $75 for a pair of frames once every two calendar years for Retirees and Dependents.

Exclusions: We do ***not*** pay benefits for:

a. an eye exam required by an employer as a condition of employment
b. extra charges for glasses with tinted lenses unless they are prescribed by an optometrist or ophthalmologist as Medically Necessary
c. sunglasses
d. special/unusual procedures, including but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography
e. vision exams, lenses, or frames that were received or ordered before you became eligible for benefits under this section
f. lenses or frames ordered while covered for vision care benefits but delivered more than 60 days after your vision coverage terminated
g. procedures which constitute refractive eye surgery, including radial keratotomy, ***however, for Eligible Employees only, we will pay a lifetime maximum of $1,000.00 per eye for such procedures.***

HEARING AID BENEFITS

We will pay 100% of the cost up to $2,000.00 in any five consecutive calendar years for you to purchase a hearing aid.

EXCLUSIONS

General Exclusions:

We will not cover any charges for the following:

a. any charges relating to any injury or Sickness for which a Covered Person has received or is entitled to receive compensation under any Workers' Compensation or occupational disease or similar law or program, including all charges payable under Workers' Compensation, occupational disease, or similar law;
b. expenses for hospitalization or medical or surgical treatment provided at no charge to the Covered Person, or paid for, by any government agency;
c. any expenses related to an injury or Sickness caused by war or any act of war;
d. any expenses related to an injury or Sickness incurred while engaged in service with the armed forces of any nation or state;
e. expenses which neither the Covered Person nor the Eligible Employee or Retiree is required to pay;

f. expenses for routine physical or screening examinations, except as specifically provided under the Wellness and Routine/Preventive Care Benefits Programs;
g. expenses for hearing aids, except as provided under the Hearing Aid Benefit Program;
h. expenses for medical or surgical treatment rendered for cosmetic purposes as well as expenses for complications arising from such treatments;
i. expenses for services and supplies that are not Medically Necessary as well as complications arising from services and supplies that are not Medically Necessary;
j. expenses that exceed the Plan's reasonable, usual, and customary charge limitations;
k. expenses for any contraceptive devices or treatments (including surgical sterilization);
l. expenses for any product or service whose use is experimental or investigational;
m. expenses for any product or service, such as air-conditioners, water beds, and filters, the principal purpose of which is convenience or general comfort;
n. expenses for any medical or surgical treatment or examination required by an employer as a condition of employment;
o. charges made for confinement in a nursing home, long-term care facility, or any facility primarily providing personal care, assisted living, and/or general custodial services, rather than acute medical care;
p. any expense that is not incurred (an expense is incurred at the time the service or supply is actually provided) while the Covered Person is covered under this Plan, unless a Plan provision specifically provides otherwise;
q. any expense incurred for speech therapy, unless necessary because of:
    1. an injury, or
    2. a Sickness <u>other than</u>: otitis media, mental illness, or a functional nervous disorder;
r. expenses for services performed by a chiropractor;
s. expenses incurred for actual or attempted impregnation or fertilization, involving either the Covered Person or a surrogate as donor or recipient or expenses incurred for diagnosis or treatment of infertility;
t. expenses incurred for any treatment of sexual dysfunction that is not caused directly by a Sickness or injury, except for prescription drug expenses, which shall be limited to a maximum of six dosages (i.e., pills or injections) per calendar month;
u. expenses incurred for the treatment of obesity as well as expenses for complications arising from such treatment;
v. expenses incurred by a Dependent child in connection with her pregnancy, the birth of her child, or complications arising from either; or
w. any expenses for Dental or Mental Health Care and substance abuse treatment that is not specifically covered under other provisions of the Plan.

<u>ANCILLARY BENEFITS</u>:

These benefits are additional benefits that accompany your Comprehensive Medical Benefits under this Plan.

What is the Death Benefit Under This Plan?

If you are an Eligible Employee or Retiree, then you are eligible for a death benefit that will be paid to a designated beneficiary. You may designate a beneficiary to receive this benefit

on a form required by the Fund. You must file the form with the Plan Administrator before you die. You can change this beneficiary at any time before you die.

