MO-KAN TEAMSTERS TRUST FUNDS

PO BOX 909500 • KANSAS CITY, MISSOURI 64190-9500
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Summary of Material Modification

October 2022

Dear Participant:

The purpose of this Summary of Material Modification (SMM) is to inform you of important changes to your comprehensive major medical benefits offered by the Mo-Kan Teamsters Health and Welfare Fund ("Fund"). Please read this SMM carefully, share it with your family, and store it with your Summary Plan Description (SPD) and other SMMs you have received from the Fund.

Effective May 15, 2022, the Fund began covering tubal ligations and vasectomies as covered medical expenses. These permanent sterilization procedures will be covered in addition to the Plan's current coverage of non-prescription contraceptive methods and certain procedures that are administered, inserted, or removed by a Physician, including Intrauterine Devices (IUDs), diaphragms, and cervical caps. Previously, the Plan did not cover any permanent sterilization procedures. Emergency contraceptives continue to be excluded from coverage by the Fund.

If you have any questions, please contact the Fund Office at the address or telephone number shown below.

Board of Trustees
Mo-Kan Teamsters
Health and Welfare Fund

The Plan's "Grandfathered" Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **866-756-3313** (toll-free) or **816-756-3313**. You may also contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This Summary of Material Modification highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. You can find full details in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MO-KAN TEAMSTERS TRUST FUNDS

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816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Summary of Material Modification

December 9, 2021

«FName» «MName» «LName»
«Address1»
«Address2»
«City» «State» «Zip»

Dear Participant:

The purpose of this Summary of Material Modification (SMM) is to inform you of important changes to the prescription drug program offered by the Mo-Kan Teamsters Health and Welfare Fund ("Fund"). Please read this SMM carefully, share it with your family, and store it with your Summary Plan Description (SPD) and other SMMs you have received from the Fund.

Effective January 1, 2022, the Fund is replacing OptumRx with CVS Caremark (CVS) as its pharmacy benefit manager ("PBM") for all active participants, early retirees and their dependents. The PBM helps to administer your prescription drug benefit on the behalf of the Fund. While your copayment for prescription drug medications will not change, CVS maintains its own drug formulary and copayment assistance program. You will receive additional information from CVS in the coming weeks if the CVS drug formulary and/or copayment assistance program affects your cost-sharing for prescription drug benefits or access to your current preferred medication.

If you have any questions about this change generally, please contact the Fund Office at the address or telephone number shown below.

Board of Trustees
Mo-Kan Teamsters
Health and Welfare Fund

The Plan's "Grandfathered" Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **866-756-3313** (toll-free) or **816-756-3313**. You may also contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This Summary of Material Modification highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. You can find full details in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MO-KAN TEAMSTERS TRUST FUNDS

PO BOX 909500 • KANSAS CITY, MISSOURI 64190-9500
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Important Information about Enhancements to Your Health Plan

December 15, 2020

Dear Participant:

The Board of Trustees is pleased to announce two new partnerships that enhance your Health Plan. Please note that these enhancements do not apply to Medicare-eligible retirees or Medicare-eligible retiree spouses.

Diagnostic Radiology Services

The Fund is partnering with *Absolute Solutions* to provide and serve your Diagnostic Radiology needs, effective January 1, 2021. ***Absolute Solutions*** offers a national network of providers that offer MRI, CT and PET scans in a comfortable environment, close to where you live or work.

When you use Absolute Solutions, a MRI, CT or PET scan for you or your eligible dependent is provided at NO COST TO YOU. You do not have to reach your deductible or pay co-insurance. If you choose to use a provider outside the ***Absolute Solutions*** network, the normal deductible and co-insurance charges will apply.

The process is simple. **If your doctor says you need an MRI, CT or PET scan, dial (800) 321-5040** and speak with a benefit coordinator, Monday – Friday, 7 a.m. – 7 p.m. CT. ***Absolute Solutions*** will schedule and manage your diagnostic radiology test from beginning to end, on behalf of you and your family members. **Your new ID cards are enclosed.**

To learn more, visit their website at **www.absolutedx.com.**

Diabetes Management

The Fund is partnering with OptumRx to launch a new Diabetes Management Program, effective December 1, 2020.

If you enroll, you have access to FREE diabetes supplies including a OneTouch Verio Flex® Bluetooth blood glucose meter and blood glucose testing supplies. By connecting your meter to your smartphone, your test results are ready right away and easy to share with anyone you choose thorough a secure online account. In addition, you can receive FREE 1-on-1 coaching sessions and a full medication screening with a pharmacist who specializes in diabetes care.

No action is needed at this time. **If you are eligible to participate, you will receive a letter at home about next steps.**

We understand that nothing is more important than your health and the health of your family. These enhancements are examples of how the Board of Trustees continues to look for ways to provide comprehensive and affordable Plan benefits to our members.

If you have any questions regarding these enhancements or your other benefits, please call the Fund office at **(816) 756-3313.**

Sincerely,

Board of Trustees

MO-KAN TEAMSTERS TRUST FUNDS

3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Summary of Material Modification

December 31, 2019

Dear Participant:

The purpose of this Summary of Material Modification (SMM) is to inform you of important changes to the medical and prescription drug benefits offered by the Mo-Kan Teamsters Health and Welfare Fund ("Fund"). Please read this SMM carefully, share it with your family, and store it with your Summary Plan Description (SPD) and other SMMs you have received from the Fund.

Effective March 1, 2020, expenses related to gene therapy are excluded from coverage under both the Medical and Prescription Drug Plans. Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Gene therapy is excluded from coverage even if the therapy has received approval from the U.S. Food and Drug Administration (FDA) or is not considered experimental or investigational. Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.

If you have any questions about this benefit change generally, please contact the Fund Office at the address or telephone number shown below.

Board of Trustees
Mo-Kan Teamsters Health and Welfare Fund

The Plan's "Grandfathered" Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **866-756-3313** (toll-free) or **816-756-3313**. You may also contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This Summary of Material Modification highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. You can find full details in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Announcing Important Plan Changes

Date: December 14, 2018

To: Active Members, Non-Medicare-Eligible Retirees and Their Qualified Dependents Participating in the Mo-Kan Teamsters Health and Welfare Fund

From: The Board of Trustees

This Summary of Material Modifications (SMM) informs you of important Plan changes, which include those made to the prescription drug and dental benefits offered by the Mo-Kan Teamsters Health and Welfare Fund, effective January 1, 2019. Please read this SMM carefully, share it with your family, and store it with your Summary Plan Description ("SPD") and other SMMs you have received from the Fund.

Switch to OptumRx, Effective January 1, 2019

As the Board of Trustees of the Fund, our goal is to provide quality benefits that meet the needs of participants and their eligible dependents. Due to the constant rise in prescription drug costs, we have taken measures to ensure that the Plan can continue to provide comprehensive, high-quality prescription drug benefits that are affordable for both you and the Fund.

Therefore, effective January 1, 2019, the Fund is switching from CastiaRx to OptumRx as the Fund's prescription drug program provider. **The switch will not affect our Plan's benefit structure and your prescription drug benefits are NOT changing.**

- The **copays** for Generic and Brand name medications, as well as the coinsurance for Specialty medications, if applicable, are **staying the same** at both retail pharmacies and through mail order.
- The **annual per person out-of-pocket maximums** are **not changing**.
- You will still have access to a **national pharmacy network**, so you will not have to switch to a different pharmacy.
- The current **mail order** program will not change, except **you will have the option to fill 90-day prescriptions for maintenance medications** at retail pharmacies **through OptumRx's 90-day program**.
- **To avoid any interruptions** with your daily prescription medications, please **make sure you have enough medication to cover your needs through the end of December 2018 and the beginning of January 2019.** Also, before January 1, 2019, be sure to ask your doctor to provide you with a new prescription for any controlled substances or compound medications that you have filled through mail order.
- **Specialty medications** will be **filled by BriovaRx**, the Optum specialty pharmacy. Information about BriovaRx will be mailed to you if you are currently taking a specialty medication.
- You will receive a **new ID card** in the mail. When you receive the new ID card, keep it in a safe place and start using it January 1.
- **Share your new ID card with your doctors** so they can review the OptumRx formulary and decide if you should continue taking the same medication or switch to an alternative medication. You should also **share the new ID card with your pharmacist**.

You will receive more information directly from OptumRx as we get closer to January 1, 2019. In the meantime, to learn more about OptumRx, visit www.optumrx.com.