If you die on or after June 1, 2004, then your designated beneficiary will receive $10,000.

If you do not designate a beneficiary before you die, or your beneficiary has died before you, then we will pay the money in the following order until the benefit has been paid: (1) first to your Surviving Spouse; (2) if you do not have a Surviving Spouse, then to your descendants; (3) if you do not have descendants, then to your parents in equal shares; (4) if you do not have parents, then to your siblings in equal shares; and (5) if you do not have any siblings, then to your estate.

When Can I Get Accident and Sickness Loss of Time Benefits?

If you are prevented from working for at least one week due to injury or Sickness, then you are eligible for loss of time benefits during that time that you are unable to work. The maximum amount you will be paid is $400 gross amount per week for up to 26 weeks for any one injury or Sickness, called the "Period of Disability." If your Period of Disability lasts less than 26 weeks and ends on a partial week, then you will receive a partial week's credit for the number of days missed that week based on the weekly rate divided by seven (7).

This Period of Disability is the total amount of time that you are completely unable to perform any work in your own occupation, or any other gainful employment due to a physical or mental condition. After your initial Period of Disability, a separate Period of Disability is triggered only if you have returned to work and have actually worked for two weeks, or if you are disabled by a second separate physical or mental condition that is not related to the first condition.

You will <u>not</u> be paid Accidental and Sickness Loss of Time benefits if:

1. Your Disability lasts less than a full week.
2. Your injury or Sickness was caused by the use of alcohol or drugs, unless you are receiving inpatient treatment in an in-network treatment facility.
3. You are gainfully employed.
4. You are receiving or entitled to receive unemployment insurance/compensation payments.
5. You are receiving benefits under the Pipefitters Local No. 533 Pension Plan.
6. You are entitled to receive Worker's Compensation benefits, occupational disease benefits, or benefits under any similar law.
7. You are disabled as a direct result of an intentionally self-inflicted injury, unless your injury was the result of any physical or mental health condition.

What if I Need Inpatient Treatment for Alcohol or Drug Use?

If you participate in an inpatient treatment program for treatment of alcoholism or substance abuse at an in-network treatment facility, you will be eligible to receive the Loss of Time Benefits. These benefits are only available for 30 days for one inpatient program per calendar year.

If you successfully complete the program, then you will be paid Loss of Time benefits for each full week of approved inpatient stay, and you will receive pro-rated benefits for each additional portion of a week included in the program, for up to 30 days.

If you do not complete the program, then the Loss of Time benefits will only be paid for each week of the program that you completed, and you will not receive benefits for any partial weeks.

If you get this type of treatment at an out-of-network treatment facility, or if you receive outpatient treatment (whether in-network or out-of-network) you will not receive the Loss of Time benefits, even though the treatment itself may be covered under the Substance Abuse Treatment Benefit Program.

What Accidental Death and Dismemberment (AD&D) Benefits Can I Get Under This Plan?

If you die or lose a body part or function because of an accidental injury, or you lose a body part or function or die within 90 days after the accident, as long as your loss is due to the accident and does not come from any Sickness or other cause, you will be compensated in the principal amount of $1500 for that loss.

The following types of losses are covered under the program:

If you lose:	***We will pay:***
Your life	$1500 (the principal sum)
Both hands or both feet	$1500 (the principal sum)
One hand and one foot	$1500 (the principal sum)
Entire sight of both eyes	$1500 (the principal sum)
One hand and or one foot, and entire sight in one eye	$1500 (the principal sum)
One hand or one foot or entire sight in one eye	$750 (half the principal sum)