New Blue Cross Blue Shield of Kansas City Dental Network (For Active Plan Participants Only), Effective January 1, 2019

If you are an Active Plan participant, the Fund currently provides dental care coverage for you and your eligible dependents. We are pleased to announce that, effective January 1, 2019, the Fund will enter into a contract with Blue Cross Blue Shield of Kansas City (BCBSKC) that will allow you access to BCBSKC's "*Blue Dental Choice / GRID+*" PPO network and discounted dental services. **Note that your medical benefits, provided through BCBSKC, are NOT changing**. With respect to your dental coverage:

- You will automatically be eligible to access the *Blue Dental Choice / GRID+* PPO network.
- You will still be allowed to see your current dentist, even if he/she **does not** participate in the *Blue Dental Choice / GRID+* PPO network.

The following table shows how eligible dental expenses will be covered by the Plan:

	"Blue Dental Choice / *GRID+*" PPO Plan Benefit	
	In Network (You Pay)	**Out of Network (You Pay)**
Annual Deductible – Per Person (waived for Preventive Services)	$25	$25
Annual Plan Maximum – Per Person*	$1,750	$1,750
Orthodontic Lifetime Maximum	$1,500	$1,500
	In Network (Plan Covers)	**Out of Network (Plan Covers)**
Diagnostic and Preventive Services Oral Examinations, Cleanings Adult/Child, Fluoride, Sealants, X-Rays – Bitewing, X-Rays – Full Mouth Series, Space Maintainers	80%	80%
Basic Services Oral Surgery, Extractions, Endodontics, Periodontics, General Anesthesia/Intravenous Sedation, Amalgam Restorations	60%	60%
Major Services Inlays/Onlays, Labial Veneers, Crowns, Crown and Bridge Repair, Prosthodontics (first installation of dentures and bridges), Pontics, Removable Bridge, Full & Partial Dentures, Prosthodontics (adding to existing partial denture)	50%	50%
Orthodontic Services (Individuals up to age 19)	50%	50%

* Note: The Annual Plan Maximum increased from $1,250 per person to $1,750 per person.

Increase in Dental Annual Plan Maximum – Per Person

Effective January 1, 2019, the Dental Annual Plan Maximum will increase from $1,250 to $1,750.

Save Money—Always Try to Use *"Blue Dental Choice / GRID+"* Network Dentists

While the percentage ("coinsurance") you pay out-of-pocket for the dental care you receive is the same regardless of whether you receive your dental care in-network or out-of-network, **you'll pay more out-of-pocket when you receive care from non-network dental providers because their services will not be discounted**. The dentists and orthodontists who participate in BCBSKC's *Blue Dental Choice / GRID+* PPO network have agreed to charge discounted rates for the dental care they provide, which means you and the Fund will save money when you use a network dentist. In addition, *Blue Dental Choice / GRID+* network dentists will not balance bill you for charges in excess of the discounted amount.

Because BCBSKC has a large, nationwide dental network, the dentist that you currently see may already participate in the *Blue Dental Choice / GRID+* PPO network. However, if he or she does not participate in the *Blue Dental Choice / GRID+* PPO network, you will still be free to get your dental care from that dentist and receive Plan benefits. To find out if your dentist participates in the network, visit www.bluekc.com. **If your dentist is not contracted with BCBSKC, we recommend that you do one of three things**:

1. **Switch** to a *Blue Dental Choice / GRID+* PPO network dentist; or
2. **Ask your dentist to join** the *Blue Dental Choice / GRID+* PPO network; or
3. **Nominate your dentist for network participation**. To do so, go to www.bluekc.com, click on 'Find a Doctor' in the upper right corner of the Home Page and then scroll down to the 'Find a Dentist' section. Click on 'Search for Dentists Nationwide' and then 'Nominate a Dentist' in the upper right hand corner. A dentist nomination form will appear, which you can complete and submit.

Active Plan Participants: Be On the Lookout for Your New ID Card—Coming in December 2018

You will receive a new ID card in the mail from BCBSKC. Be sure to show the ID card to any medical and dental providers from whom you wish to receive care, beginning January 1, before the care is provided. Also, remember to throw your old medical ID card away and replace it with the new card that you will receive.

Changes to Claims and Appeals Procedures for Disability Benefits, Effective April 1, 2018

The Trustees have amended the Plan to comply with new federal regulations. If you filed a disability claim on or after April 1, 2018 and your claim was or is denied, if you file an appeal, you will have access to additional information, including:

- An explanation of why the Plan may have disagreed with some of the medical information you submitted; and
- Any internal rules relied on and technical scientific or medical information used to process your claim.

Required Court to File a Lawsuit, Effective August 2, 2018

Effective August 2, 2018, if you or one of your eligible dependents files a lawsuit or legal action against the Fund, that lawsuit or legal action can only be filed in the U.S. District Court for the Western District of Missouri. Your right and those of your eligible dependents to file a lawsuit or other legal action against the Fund or in connection with the Fund have not changed.

Notice of Grandfathered Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 866-756-3313 (toll-free) or 816-756-3313. You may also contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Questions?

If you have any questions about the information in this SMM or your benefits in general, please call the Fund Office at 866-756-3313 (toll-free) or 816-756-3313.

Sincerely,

Board of Trustees

This Summary of Material Modifications highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. Full details are contained in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Important Plan Enhancements
Effective January 1, 2018

December 1, 2017

Dear Participant:

As your Trustees, we are pleased to announce a test program regarding your Telehealth Services.

Telehealth Services have been available to our participants since July 1, 2016. These service are provided by Blue Cross and Blue Shield of Kansas (BCBSKS) through American Well® (Amwell). Amwell is an urgent care provider that brings health care to where you are, through your mobile device or computer.

Telehealth is easier and less costly than other alternatives. For example, the average physician office visit charge is $92, and the average emergency room visit charge is $742. The cost of an Amwell "visit," however, is only $49 for 2018. Telehealth Services save you and the Fund money.

To help increase the use of Amwell Telehealth Services, the Fund will pay the full amount so that **your Amwell visit cost will be $0 for 2018.** That's right, effective January 1, 2018, the Fund will pay all fees associated with an Amwell visit. We will evaluate the amount that the Fund will subsidize for this program annually.

We hope that you will take advantage of this easily accessible and cost-effective service when you need non-emergency services. These services are available for our members and their eligible dependents.

When to use Amwell services. You can use Amwell to interact with a doctor for common conditions such as:

- Cold
- Flu
- Fever
- Rash
- Stomach pain
- Sinus infection
- Pink eye
- Ear infection
- Migraine

Amwell also offers behavioral health and counseling services with a licensed therapist for conditions such as:

- Anxiety
- Attention deficit hyperactivity disorder (ADHA)
- Stress
- Bereavement
- Obsessive-compulsive disorder (OCD)
- Panic attacks
- Depression
- Trauma/post-traumatic stress disorder

Why use Amwell?

- You can choose your own physician or therapist for your visit from a list of U.S. board-certified provider profiles, including physician certifications, licenses, and online patient ratings.
- The service is available 24 hours a day, seven days a week, and 365 days a year.
- If a medication is prescribed, you can pick it up at your local pharmacy.
- For 2018, the service is free to you and your eligible dependents.
- A record of each visit is securely maintained and you can access that record. This ensures that both you and the physician on your next visit will have the information needed.

How to Access Amwell. You can access Telehealth through any mobile device by downloading the Amwell app from the App Store or Google Play. You can also access Telehealth on your computer through amwell.com. Set up the profile for each member of your family so that, when the need arises, you can get help quickly and easily.

For More Information. If you have any questions about Telehealth Services, please call the Fund Office at 816-756-3313 or toll free at 1-866-756-3313.

For More Information

If you have any questions about these benefit enhancements or your health care coverage in general, call the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Sincerely,

Board of Trustees

The Plan's "Grandfathered" Status

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MO-KAN TEAMSTERS TRUST FUNDS

3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Summary of Material Modification

April 1, 2015

Dear Participant:

The Trustees announce the following changes to the Health and Welfare plan of benefits:

Effective for claims incurred on or after May 1, 2015, the deductible under Plan 1 will be $320 per individual and $640 per family. The medical claims out-of-pocket maximum (OOP) will be $2,890 per individual for in-network PPO services and $5,780 per individual per year for out-of-network services.