You will not receive more than $1500 for any losses resulting from one accident.
You will not receive AD & D benefits if your loss is:

a. caused by any Sickness or other physical or mental condition; or
b. caused by any type of infection, except an infection introduced through a wound sustained in an accidental injury, simultaneously with such accidental injury and not occurring as a result of later treatment or failure to treat the accidental injury; or
c. caused by or contributed to by any medical, surgical, or dental treatment, even if such treatment is provided in response to an accidental injury; or
d. caused by or resulting from your own act, regardless of your physical or mental state at the time of the act, regardless of voluntariness of the act, and regardless of whether the loss, or the act causing the loss, was intended or not; or
e. caused by ingestion of or exposure to poisons, drugs, medicines, chemicals, or other substances, regardless of the state of matter of the substance (including, but not limited to, food poisoning or exposure to carbon monoxide gas); or
f. incurred during the commission or attempted commission of a crime; or
g. incurred in connection with war, insurrections, or participation in a riot; or

h. incurred while you are serving in any military, naval, or air force of any country at war, declared or undeclared, or in any auxiliary or civilian non-combatant unit serving in a war-related capacity with any such force; or

i. incurred while traveling or flying in or on any type of aircraft, except while riding as a passenger on a regularly scheduled commercial airline operated by a common carrier or by a U.S. Government transport service.

COORDINATION OF BENEFITS:

If you or your Dependents have health care coverage under this Plan and another plan, these "Coordination of Benefits with Another Plan" rules apply because sometimes your coverage under these plans may be duplicated, meaning that both plans pay benefits for the same medical expenses. There are more detailed rules in the Plan document. Ask your Plan Administrator for more information.

What if I am Covered by Another Health Plan?

When benefits are coordinated you receive payment from both plans, but not more than your reasonably incurred medical expenses.

We coordinate with other plans such as:

a. any group or group-type insurance or group or group-type subscriber contract;
b. uninsured arrangements of group or group-type coverage;
c. group or group-type coverage through HMOs and other pre-payment, group practice, and individual practices plans;
d. the amount by which group or group-type Hospital indemnity benefits that exceed two hundred dollars ($200.00) per day;
e. the medical benefits coverage in group, group-type, and individual automobile insurance contracts;
f. the medical care component of long-term care contracts, such as coverage for skilled nursing care; and
g. individual or family insurance contracts, subscriber contracts, or coverage through closed-panel or other pre-payment, group practice, and individual practice plans.

If you are eligible to enroll in another plan, but do not enroll, the plan will only be treated as another plan with which benefits may be coordinated if there is no cost for you to enroll. If you are eligible to enroll in another plan at no cost, then that plan will be treated as another plan with which benefits may be coordinated.

The plan that pays benefits first is the "primary plan" and the plan that pays benefits second, is called the "secondary plan." There are special detailed rules to determine which plan is primary and which is secondary. These are determined by your status at the time of coverage and are briefly explained below:

Eligible Employees:

If you are covered under another plan as the employee, member, or "primary insured," then that plan will be primary and this Plan will be secondary.

If you are covered under another plan as a dependent, or as a laid -off or retired employee, then this Plan will be primary and the other plan will be secondary.

Generally, we will not take into account any benefits you are entitled to under Medicare in determining the benefits payable by this Plan. We will generally be primary for you and your Dependents while you are an active Employee, and Medicare will be secondary.

Spouses:

If your spouse is covered under this Plan as a Dependent and under another plan as the employee, member, or "primary insured", then that other plan will be primary and this Plan will be secondary.

If your spouse is covered under this Plan as a Dependent and is covered under another plan as a dependent, the plan that has covered your spouse the longest will be primary, unless the other plan covers your spouse as a dependent of a laid-off or retired employee, in which case that plan will be secondary and this Plan will be primary.

If your spouse is age 65 or older and is covered as a Dependent of an active Eligible Employee under this Plan, this Plan will not take into account any benefits that you are entitled to under Medicare in determining the benefits payable by this Plan. We will always be primary for your spouse while you are an active Employee, and Medicare will be secondary.

If your spouse is age 65 or older and is covered as a Dependent of a Retiree under this Plan, Medicare will be primary and this Plan will be secondary.

Retirees:

If you are covered under this Plan and another plan, the other plan will be primary and this Plan will be secondary. If you are age 65 or older and covered by this Plan, Medicare will be primary and this plan will be secondary.