Example: If you had a hospital claim in February 2015 and paid your current $250 deductible for using an in-network PPO hospital and providers and reached your $2,250 individual in-network out-of-pocket maximum, and have another hospitalization in September 2015 for another medically necessary procedure, you will be responsible for your copayments up to the new OOP balance, or another $70 for deductible (the difference between $320 and $250) and $640 total for the out-of- pocket maximum ($2,890 - $2,250 = $640) for the second procedure.

Please keep this Summary of Material Modification with your benefit plan booklet so that you will have an up-to-date description of the Fund's benefits. If you have any questions about this benefit change, please contact the Fund Office at the address or telephone number shown below.

Board of Trustees
Mo-Kan Teamsters
Health and Welfare Fund

MO-KAN TEAMSTERS TRUST FUNDS

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Changes to Coverage for Transplants
Effective November 3, 2016

Dear Participant:

February 1, 2017

As you are probably aware, the Plan provides a Transplant Benefit. In-network benefits are provided through the Designated Transplant Providers available through the Plan's PPO Network contract with Blue Cross and Blue Shield of Kansas City. There are two benefit improvements being made effective November 3, 2016.

First, the $1,000 deductible for transplants will no longer apply. Second, the $15,000 limit on organ procurement expenses will no longer apply.

There are no changes to out-of-network coverage for transplants.

The Plan's "Grandfathered" Status

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For More Information

If you have any questions about this Plan change or your health care coverage in general, call the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Sincerely,

Board of Trustees

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Important Plan Enhancements
Effective January 1, 2014

April 2014

Dear Participant:

As the Board of Trustees of the Mo-Kan Teamsters Health and Welfare Fund, we are pleased to inform you of several Plan enhancements, effective January 1, 2014. In accordance with the Affordable Care Act, ***the Plan removed or reduced the limitations that existed on certain benefits for active and retired participants. In addition, if you are an active participant, the Plan now covers your eligible dependent children regardless of whether they can enroll in another health plan sponsored by either their employer or their spouse's employer.***

Annual Benefit Maximums Have Been Eliminated for Active and Retired Participants

To ensure you and your family members have the benefit coverage you need, the Plan eliminated the $750,000 per person annual benefit maximum for active participants and the $350,000 per person annual benefit maximum for retired participants, effective January 1, 2014.

Limitations Have Been Removed or Reduced on Certain Medical Benefits for Active and Retired Participants

- ***Adult Restorative Speech Therapy***—The $5,000 per calendar year limit and $10,000 lifetime limit have been eliminated and replaced with a limit of 20 visits per calendar year.
- ***Chiropractic Treatment***—The Plan now covers five chiropractic treatments at 100%, including x-rays. No benefits are paid thereafter.
- ***Hospice Care***—The $10,000 lifetime limit has been eliminated and replaced with a maximum benefit of six months in a three-year period (no deductible or coinsurance).
- ***Durable Medical Equipment***—The limit of $10,000 per limb or device in any three consecutive calendar years has been eliminated and replaced with a limit of one device per limb in any three consecutive calendar years.

  For purposes of this benefit, the Plan defines an "*orthotic*" as a corrective appliance or device, either customized or available "over-the-counter," that is designed to support a weakened body part. This includes, but is not limited to, crutches, specially designed corsets, leg braces, extremity splints and walkers. This definition does not include dental orthotics.

  For purposes of this benefit, the Plan defines a "*prosthetic*" as a corrective appliance or device designed to replace all or part of a missing body part, such as an artificial limb.

- ***Physical Exams***—Active employees (including retirees not yet eligible for Medicare), their spouses and their dependent children who are over age 18 may obtain a physical exam at no cost if the exam is performed at a Concentra network location. If you receive your physical exam at a non-Concentra location, the Plan will cover 100% up to $350 toward the cost of the exam.

In addition, the Plan covered only one physical exam performed at a Concentra location every other year for participants under age 50 (participants age 50 and older can get an exam every year). The "once every other year" limitation on Concentra exams for participants under age 50 has been eliminated.

- ***Well Child Benefit***—Up until January 1, 2014, the Well Child Benefit covered expenses for such things as office visits, immunizations and vaccines. Effective January 1, 2014, immunization and vaccine expenses will be covered under the *Immunizations and Vaccines Benefit* described below, and will not be charged against the annual $500 Well Child Benefit.
- ***Immunizations and Vaccines Benefit***—Flu shots are covered the same for adults and children, at 100% (no deductible or coinsurance), regardless of whether they are administered by a contracted PPO network provider or a non-contracted PPO provider. Other immunizations and vaccines are also covered the same for adults and children, which is at 100% (no deductible or coinsurance) when they are administered by a contracted Blue Cross and Blue Shield of Kansas City (Blue KC) PPO network provider, or at 100% for up to $100 when they are **not** administered by a contracted Blue KC PPO network provider. The Plan does not cover immunizations or vaccines for foreign travel.

The Fund contracts with Blue KC to provide you with access to two PPO networks comprised of doctors, hospitals, ancillary service providers, and health care facilities that have agreed to provide quality services at discounted fees—the *Preferred-Care Blue* PPO network for medical care in the Kansas City Metro area and the nationwide *Blue Card* PPO network for medical care outside of the Kansas City Metro area. You can see any provider you wish, but you pay less out of your pocket when you receive care from providers who participate in a contracted Blue KC PPO network. The Fund covers a higher percentage of your incurred covered expenses **and** your out-of-pocket maximum under the Plan is lower when you receive your care from Blue KC PPO network providers. To find out if a particular health care provider participates in either of the two contracted Blue KC PPO networks, call **800-340-0109** or visit **www.bluekc.com**.

Coverage Has Increased for Eligible Dependent Children of Active Participants

If you are an active Plan participant, effective January 1, 2014, your dependent children are eligible for coverage under this Plan, even if they are eligible to enroll in another health plan sponsored by either their employer or their spouse's employer. The Plan defines your eligible dependent child(ren) as:

- Any child, whether married or unmarried, until the day he/she turns age 26;
- An unmarried child who is incapable of self-sustaining employment because of a permanent physical or mental condition that is expected to result in death or last for a continuous period of 12 months or more, provided:
  - Such incapacity begins before the child reaches age 19;
  - The child receives more than one-half of his or her financial support and maintenance from you;
  - The child maintains a permanent residence with you during more than one-half of the calendar year; and
  - Proof of such incapacity is submitted to the Trustees within 31 days of the date the child's eligibility would otherwise terminate.

In the case of a divorce or separation, if the disabled child does not have the same principal place of residence as you for over one-half of the calendar year, or if you do not provide over one-half of the disabled child's support, the child will be an eligible dependent provided that:

- You and the disabled child's other parent are:
  - Divorced or legally separated under a decree of divorce or separate maintenance;
  - Separated under a written separation agreement; or are
  - Living apart at all times during the last six months of the calendar year;
- You and the disabled child's other parent provide over one-half of the child's support during the calendar year;

- The disabled child is in the custody of one or both of his/her parents for more than one-half of the calendar year; and
- The disabled child meets all other required eligibility criteria.

Please contact the Fund Office for an enrollment card to enroll any new dependents.

Important Note: If your spouse or child is eligible for benefits as an employee under this Plan, he or she cannot also be covered as your dependent under this Plan.

Dependent Eligibility for Retired Participants Has Not Changed

If you are a retired participant, your spouse becomes eligible for retiree coverage on the date you become eligible, or if later, on the date you marry your spouse. Your dependent children are not eligible for coverage under the Retiree Benefit Plan, but may be eligible to continue their coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 when you retire. For more information about COBRA, contact the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

The Plan's "Grandfathered" Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **816-756-3313** or toll-free at **866-756-3313**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For More Information

If you have any questions about these benefit enhancements or your health care coverage in general, call the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Sincerely,

Board of Trustees

This Summary of Material Modification highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. You can find full details in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND - WAIVER NOTICE

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by the Mo-Kan Teamsters Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit on the following benefits:

- **$350,000 on all covered benefits under Plan 1 (Retirees Only).**
- **$500 on well child care for children through age 18.**
- **$100 on adult vaccines.**
- **$350 on physical exams.**
- **$500 on speech therapy for childhood developmental speech delays.**
- **$150 on office visits related to chiropractic treatment and $50 on x-rays related to chiropractic treatment.**
- **$10,000 per person per limb or device for corrective appliances (prosthetic and orthotic devices, other than dental).**
- **$1,000 on hearing exams and hearing aids.**
- **$1,250 per person for dental coverage for children from birth through age 18.**
- **$250 on vision care received during two consecutive calendar years for children from birth through age 18.**
- **$12,000 per person on chemical dependency treatment.**
- **$500,000 on organ transplants.**

In order to apply the lower limits listed above, the Mo-Kan Teamsters Health and Welfare Fund requested for the Retirees under Plan 1 a waiver of the requirement that coverage for key benefits be at least $750,000. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits in 2011 would result in a significant increase in your premiums or a significant decrease in your access to benefits. The waiver is valid for one year.

- **Wellness and Other Benefits** — The Plan's current annual maximums that apply to wellness benefits, such as well child care, adult vaccines, physical exams, speech therapy, chiropractic treatment, and corrective appliances will still apply.

- **Hearing, Dental and Vision Benefits** — The Plan's current annual maximums for hearing, dental, and vision coverage will still apply.

Refer to the attached Waiver Notice and your Summary Plan Description (SPD) for details on the Plan's current benefit provisions.

THE PLAN'S "GRANDFATHERED" STATUS

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at **816-756-3313** or toll-free at **866-756-3313**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

FOR MORE INFORMATION

If you have questions or concerns about these benefit changes, health care reform in general, or what grandfathered health plan status means and what may cause a plan to lose its grandfathered status, call the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Sincerely,

Board of Trustees

This Summary of Material Modification highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. You can find full details in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MO-KAN TEAMSTERS TRUST FUNDS

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Important Plan Changes
Effective January 1, 2011

April 2011

Dear Participant:

You should have received a letter from the Fund Office in December 2010 announcing Plan changes that became effective January 1, 2011 as a result of the Patient Protection and Affordable Care Act (ACA). However, in light of these economic times, the Board of Trustees requested a waiver of the ACA provision requiring the Plan to eliminate specific annual limits for certain benefits that may be essential health benefits. Consequently, the Fund recently received a one-year waiver from the U.S. Department of Health and Human Services. In order to maintain the Fund's financial stability, the Board of Trustees has decided to accept the waiver. Therefore, **effective January 1, 2011 through December 31, 2011, certain lower annual limits will apply, once again.**

We will notify you immediately of any future changes made to the health benefits the Fund provides to you and your family. In the meantime, this letter provides you with details on the Plan's benefit provisions effective January 1, 2011.

EFFECTIVE JANUARY 1, 2011

- **Annual Limit for Actives in Plan 1 and Plan 2 — A $750,000 annual dollar limit will apply to essential health benefits.** This means the Plan will cover up to $750,000 in essential health benefits' claims cost each year for you and your eligible dependents. The $750,000 per person *lifetime* maximum has been eliminated.

- **Annual Limit for Retirees in Plan 1 — A $350,000 annual dollar limit will apply to essential health benefits.** This means the Plan will cover up to $350,000 in essential health benefits' claims cost each year for you and your eligible dependents. The $350,000 per person *lifetime* maximum has been eliminated.

- **Chemical Dependency Treatment** — The $12,000 per person lifetime maximum on chemical dependency treatment will be changed to a $12,000 annual limit. The Plan will cover only one course of treatment per year.

- **Organ Transplants** — The $500,000 per person lifetime maximum on organ transplants will be changed to a $500,000 annual limit.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Fund Office of the Mo-Kan Teamsters Health and Welfare Fund at 816-756-3313 or toll-free at 866-756-3313.

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Important Plan Changes
Effective January 1, 2011

December 2010

Dear Participant:

As the Board of Trustees of the Mo-Kan Teamsters Health and Welfare Fund, we are pleased to announce the following eligibility and benefit enhancement being made to the Plan, effective January 1, 2011 to comply with the Patient Protection and Affordable Care Act (often referred to as "ACA" or "health care reform").

THE PLAN'S "GRANDFATHERED" STATUS

The Trustees believe this plan is a "grandfathered health plan" under the ACA. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. It is important for you to understand that while the Plan is undergoing changes in order to comply with the ACA, being considered a "grandfathered health plan" under the ACA means that the Plan:

1. Is not required to include certain consumer protections of the ACA that apply to other plans – *for example, provide preventive health services without any cost sharing.*

2. Must comply with certain other consumer protections in the ACA – *for example, the elimination of lifetime limits on benefits.*

3. May not rescind your coverage unless you are provided with 30 days advance written notice. Coverage may not be terminated retroactively except for fraud, intentional material misrepresentation, or non-payment of premiums or contributions.

For further information on grandfathered health plans, you can contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at **1-800-444-3272** or at **www.dol.gov/ebsa/healthreform**, or call the Fund Office at **816-756-3313** or toll free at **866-756-3313**.

BEGINNING JANUARY 1, 2011

- **The Plan will cover children to age 26**

The Plan will cover your children until the day they turn age 26, regardless of whether they are students, live with you, are married or unmarried, disabled, or are receiving continuation coverage under COBRA. This applies to your natural children, and those you have legally adopted or were placed with you for adoption, stepchildren, and foster children. In addition, the Plan will continue to cover children under a Qualified Medical Child Support Order (QMCSO).

In addition, there is no age limit on coverage for an unmarried disabled child who sustains a disability before the day the child reaches age 26, as long as the child is chiefly dependent upon you for financial support, the Fund receives proof of the child's incapacity within 31 days of the date eligibility would otherwise end, and the child meets the other requirements for such dependents that are outlined in the SPD.

Important Note:
If your adult children are eligible to enroll in another health plan sponsored by either their employer or their spouse's employer, they are not eligible for coverage under this Plan until 2014.

- **There will be an "Annual Maximum" instead of a "Lifetime Maximum"**

The $750,000 per person lifetime maximum is being eliminated. However, the Plan may adopt a new per person annual maximum. Further information will be available soon.

If you or your dependent(s) lost coverage because of reaching the Plan's current $750,000 lifetime maximum, you will be given the opportunity to re-enroll yourself and/or your dependent(s) in the Plan during the Special Enrollment period. Refer to the section below.

- **There will be no lifetime maximum on essential benefits**

The Plan is eliminating the lifetime maximums on the following essential benefits:

- The $12,000 per person lifetime maximum on ***chemical dependency treatment***. The Plan will cover only one course of treatment per year.

- The $500,000 per person lifetime maximum on ***organ transplants***.

SPECIAL ENROLLMENT

The Fund is conducting a Special Enrollment period (**December 22, 2010** through **January 22, 2010**). If you enroll yourself or any of your dependents during Special Enrollment, your coverage will be effective January 1, 2011. This special enrollment opportunity applies to:

- You or your dependents who lost coverage due to reaching the lifetime maximum benefit; and

- Because coverage is now being extended to age 26, to children who were not previously eligible to be covered under the Plan because generally, eligibility for dependent coverage previously ended before a child reached age 23.

You can enroll your child in the Plan during the Special Enrollment period if your child does not have coverage through another employer-sponsored health. You will be required to provide a copy of the child's birth certificate.

If your child's eligibility ended when he or she reached age 19 (in accordance with the Plan's current eligibility rules for dependent children) or your child is about to turn age 26, you should notify the Fund Office.

Enclosed with this letter are an Enrollment Form and a Definition of Dependent sheet. To enroll your eligible dependents in the Plan, please do the following:

- **Read the Definition of Dependent sheet to identify your eligible dependents.**

- **Complete the Enrollment Form by filling in the information for all ELIGIBLE dependents.**

- **Sign the Enrollment Form.**

MO-KAN TEAMSTERS HEALTH AND WELFARE FUND
CHILD ENROLLMENT FORM (AGES 19 up to 26th BIRTHDAY)

To be completed for Enrollment for all those natural, adopted and stepchildren of participant who are age 19 to 26. A separate form is required for each child enrollment. Make additional copies of this form if necessary.