Your Dependent Children:

If your child is covered as a Dependent under this Plan, and is covered as an employee, member, or "primary insured" under another plan, then that other plan will be primary and this Plan will be secondary.
If your child is covered by both parents who live together, then this Plan will follow the "birthday rule." The plan of the parent whose birthday is earliest in the calendar year will be the child's primary plan, and the plan of the other parent will be the child's secondary plan.

If your child is covered by both parents who do not live together, then the custodial parent's plan will be the child's primary plan, the plan of the child's step-parent who lives with the child will be secondary, and the non-custodial natural or adoptive parent's plan will pay after the first two plans have paid. [If the child is not covered by three plans then the order will be the same as listed here, just skipping the parent's plan that does not cover the child.]

Any plan ordered to provide coverage under a Qualified Medical Child Support Order (QMCSO) will be the child's primary plan.

If two Eligible Employees covered under this Plan share a child, then the child will be considered a Dependent of both.

Which Plans and Programs Do Not Coordinate With This Plan?

We do not coordinate benefits with Workers' Compensation.

We do not treat Medicare or Medicaid as another plan, but each will be coordinated under separate rules.

We do not coordinate with other insurance policies, such as school accident-type policies, and other policies which provide benefits to cover for losses other than the payment of health care expenses.

If a third party (other than "another plan") is liable for your injury or Sickness, we will not have any liability for payment of any of those medical care expenses except under the Plan's Subrogation rules. (See page 42)

What Are The Medicare Coordination Rules?

The Medicare rules apply to you or your Dependent when eligible for Medicare whether or not you or the eligible Dependent is enrolled.

If you are an active Employee and you or your covered Dependent is eligible for Medicare, then this Plan is primary and Medicare will be secondary.

However, if you or your covered Dependent is eligible for Medicare based on Disability or age, and are covered by this Plan's COBRA continuation coverage, or as a Retiree, then Medicare will be primary and this Plan will be secondary. When coverage under this Plan is secondary to Medicare, we will coordinate benefits by paying all remaining charges, up to the lesser amount of Medicare's total Allowable Charge or the Plan's total Allowable Charge. We will pay benefits regardless of whether you have met your deductible under Medicare.

We have special rules for persons on Medicare with End Stage Renal Disease (ESRD). Contact the Plan Administrator if you need more specific information.

For dental benefits, prescription drug benefits, or vision care benefits that are not covered by Medicare, this Plan is primary for claims filed under those benefit programs. If any of those benefits are provided by your Medicare plan, the Plan will follow the ordinary coordination of benefit rules explained in the above paragraphs.

What Are The Medicaid Coordination Rules?

We will pay benefits without regard to any coverage you or your Dependents may have under Medicaid. However, we will honor an assignment of rights by or on behalf of you or your Dependents as required by Medicaid.

SUBROGATION

What is subrogation?

Subrogation allows the plan to "stand in your shoes" to recover benefits paid under this Plan from any other plan or person who should have properly paid those benefits. For example, if you are injured in an auto accident due to another driver's fault, and the Plan pays expenses for the treatment of your injuries, the Plan can "stand in your shoes" and make a claim to recover those expenses from either the responsible driver or the responsible driver's insurance company. In subrogation, the Plan is asserting your rights to collect against a responsible party.

What is reimbursement?

With reimbursement, the Plan is not asserting your rights but instead is simply requiring repayment of the benefits paid on your behalf. For example, say you are crossing the street and are hit by a car that failed to stop for the crosswalk. The Plan pays expenses for the treatment of your injuries. You hire an attorney and file suit against the driver, eventually arriving at a settlement. Under the Plan's reimbursement provisions, the Plan must be repaid for the benefits it paid out of the proceeds of your settlement. You have asserted your rights to collect against the responsible party, but the Plan must be repaid.

Reimbursement also covers the situation where the Plan makes payment that is in excess of the maximum allowable amount of payment necessary.

How does the Plan collect money under the subrogation provision?