Participant's Name _____ Participant's SSN _____

Participant's Address _____

_____

Child's Name _____ Child's SSN _____

Child's Address (*if different from Participant's*) _____

_____

Child's Date of Birth _____ Child's Telephone Number: _____

Your Relationship to Child: ☐ Natural Child ☐ Adopted Child ☐ Step Child ☐ Other: _____

***NOTE:** Unless you have already provided documentation to the Fund Office, you will need to provide a copy of the Child's birth certificate and/or a copy of the legal order to provide medical coverage to the Child.*

Is Child Employed? ☐ YES ☐ NO If YES, Name of Employer _____

Address of Child's Employer (*If employed*) _____

_____

Telephone Number of Child's Employer (*If employed*) _____

Is Child Married? ☐ YES ☐ NO If YES, Name of Child's Spouse _____

Is Child's Spouse Employed? ☐ YES ☐ NO If YES, Name of Employer _____

Address of Child's Spouse's Employer (*If employed*) _____

_____

Telephone Number of Child's Spouse's Employer (*If employed*) _____

_____

I hereby attest that health care coverage is not available to this Child through either his/her direct employer or through his/her spouse's employer. You have our permission to contact the employer(s) listed above, if applicable, for verification of health care coverage availability. I understand that if this information changes, it is our responsibility to notify the Fund Office immediately.

Participant's Signature _____ Date _____

Child's Signature _____ Date _____

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Return this completed Form to the Fund Office:

- **Mail the Enrollment Form in the enclosed pre-addressed envelope.**
- **Make sure that you mail the envelope so that it is postmarked before or on January 22, 2011.**

PLEASE NOTE: you can re-enroll your children who are between the ages of 19 and 26 (whether married or unmarried) and children currently receiving continuation coverage under COBRA—***as long as they do not have access to other employer health care coverage.*** This applies to:

1. Children whose coverage under the Plan already ended;
2. Children who were previously denied coverage under the Plan; and
3. Children who were not previously eligible to enroll in the Plan because eligibility for dependent coverage under the Plan previously ended before the child reached age 26.

Remember: If you do not enroll your dependents by January 22, 2011, they will not be covered under the Plan as of January 1, 2011.

A FINAL NOTE

If you have questions or concerns about the upcoming benefit changes, health care reform in general, or what grandfathered health plan status means and what may cause a plan to lose its grandfathered status, call the Fund Office at **816-756-3313** or toll free at **866-756-3313**.

Sincerely,

Board of Trustees

This Summary of Material Modification (SMM) highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. Full details are contained in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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MO-KAN TEAMSTERS TRUST FUNDS

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MO-KAN TEAMSTERS WELFARE FUND

December 2010

Dear Active Participant,

The Trustees have made some changes and improvements to your Plan of benefits, as follows:

Physical Exam Benefit

The provider for the Physical Exam Benefit has changed to Concentra. Generally, you must use a Concentra provider in order to receive this benefit. However, the Trustees realize that a Concentra provider may not be convenient for you if you live outside of a county in which a Concentra provider is located and they wished to provide you with a physical exam benefit in that case.

Effective July 1, 2005, if you live outside of a county with a Concentra location (currently, outside of the Missouri counties of Bates, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte or Ray, or outside of the Kansas counties of Johnson, Leavenworth, Miami or Wyandotte), the Plan will reimburse you up to $315 toward the cost of your physical exam services. Benefits are provided to you and your spouse once each calendar year if you are age 50 or over, and once every two calendar years if you and your spouse have not yet reached age 50.

Keep in mind that by using Concentra facility, you will receive a comprehensive examination, including all of the services listed on page 46 of your Summary Plan Description. However, if you use a non-Concentra provider, your reimbursement for services is limited to $315, which may not cover as many services provided by Concentra.

Dental Benefits

The Plan's covered medical expenses listed at item 11 on page 25 of your Summary Plan Description has been changed, effective July 1, 2005, to include disabled children, even if they have reached age 23, as follows:

11.	Oral surgery performed by a dentist or dental surgeon except for simple extractions. Such oral surgery includes outpatient oral surgery performed on dependent children who are permanently and totally disabled, even if such Dependent children have reached the age of 23.

The following benefit has been added to the covered medical expenses on page 27 of your Summary Plan Description, effective April 1, 2004:

20.	Hospital, anesthesia, and Physician charges for outpatient dental care for dependent children less than 5 years of age.The following benefit has been added to the covered medical expenses on page 27 of your Summary Plan Description, effective April 1, 2004:

21. Claims for treatment of a dental injury that is the result of an accidental injury, after you have exhausted your benefits under the Plan's dental benefit provisions. You will be subject to the calendar year deductible, coinsurance percentages and lifetime maximum limits for Comprehensive Major Medical Benefits listed in the Schedule of Benefits

Continuation of Coverage if You Enter Military Service

The Plan allows you to continue coverage under the same terms as COBRA coverage when you enter military service. Effective December 10, 2004, you may elect continuation coverage under the Plan for 24 months when you enter military service (18 months if you made your election to continue coverage before December 10, 2004). To prevent a loss of coverage, we recommend you call the Fund Office before you enter military service.

COBRA Continuation Coverage

The explanation of COBRA coverage has been clarified by changing the first paragraph of the section entitled CONTINUATION OF COVERAGE in your Summary Plan Description, as follows:

Under certain circumstances, coverage for you or your eligible dependents under the Mo-Kan Teamsters Health and Welfare Plan can be temporarily continued after it would normally end when you experience a "qualifying event." A qualifying event is one that would cause you and/or your eligible dependents to lose coverage under the Plan, were it not for the continuation provisions of the Federal law known as the Comprehensive Omnibus Budget and Reconciliation Act (COBRA). The Plan's continuation provisions comply with the requirements of COBRA.

The section WHEN COVERAGE CONTINUES FOR 36 MONTHS has been revised, as follows:

WHEN COVERAGE CONTINUES FOR 36 MONTHS

Your eligible dependents may choose to purchase continued benefits for up to thirty-six (36) months if their coverage under the Plan ends for any of the following reasons or "qualifying events":

1. your death;
2. your divorce;
3. your dependent child no longer qualifies for dependent coverage under the Plan; or
4. your entitlement to (eligibility for and enrollment in) Medicare coverage.

If any of these events (1-4) occur when you are retired, your eligible dependents may extend your retiree coverage for 36 months.

If you become entitled to Medicare before you retire and then you terminate employment within 18 months of becoming entitled to Medicare, your coverage may continue under COBRA for up to 18 months from the termination of your employment. However, coverage for your eligible dependents may continue under COBRA for up to 36 months from the date you became entitled to Medicare.

The Plan's Eligibility Provisions

Effective March 1, 2004, the following sections have been added to page 8 of your Summary Plan Description after the REINSTATEMENT OF ELIGIBILITY section:

TERMINATION OF ELIGIBILITY

Your coverage under the Plan will end on the earlier of:

- The last day of the month that the Fund does not receive the required employer contributions made on your behalf; or,
- The first day that you work for an employer whose contractual obligation to contribute to the Fund has ended.

SPECIAL ENROLLMENT PROCEDURES

1. For Active Employees:

If you are an Active Employee, and you decline enrollment for yourself or your dependents (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards that other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption by contacting the Fund Office.

2. For Retirees:

If you are a Retiree who is participating in the Plan and you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll the new dependent in the Plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption by contacting the Fund Office.

The Board of Trustees will continue to monitor the financial condition of the Welfare Fund in order to provide the best benefits possible for all Plan participants, while maintaining the long-term stability of the Fund.

If you have any questions about the changes to the Plan, please call the Fund Office at 816-756-3313 or toll-free at 866-756-3313.

Sincerely,

BOARD OF TRUSTEES

This announcement contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there are any variations between the information contained in this announcement and the documents that establish the Plan provisions, the documents describing the Plan provisions will prevail. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime.

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

Announcing Important Changes to Your Health Plan Benefits

June 2009

Dear Plan 1 and Plan 2 Participants:

As the Trustees of your Health and Welfare Plan, we are committed to providing you and your eligible dependents with the best possible benefits. As part of our ongoing efforts to enhance coverage whenever possible, we have recently made some important changes to your Health and Welfare Plan benefits.

Specifically, the Trustees have approved the following changes to the benefits available to you, and your spouse and eligible dependent children, if any:

- **Coverage for Physician Services and Procedures Related to Contraception—Effective March 31, 2008**

  The Plan covers the costs associated with non-prescription contraceptive methods that are administered, inserted or removed by a physician, including Intrauterine Devices (IUDs), diaphragms, and cervical caps. Coverage is in accordance with the same Plan provisions that currently apply to other covered medical benefits as follows:

Medical Benefits	Plan 1	Plan 2
Calendar Year Deductible	$250 per person; $500 family maximum	$400 per person; $800 family maximum
Coinsurance:	After deductible is met, Plan pays:	After deductible is met, Plan pays:
PPO	85%	75%
Non-PPO	70%	60%

  The Medical Plan's annual out-of-pocket maximum and lifetime maximum also apply.

  This benefit **does not** include coverage for emergency contraceptives or procedures for permanent sterilization, such as vasectomies and tubal ligation.

Coverage for Contraceptives Prescribed by a Physician—Effective August 1, 2008

The Plan covers the costs associated with the purchase of any birth control method prescribed by a physician, including oral contraceptives, skin patches, and hormonal vaginal contraceptives. Coverage is in accordance with the same Plan provisions that currently apply to other covered prescription medications as follows:

Prescription Drug Benefits	Plan 1 and Plan 2
Retail Mail Order	34-day supply or 100 unit dose 90-day supply
Coinsurance: Plan Pays You Pay	 80% 20%

Your prescription drug out-of-pocket expenses will not count toward meeting your medical calendar year deductible or out-of-pocket maximum.

This benefit **does not** include coverage for over-the-counter contraceptives.

Allowing Cancellation of Plan Coverage to Allow Eligibility in a Health Savings Account—Effective November 1, 2008

Effective November 1, 2008, the Fund will allow your spouse to cancel his or her participation in the Mo-Kan Teamsters Health and Welfare Plan if he or she wants to enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) program sponsored by his or her employer. To cancel participation in the Plan, you and your spouse must submit a written request to the Fund Office which is effective only upon Trustee approval.

Note: Your spouse may resume his or her participation in the Plan if the other coverage is terminated and he or she still meets the definition of a dependent as defined by the Plan. However, he or she will be required to submit a written application to the Plan no later than 45 days after termination of the other coverage, and provide the Fund Office with a Certificate of Creditable Coverage showing proof of coverage under his or her employer-sponsored HDHP.

Allowing Special Enrollment in the Plan to Comply with the Children's Health Insurance Program Reauthorization Act of 2009—Effective April 1, 2009

You, your spouse, and your dependents may enroll in the Plan if you have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You, your spouse, and your dependents may also enroll in the Plan if you become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Removing the Separate Calendar Year Maximum and Lifetime Maximum for Physical Therapy Benefits—Effective August 1, 2008

Coverage for physical therapy is now paid in accordance with the same Plan provisions that currently apply to other covered medical benefits as follows:

Medical Benefits	Plan 1	Plan 2
Calendar Year Deductible	$250 per person; $500 family maximum	$400 per person; $800 family maximum
Coinsurance: PPO Non-PPO	After deductible is met, Plan pays: 85% 70%	After deductible is met, Plan pays: 75% 60%

The separate $5,000 per calendar year maximum and $10,000 per lifetime maximum no longer apply. Physical therapy benefits are subject to the annual out-of-pocket maximum and lifetime maximum applicable under the Plan's Medical Benefit.

Coverage for Dental Claims In Excess of Annual Maximum When Recommended by a Physician Prior to Radiation Therapy—Effective September 1, 2008

The Plan does not apply an annual maximum limit to coverage associated with dental work you receive before you undergo radiation therapy to treat cancer, *if* the pre-radiation dental treatment is recommended by a physician. Charges in excess of the annual maximum dental benefit will be paid as a Major Medical benefit.

Coverage for all other dental work is paid in accordance with the Plan provisions that currently apply, as follows:

Dental Benefits	Plan 1 and Plan 2
Calendar Year Maximum	$1,250 per person
Calendar Year Deductible	$25 per person
Coinsurance: Type A Expense (includes routine oral exams and x-rays) Type B Expense (includes root canal therapy, extractions, oral surgery, and repairs) Type C Expense (includes inlays, crowns, and installation of dentures)	After deductible, Plan pays: 80% 60% 50%
Orthodontia – Type D Expense	No deductible. Plan pays 50% up to $1,500 lifetime maximum

Extended Coverage for Dependent Students—Effective January 1, 2010

The Fund currently provides benefit coverage for any unmarried children who depend on you for over one-half of their support during the calendar year while they attend an accredited college, university, or vocational school on a full-time basis. The Fund provides such coverage until the child's 24th birthday.

In compliance with federal legislation recently adopted called "Michelle's Law," beginning January 1, 2010, the Fund will provide extended benefit coverage for up to one year for any of your dependent children who take a medical leave of absence from a post-secondary educational institution—***if all of the following apply***:

1. The child's medical leave of absence begins on or after January 1, 2010;

2. The leave results from a serious illness or injury and is medically necessary, as certified in writing by the physician treating the child;

3. On the day before the medical leave of absence begins, the child is entitled to coverage under the provisions of the Plan applicable to students at post-secondary educational institutions; and

4. The leave otherwise would result in the child's loss of student status for Plan coverage purposes.

If the child's medical leave of absence meets ***all*** of the criteria listed above, coverage for that child will be continued for up to one year from the beginning of the leave. However, the extended coverage may end before the year is up if the child reaches age 24—at which time you or your child can choose to continue his or her coverage by electing COBRA Continuation Coverage and making the necessary self-payments to the Fund.

Remember, determination of whether you are covered under Plan 1 or Plan 2 is based on the hourly contribution rate paid by your employer on your behalf. If you have any questions about your enhanced benefits or need to find out which plan you are eligible for, contact the Fund Office at **816-756-3313** or toll-free at **866-756-3313**.

Sincerely,

Board of Trustees

This announcement contains only highlights of certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there are any variations between the information contained in this announcement and the documents that establish the Plan provisions, the documents describing the Plan provisions will prevail. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime.

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MO-KAN TEAMSTERS TRUST FUNDS

3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

May 22, 2007

Dear Participants and Retirees:

The Board of Trustees would like to take this opportunity to announce the following improvements to the Mo-Kan Teamsters Welfare Plan:

- Effective January 1, 2007, the per person Lifetime Maximum is being increased from $500,000 to $750,000 for Actives and their beneficiaries.
- Effective January 1, 2007, the per person Lifetime Maximum is being increased from $250,000 to $350,000 for Retirees and their beneficiaries.

If you have any questions regarding these benefit changes please contact the Fund Office at (816) 756-3313, or toll-free at 1-866-756-3313.

Sincerely,

Board of Trustees
Mo-Kan Teamsters Health & Welfare Fund

MO-KAN TEAMSTERS TRUST FUNDS
3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
816.756.3313 • FAX 816.756.3659 • TOLL FREE 1.866.756.3313

Announcing Important Plan Changes

Date: December 2018

To: Active Members, Non-Medicare-Eligible Retirees and Their Qualified Dependents Participating in the Mo-Kan Teamsters Health and Welfare Fund

From: The Board of Trustees

This Summary of Material Modifications (SMM) informs you of important Plan changes, which include those made to the prescription drug and dental benefits offered by the Mo-Kan Teamsters Health and Welfare Fund, effective January 1, 2019. Please read this SMM carefully, share it with your family, and store it with your Summary Plan Description ("SPD") and other SMMs you have received from the Fund.

Switch to OptumRx, Effective January 1, 2019

As the Board of Trustees of the Fund, our goal is to provide quality benefits that meet the needs of participants and their eligible dependents. Due to the constant rise in prescription drug costs, we have taken measures to ensure that the Plan can continue to provide comprehensive, high-quality prescription drug benefits that are affordable for both you and the Fund.

Therefore, effective January 1, 2019, the Fund is switching from CastiaRx to OptumRx as the Fund's prescription drug program provider. **The switch will not affect our Plan's benefit structure and your prescription drug benefits are NOT changing.**

- The **copays** for Generic and Brand name medications, as well as the coinsurance for Specialty medications, if applicable, are **staying the same** at both retail pharmacies and through mail order.
- The **annual per person out-of-pocket maximums** are **not changing.**
- You will still have access to a **national pharmacy network**, so you will not have to switch to a different pharmacy.
- The current **mail order** program will not change, except **you will have the option to fill 90-day prescriptions for maintenance medications** at retail pharmacies **through OptumRx's 90-day program.**
- **To avoid any interruptions** with your daily prescription medications, please **make sure you have enough medication to cover your needs through the end of December 2018 and the beginning of January 2019.** Also, before January 1, 2019, be sure to ask your doctor to provide you with a new prescription for any controlled substances or compound medications that you have filled through mail order.
- **Specialty medications** will be **filled by BriovaRx**, the Optum specialty pharmacy. Information about BriovaRx will be mailed to you if you are currently taking a specialty medication.
- You will receive a **new ID card** in the mail. When you receive the new ID card, keep it in a safe place and start using it January 1.
- **Share your new ID card with your doctors** so they can review the OptumRx formulary and decide if you should continue taking the same medication or switch to an alternative medication. You should also **share the new ID card with your pharmacist.**

You will receive more information directly from OptumRx as we get closer to January 1, 2019. In the meantime, to learn more about OptumRx, visit www.optumrx.com.