To collect money under the subrogation provision, the Plan will send written notice to you informing you that the Plan is enforcing its rights. The Plan may then collect money directly from the other person or plan without your consent.

Do I get any of the money the Plan recovers in a subrogation action?

The Plan will apply any monies collected from another plan or person to any reasonable costs and expenses the Plan incurs in collecting that money (including attorney fees) up to the amount of the award or settlement. If there is any remaining balance, that balance will be paid to you.

If I am injured by a third party, is there anything I have to do before the Plan will pay benefits?

Yes. You must complete a subrogation agreement and provide any requested information to the Plan before any benefits will be paid.

What if I hire an attorney and my attorney negotiates a settlement?

As discussed in the reimbursement example above, the Plan's rights to subrogation and reimbursement take priority over any other use of money you recover. This includes the payment of attorney fees and expenses. The Plan must be paid first, regardless of the amount

of your recovery, and regardless of whether that recovery comes from lawsuit or settlement. The Plan is entitled to be reimbursed from your recovery, regardless of how your recovery is characterized or paid.

Are the Plan's rights limited by the "make whole" or "common fund" doctrines?

No. The Plan's subrogation and reimbursement rights are not limited by the common fund doctrine or the make whole doctrine. The Plan specifically disclaims these two doctrines.

Will the Plan pay the costs or expenses incurred in connection with recovery from another plan or person?

No. The Plan will not be responsible for any costs or expenses incurred in connection with your recovery from any other plan or person unless the Plan agrees in writing to pay a part of those expenses.

Are there any times the Plan will accept less than full reimbursement?

The Board of Trustees, within its sole discretion, may decide to recover less than the full amount of reimbursement if:

- This Plan has made reasonable and diligent collection efforts appropriate under the circumstances, and
- Such decision is reasonable under the circumstances based on the likelihood of collecting monies in full or based on the expenses the Plan would incur in an attempt to collect additional funds.

Will the Plan ever reduce my benefits to recover benefits that were overpaid?

The Trustees may, in their discretion, elect to set-off amounts paid by the Plan in excess of benefits due against any amount owed in the future. For example, if the Plan pays $200.00 for a medical expense later determined to not be covered under the Plan, the Plan may require you to pay the next $200.00 in submitted claims to set-off the amount that was overpaid.

Can the Plan recover overpaid benefits from anyone other than me?

Yes. The Plan has the right to recover excess payments from any one or more of the persons it has paid (for example, a provider), from one or more persons for whom it has made payments (the person who is the subject of the medical claim), or from any other person or organization that may be responsible for the benefits or services that were provided and paid for.

How does the Plan determine who will repay the benefits?

The Trustees have the sole and absolute discretion to determine from whom they will recover.

Do the subrogation and reimbursement provisions apply to any payment I receive from a responsible third party?

Yes. If a responsible third party (or that person's insurer, or anyone else on that person's behalf) makes a payment to you as compensation for an injury or sickness, the Plan is entitled to reimbursement in an amount equal to the lesser of the amount of benefits paid by the Plan and the amount of compensation paid by the third party.

If I receive payment for my injury and the injury still requires treatment, will that treatment be covered by the Plan?

Whether any future treatment will be covered by the Plan will depend on the terms of your settlement agreement. If you are compensated for future medical expenses, those expenses will not be covered by the Plan.

Do I have any responsibility to the Plan?

Yes. You have a duty to cooperate with this Plan. As a condition of receiving benefits under this Plan, you agree that at the request of the Board of Trustees or its designee you will take any action, give any information and assistance, and execute any documents required by this Plan to enforce its subrogation and reimbursement rights. The Plan will make no payments to you or on your behalf unless you satisfy these terms.

Additionally, the Plan has the right to release or to obtain from any person any information which the Board of Trustees determines necessary to make payment for medical care, to determine and to enforce any cost sharing requirements, and to enforce the Plan's right to recovery, reimbursement and/or subrogation.