New Blue Cross Blue Shield of Kansas City Dental Network (For Active Plan Participants Only), Effective January 1, 2019

If you are an Active Plan participant, the Fund currently provides dental care coverage for you and your eligible dependents. We are pleased to announce that, effective January 1, 2019, the Fund will enter into a contract with Blue Cross Blue Shield of Kansas City (BCBSKC) that will allow you access to BCBSKC's "*Blue Dental Choice / GRID+*" PPO network and discounted dental services. **Note that your medical benefits, provided through BCBSKC, are NOT changing**. With respect to your dental coverage:

- You will automatically be eligible to access the *Blue Dental Choice / GRID+* PPO network.
- You will still be allowed to see your current dentist, even if he/she **does not** participate in the *Blue Dental Choice / GRID+* PPO network.

The following table shows how eligible dental expenses will be covered by the Plan:

	"Blue Dental Choice / *GRID+*" PPO Plan Benefit	
	In Network (You Pay)	**Out of Network (You Pay)**
Annual Deductible – Per Person (waived for Preventive Services)	$25	$25
Annual Plan Maximum – Per Person*	$1,750	$1,750
Orthodontic Lifetime Maximum	$1,500	$1,500
	In Network (Plan Covers)	**Out of Network (Plan Covers)**
Diagnostic and Preventive Services Oral Examinations, Cleanings Adult/Child, Fluoride, Sealants, X-Rays – Bitewing, X-Rays – Full Mouth Series, Space Maintainers	80%	80%
Basic Services Oral Surgery, Extractions, Endodontics, Periodontics, General Anesthesia/Intravenous Sedation, Amalgam Restorations	60%	60%
Major Services Inlays/Onlays, Labial Veneers, Crowns, Crown and Bridge Repair, Prosthodontics (first installation of dentures and bridges), Pontics, Removable Bridge, Full & Partial Dentures, Prosthodontics (adding to existing partial denture)	50%	50%
Orthodontic Services (Individuals up to age 19)	50%	50%

* Note: The Annual Plan Maximum increased from $1,250 per person to $1,750 per person.

Save Money—Always Try to Use *"Blue Dental Choice / GRID+"* Network Dentists

While the percentage ("coinsurance") you pay out-of-pocket for the dental care you receive is the same regardless of whether you receive your dental care in-network or out-of-network, **you'll pay more out-of-pocket when you receive care from non-network dental providers because their services will not be discounted.** The dentists and orthodontists who participate in BCBSKC's *Blue Dental Choice / GRID+* PPO network have agreed to charge discounted rates for the dental care they provide, which means you and the Fund will save money when you use a network dentist. In addition, *Blue Dental Choice / GRID+* network dentists will not balance bill you for charges in excess of the discounted amount.

Because BCBSKC has a large, nationwide dental network, the dentist that you currently see may already participate in the *Blue Dental Choice / GRID+* PPO network. However, if he or she does not participate in the *Blue Dental Choice / GRID+* PPO network, you will still be free to get your dental care from that dentist and receive Plan benefits. To find out if your dentist participates in the network, visit www.bluekc.com. **If your dentist is not contracted with BCBSKC, we recommend that you do one of three things:**

1. **Switch** to a *Blue Dental Choice / GRID+* PPO network dentist; or
2. **Ask your dentist to join** the *Blue Dental Choice / GRID+* PPO network; or
3. **Nominate your dentist for network participation.** To do so, go to www.bluekc.com, click on 'Find a Doctor' in the upper right corner of the Home Page and then scroll down to the 'Find a Dentist' section. Click on 'Search for Dentists Nationwide' and then 'Nominate a Dentist' in the upper right hand corner. A dentist nomination form will appear, which you can complete and submit.

Active Plan Participants: Be On the Lookout for Your New ID Card—Coming in December 2018

You will receive a new ID card in the mail from BCBSKC. Be sure to show the ID card to any medical and dental providers from whom you wish to receive care, beginning January 1, before the care is provided. Also, remember to throw your old medical ID card away and replace it with the new card that you will receive.

Changes to Claims and Appeals Procedures for Disability Benefits, Effective April 1, 2018

The Trustees have amended the Plan to comply with new federal regulations. If you filed a disability claim on or after April 1, 2018 and your claim was or is denied, if you file an appeal, you will have access to additional information, including:

- An explanation of why the Plan may have disagreed with some of the medical information you submitted; and
- Any internal rules relied on and technical scientific or medical information used to process your claim.

Required Court to File a Lawsuit, Effective August 2, 2018

Effective August 2, 2018, if you or one of your eligible dependents files a lawsuit or legal action against the Fund, that lawsuit or legal action can only be filed in the U.S. District Court for the Western District of Missouri. Your right and those of your eligible dependents to file a lawsuit or other legal action against the Fund or in connection with the Fund have not changed.

Notice of Grandfathered Status

The Mo-Kan Teamsters Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 866-756-3313 (toll-free) or 816-756-3313. You may also contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Questions?

If you have any questions about the information in this SMM or your benefits in general, please call the Fund Office at 866-756-3313 (toll-free) or 816-756-3313.

Sincerely,

Board of Trustees

This Summary of Material Modifications highlights certain features of the Mo-Kan Teamsters Health and Welfare Fund. Full details are contained in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

MO-KAN TEAMSTERS TRUST FUNDS
3100 BROADWAY • SUITE 805 • KANSAS CITY, MISSOURI 64111
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COBRA Continuation of Coverage Rights

Group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. Written notice of your COBRA rights must be provided within 90 days after you first become a participant under the plan. In addition, group health plans must give an employee's spouse a general notice describing COBRA rights within the first 90 days of becoming eligible for coverage under the plan.

MO-Kan Teamsters Trust Funds or the "Plan" provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

What is COBRA Continuation Coverage?
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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under the Plan.

This notice contains important information about your right to COBRA continuation coverage, which is a *temporary extension* of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This notice generally explains COBRA coverage, when it may become available to an Employee and their family and what you need to do to protect the right to receive it. As used in this notice, the term "Employee" includes Retirees as the case may be.**

Under COBRA, what benefits must be covered?
Coverage options may be limited depending on the type of coverage that the Qualified Beneficiary had at the time of the Qualifying Event. COBRA applies only to the following group health plan benefits offered under the Plan:

- Comprehensive Medical Benefits
- Mental Health and Substance Abuse Benefits
- Organ Transplant Benefits
- Prescription Drug Benefits
- Dental and Vision Benefits

COBRA does *not* apply to other benefits offered under the Plan:

- Basic and Supplemental Life Insurance and AD&D Benefits
- Disability Hours Credit
- Long-Term Disability Benefit
- Surviving Dependent Extension

Who is entitled to continuation coverage under COBRA?
In order to be entitled to elect COBRA continuation coverage, your group health plan must be **covered** by COBRA; a **Qualifying Event** must occur; and you must be a **Qualified Beneficiary** for that event.

Is the Plan covered by COBRA?	Qualified Beneficiary	Individual	Qualifying Event
Yes	A Qualified Beneficiary is an individual who is entitled to COBRA continuation coverage or a child born to, or placed for adoption with a Qualified Beneficiary who is an Employee or Retiree. An Employee, Retiree or Dependent may become a Qualified Beneficiary if coverage under the Plan is lost because of a Qualifying Event.	Eligible Employee	▪ Hours of employment are reduced; or ▪ Employment ends for any reason other than gross misconduct.
		Dependent Spouse or Dependent Child	▪ The death of an Employee or Retiree; ▪ The Employee's hours of employment are reduced; ▪ The Employee's employment ends for any reason other than gross misconduct; ▪ Divorce or legal separation; or ▪ The Dependent Child no longer meets the Plan's definition of a Dependent Child.