HOW TO FILE A CLAIM UNDER THIS PLAN

Generally:

Generally, your provider will file your claim for you, as long as you provide all of the necessary information about your coverage. Always present your Plan identification card to your provider when you receive any health care services to help him/her determine if he or she can file the claim on your behalf.

We have entered into a Preferred Provider Organization (PPO) contract with Blue Cross and Blue Shield of Kansas City (BCBSKC). Your claims will first go to BCBSKC, whose sole responsibility is to apply the appropriate discounts to your claims. The claim is then sent to the Plan Administrator who actually administers the Plan. You should contact the Fund Office if you have any questions regarding coverage.

Where Do I File My Claim?

You should file all your health benefit claims with Blue Cross and Blue Shield of Kansas City (BCBSKC) at the address shown on your identification card. You can file in either paper

format, using either your provider's form or a standard health claim form, or EDI compliant electronic format.

If this Plan is secondary, you should still file health benefits claims with BCBSKC at the address shown on your identification card. This includes any Medicare related claims that must be filed with this Plan.

Death benefits, AD&D, and Loss of Time benefits are administered directly by the Fund Office. Claim forms are available from, and must be returned to, the Fund Office.

Express-Scripts will handle your prescription drug claims. Participating retail pharmacies will submit your claim for you, and mail order and reimbursement claim forms are available at the Fund Office.

Dental claims must be filed with Delta Dental of Missouri on Delta Dental's claim form.

If you file the claim yourself, *always* include the following information:

Name and Social Security Number of the Participant;
Name and Date of Birth of the Patient
Patient's Relationship to Participant
Date Health Care Service Was Provided
Name and Billing Address of Provider
Tax Payer ID Number of Provider
Type of Treatment-Service Provided
Number of Units (for anesthesia and certain other claims)
Diagnosis for which Treatment was Provided
Whether treatment was result of Accident, and Details
Information on Any Other Insurance the Patient Has
Include Billing Statement or Receipt
Signature of Patient or Patient's designated representative and Provider
Your Provider Must Fill Out Part of the Form.

**See the Claim form for more specific information. You must use the correct form in order for your claim to be processed properly and timely.

**Only a written notification from the Plan Administrator (in the form of an Explanation of Benefits or other formal correspondence) will constitute notice of a benefit determination.

When Do I Have to File My Claim?

Your claims for payment of health care expenses must be filed by the last day of the calendar year following the calendar year in which the expense was incurred.

Claims for Loss of Time benefits must be filed within the calendar year in which the Period of Disability ended, or if less than 90 days remains in the calendar year, within 90 days after the end of the Period of Disability.

Claims for death benefits and accidental death and dismemberment (AD&D) benefits must be filed within one year from the date of death or the date of loss. If you are submitting a claim for death benefits, you must submit proof of death (such as a death certificate) with the claim. If you are submitting a claim for AD&D benefits, you must submit proof of accident (such as a police report or coroner's report) with the claim.

You can only file claims after the periods described above with the express approval of the Trustees or their designated representative. If you cannot file your claim within this period, you must send a written request to file a late claim to the Trustees that includes an explanation of the circumstances preventing timely filing.

We will process claims filed by you or your authorized representative. You may designate an authorized representative by completing and filing an Authorized Representative form that is available from the Fund Office. No form needs to be on file for your spouse, the parent or legal guardian of a minor participant, or your treating Physician to file a claim on your behalf.

How is My Claim Processed?

You will receive notice of all claim determinations. In some instances, if the claim is paid in full, payment of the claim will serve as your written notice of our decision. If your claim is denied, in whole or in part, or if we pay less than the total amount you are charged, you will receive a written notice that will include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary;
- a description of the Plan's review (appeals) procedures and the time limits applicable to those procedures, including a statement of your right to bring a lawsuit under section 502(a) of the Employee Retirement Income Security Act (E.R.I.S.A.) following an adverse benefit determination on review;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either set forth the specific rule, guideline, protocol, or other similar criterion in full, or it will contain a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in making a determination, and that a copy of the specific rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- if the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limitation, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances of the claim, or the notice will contain a statement that such an explanation will be provided free of charge upon request.

ONLY A FORMAL NOTICE OF BENEFIT DETERMINATION, AS DESCRIBED IN THIS SECTION, SHALL CONSTITUTE AN OFFICIAL PLAN DECISION AS TO WHETHER BENEFITS ARE AVAILABLE, SUBJECT ONLY TO APPEAL AS SET

FORTH BELOW. NO OTHER COMMUNICATION, WHETHER WRITTEN OR ORAL, SHALL CONSTITUTE A PROMISE TO PAY OR A GUARANTEE OF BENEFITS UNDER THIS PLAN.

For claims for death benefits and AD&D benefits, notice of any adverse benefit determination will be sent to you within 90 days after the Plan receives your claim, unless the Plan Administrator determines that special circumstances require a 90 day extension of time for processing the claim. We will send you written notification of any extension.

For claims for loss of time benefits, notice of any adverse benefit determination will be sent to you within 45 days after the Plan receives your claim, unless the Plan Administrator determines that circumstances beyond control of the Plan require an extension. We will send you written notification of any extensions before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. If circumstances beyond control of the Plan cause the Plan to be unable to decide the claim within the additional 30 days, the Plan may extend the time for deciding the claim for up to an additional 30 days. If another extension is required you will get another written notice from us prior to the expiration of the first 30 day extension period that tells you the reason for the extension and the date which the Plan expects to render a decision.

If an extension is necessary because we need additional material or information from you, the time period for deciding the claim will be suspended from the date we send you notice, until we receive the information or material from you. If you need more than 45 days to supply the material or information, you should request it in writing. When the Plan has received your information (or the time within which you were to have supplied the material or information has passed, if you do not provide it), we will make a decision on your claim within 30 days.

For all health care claims, your claim will be decided and notice of any adverse benefit determination will be sent to you within 30 days after we receive your claim. If the Plan Administrator determines that an extension is necessary due to matters beyond our control and send you notice within the initial 30 day period, we may extend the decision up to 15 days. If we need additional material or information from you, the time period for deciding the claim will be suspended from the date that we send you notice of this, until we receive the information or material from you. If you need more than 45 days to supply the material or information, you should request it in writing. When we have received your information (or the time within which you were to have supplied the material or information has passed, if you do not provide it), we will make a decision on your claim within 15 days.

How Do I File an Appeal?

If a claim is denied, in whole or in part, or if the amount approved or paid varies in any other way from the total amount claimed, and you believe that you are entitled to benefits under this Plan which you did not receive, you may appeal the determination by requesting that the Board of Trustees review the determination.

Your request must be made in writing and must explain the reasons you believe you are entitled to the benefit or portion of your claim that was denied. ***Send your written request for review to the Board of Trustees, Pipe Fitters Local 533 Health and Welfare Plan, 3100 Broadway, Suite 805, Kansas City, MO 64111.***

A request for review concerning a claim for death or AD&D benefits must be made within 60 days after you receive notice of adverse benefit determination.
All other requests for review must be made within 180 days after you receive notice of adverse benefit determination.

The Board of Trustees will provide a full and fair review of the claim and the adverse benefit determination, and will not give deference to the initial determination.

You may submit written comments, documents, records, and other information relating to the claim for benefits.

In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Board shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Board of Trustees shall make a benefit determination on your appeal at the next regularly scheduled quarterly meeting after it has received your request for review unless the request for review is filed within thirty (30) days of that meeting. In such case, the Trustee's review and determination will be made at the second meeting following receipt of the request for review. If unusual circumstances (such as the need to hold a hearing) require a further extension of time, the Trustees review and determination will be made no later than the meeting following the meeting where it was determined that an extension of time is required. The Plan Administrator will provide you with written notice of any extension

The Plan Administrator will provide you written notice of the decision on review as soon as possible, but not later than five (5) days after the decision is made. The notice will include an explanation of the decision, and a statement of your rights to bring a lawsuit under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) after you have exhausted all administrative remedies. That lawsuit must be brought within one year.

YOUR PRIVACY AND PROTECTED HEALTH INFORMATION

We take all reasonable efforts to protect the privacy and security of your information, and maintaining that privacy is a high priority. Staff members who use and access your Protected Health Information in the course of administering the Plan are bound by rules of conduct to protect that information. We have a separate "Notice of Privacy Practices" that explains in detail how this information is handled. You can obtain a copy of the Notice free of charge from the Plan Administrator.

OTHER INFORMATION ABOUT THIS PLAN THAT YOU SHOULD KNOW:

The name of your Plan: Pipe Fitters Local No. 533 Health and Welfare Plan.

Employee Organization: Pipe Fitters Local Union No. 533

Employer Organization: Mechanical Contractors Association of Greater Kansas City

Plan Sponsor: The Board of Trustees of the Pipe Fitters Local No. 533 Health & Welfare Fund.

Employer Identification Number of Plan Sponsor: 44-0651452

Plan Number: 501

Plan Fiscal Year: June 1 through May 31

Type of Plan: This is a group health plan that also provides ancillary welfare benefits.

Type of Administrator: The Plan is self-funded and is administered by a third-party administrator under the direction of the Board of Trustees.

Plan Administrator: The Board of Trustees of the Pipe Fitters Local No. 533 Health and Welfare Fund retains ultimate authority as the Plan Administrator for this Plan, but it has delegated responsibility for the day to day administration of the Plan to:

Wilson-McShane Corporation
3100 Broadway, Suite 805
Kansas City, MO 64111
Phone: (816)756-3313
Toll Free: (866)756-3313
Fax: (816)756-3659

Satellite Office Maintained at:
8600 Hillcrest Rd., Suite A
Kansas City, Missouri 64138
Phone: (816) 361- 0206

Plan's Designated Agent for Service of Process: Ms. Carolyn Papuga at the address for Wilson-McShane Corporation above. You may also serve process on any Trustee or the Plan Administrator.

Board of Trustees:

Union Trustees:

Pat Julo, Trustee
Pipe Fitters Local Union No. 533
8600 Hillcrest Rd.
Kansas City, MO 64138

Robert A. Welch, Trustee
Pipefitters Local No. 533
8600 Hillcrest Rd., Suite A
Kansas City, MO 64138

Chris Parrino, Trustee
1320 NW 3rd St.
Blue Springs, MO 64104

Employer Trustees:

Michael Gossman, Trustee
P1 Group, Inc.
2151 Haskell Ave., Bldg #1
Lawrence, KS 66046

Michael Palmer, Trustee
18070 S. Bond Avenue
Bucyrus, KS 66103

William Alexander, Trustee
Alexander Mechanical Contractors
8744 E. Alice Street
Kansas City, MO 64126

Plan's Legal Counsel: Blake & Uhlig, P.A.
753 State Ave., Suite 475
Kansas City, KS 66101
Ph: 913-321-8884
Fax: 913-321-2396

Plan's Consultant: Hans Kraabel
United Actuarial Services
11590 North Meridian St., Suite 610
Carmel, IN 46032-4529
Ph: 317-580-8670
Fax: 317-580-8651

Plan's Accountant: James F. Gillespie, CPA, P.A.
7270 West 98th Terrace, Suite 210
Overland Park, KS 66212
Ph: (913) 648-2130
Fax: (913) 648-2150

- You may get a complete list of the employers and employee organizations sponsoring this Plan if you submit a written request to the Plan Administrator. A list is also available for examination by you or your beneficiaries at the Fund Office.
- You may get information regarding whether a particular employer or employee organization is a Plan sponsor, and if so the sponsor's address, if you submit a written request from the Plan Administrator.

- You may also get a copy of any Collective Bargaining Agreement under which the Plan is maintained if you submit a request in writing to the Plan Administrator. A copy is also available for examination by you or your beneficiaries at the Fund Office.

YOUR RIGHTS UNDER ERISA:

As a participant in the Pipe Fitters Local 533 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is required by Federal law to provide you with information about your rights under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. 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 preexisting condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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