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Notice of Some Qualifying Events must be given
When the Qualifying Event is the end of employment or reduction of hours of employment, or the death of the employee, the Plan Administrator will determine whether and when the Qualifying Event has occurred. However, notice of other Qualifying Events must be provided to the Fund Office. The Fund Office must be notified in writing, of a legal separation, divorce, or a child losing Dependent status under the Plan within 60 days after the later of:

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

To help ensure that you do not suffer a gap in coverage, **we urge you or your family to notify the Fund Office, in writing, of Qualifying Events as soon as they occur. If you do not notify the Fund Office within the applicable 60-day time period, you will lose your right to elect COBRA continuation coverage.**

Electing COBRA Continuation Coverage
Once the Fund Office has determined that a Qualifying Event has occurred, you will be notified whether you have a right to elect COBRA continuation coverage. If you are *not* eligible for COBRA continuation coverage, you will be notified of the determination and you will be provided information regarding why you are not eligible.

Once you receive a COBRA continuation coverage notice, if you wish to elect COBRA continuation coverage, you must respond within 60 days after the *later* of:

- The date the COBRA continuation coverage notice was mailed.
- The date you would lose coverage due to the applicable Qualifying Event.

Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries and parents may elect COBRA continuation coverage on behalf of their children. **Any Qualified Beneficiary for whom COBRA continuation coverage is *not* elected within the 60-day election period will lose his or her right to elect COBRA continuation coverage.**

How Long does COBRA Continuation Coverage Last?

<u>When COBRA Coverage Continues for 18 Months</u>

You may elect COBRA continuation coverage for up to 18 months if coverage ends due to termination of employment or reduction in hours.

When COBRA Coverage Continues for 29 Months

If coverage ends due to termination of employment or reduction in hours and, at that time or within 60 days of the date coverage ends, a Qualified Beneficiary is Totally Disabled (as determined by the Social Security Administration), coverage may continue for the Employee and Dependents for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Fund Office. In addition, if the Employee (or a Dependent) later learns that he or she is no longer considered Totally Disabled by the Social Security Administration, you must notify the Fund Office, in writing, within 30 days of the determination.

When COBRA Coverage Continues for 36 Months

An Employee's Dependents may elect COBRA continuation coverage for up to 36 months if coverage ends because of an Employee's:

- Death
- Legal separation or divorce
- Dependent child no longer qualifying for Dependent coverage under the Plan

If a second Qualifying Event occurs during the initial 18 month coverage period, the maximum period of continuation coverage is extended to 36 months. A second Qualifying Event may include the death of the Employee, divorce, or legal separation or a Dependent child no longer meeting the Plan's definition of a Dependent. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. To be eligible for the extension from 18 to 36 months, a Qualified Beneficiary must notify the Fund Office in writing of the second Qualifying Event within 60 days of the date of the second Qualifying Event.

Enrollment in Medicare

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment and the employee became eligible for Medicare, the maximum period of coverage will be the longer of 36 months from the date the Employee's Medicare initially became effective or 18 months from the date his Dependent's coverage would have been lost due to the Qualifying Event. Please keep in mind that Medicare entitlement by an Employee *following* a termination of employment or reduction in hours is *not* a second Qualifying Event and does not result in an extension of coverage for Dependents.

Additional Notices You Must Give to the Fund Office

Notice of Second Qualifying Event

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 Fund Office within 60 days of the second Qualifying Event in order to extend the maximum COBRA continuation coverage period to 36 months.

Notice of Disability

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 60 days of COBRA continuation coverage, the Qualified Beneficiary must provide written notice of such disability to the Fund Office 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 and before the end of the 18 month period of COBRA continuation coverage. 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 Fund Office within 30 days after the Social Security Administration's determination.

Content of Notices
All notices must be in writing and submitted to the Fund Office. The notices must contain the following information:

- The Eligible Employee's name.
- The Eligible Employee's Social Security number.
- The eligible Dependents' names and Social Security numbers.
- The Eligible Employee's mailing address and/or the eligible Dependents' mailing addresses.
- The date and nature of the Qualifying Event.

The chart below shows the additional documents that will be required and the time limits within which you must send the documents to the Fund Office:

Qualifying Event	Document(s) Required	Time Limits to Send to Fund Office
Divorce	Divorce decree	Within **60 days** after the Qualified Beneficiary would lose coverage as a result of the divorce.
Disability Determination	Copy of Social Security or Railroad Retirement Disability Determination Letter	Within **60 days** after the date of the disability determination letter.
Change in Disability Status	Copy of Social Security or Railroad Retirement Determination Letter	Within **30 days** after the date of the Social Security Administration's or Railroad Retirement's final determination that the individual is no longer disabled.

Paying for COBRA Continuation Coverage
Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost for COBRA continuation coverage will be determined by the Trustees on an annual basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended disability COBRA continuation coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first payment for COBRA continuation coverage must include payments for any months retroactive to the day coverage under the Plan ended through the month the initial payment is made. Your first payment is due no later than 45 days after the date you or your Dependents signed the COBRA continuation coverage election form and returned it to the Fund Office.

Subsequent payments are due on a monthly basis and must be postmarked or delivered by the 15th day of the month before the coverage month. **Note**: Self-payments will not be accepted after the expiration of a 30-day grace period from the payment due date. **Once your COBRA continuation coverage ends, it cannot be reinstated.**

Certificate of Creditable Coverage
When your medical coverage under the Plan ends and again when COBRA continuation coverage ends, you will be provided with a Certificate of Creditable Coverage. The Certificate will specify the period you were covered under the Plan and additional information required by law. This may help reduce or eliminate any pre-existing limitation under a new group medical plan.

In addition, a Certificate of Creditable Coverage will be provided after receipt of a request for such Certificate. The request must be filed with the Fund Office and must include the names of the individuals for whom a certificate is requested and the address where the certificate should be mailed.

Termination of Continued Coverage
The period of COBRA continuation coverage will terminate before the end of the 18, 29, or 36 month period if:

- A COBRA self-payment is not made by the due date.
- The Fund stops providing any group health benefits.
- A Qualified Beneficiary becomes covered under any other group health care plan after the date on which COBRA continuation coverage is elected (provided such plan does not contain any pre-existing condition exclusions or limitations).
- The date a Qualified Beneficiary becomes entitled to Medicare after the date on which COBRA continuation coverage is elected.
- With respect to a totally and permanently disabled Qualified Beneficiary and his eligible family members who are extending continuation coverage an additional 11 months, 30 days after the month in which Social Security determines that the totally and permanently disabled Qualified Beneficiary is no longer disabled.
- The Qualified Beneficiary's continuation coverage is terminated for cause (for example, because the Qualified Beneficiary submitted fraudulent claims).

Effect on Retiree Medical Plan Eligibility or Surviving Dependents Extension Eligibility
An election or rejection of COBRA continuation coverage will have the following effect on Retiree coverage eligibility and/or the option to elect the surviving dependent's extension:

- When a Qualified Beneficiary is offered COBRA continuation coverage and is also offered Retiree coverage due to the Eligible Employee's Annuity Starting Date, an election of COBRA continuation coverage (made by or on behalf of such Qualified Beneficiary) will constitute a waiver of the Qualified Beneficiary's right to enroll in Retiree coverage at any time.
- If a Qualified Beneficiary rejects COBRA continuation coverage, that rejection does not preclude his right to enroll in Retiree coverage.
- When a Dependent is offered COBRA continuation coverage and that Dependent is also eligible for the surviving dependent's extension, an election of COBRA continuation coverage (made by or on behalf of the Dependent) will constitute a waiver of the Employee's Dependent's right to enroll in the surviving dependent's extension at any time.

Loss of Other Coverage
A Qualified Beneficiary enrolled in COBRA continuation coverage may enroll his Dependent(s) under his coverage option subsequent to the initial election period under the following conditions:

- The Dependent must have been eligible to enroll in COBRA continuation coverage.
- When continuation coverage was initially offered to the Dependent and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage.
- The Dependent's other health coverage is lost before the expiration of the Qualified Beneficiary's COBRA continuation coverage period and such loss is due to exhaustion of continuation coverage under the other plan or loss of eligibility for the coverage, or employer contributions toward the Dependent's other health coverage cease.

If all of the above requirements are met, the Qualified Beneficiary may enroll the Dependent(s) for the remaining period of his continuation coverage upon the proper application and required

proof of dependency and payment of the applicable self-payment within 31 days from the date the Dependent's other coverage terminates.

Affordable Care Act
Please consider that when you become eligible for COBRA, you may also become eligible for other health coverage options that may cost less than COBRA continuation coverage. For example, you may be able to buy an individual plan through the Health Insurance Marketplace, which could mean lower monthly premiums and out-of-pocket costs. You can learn more about options through the Marketplace at www.HealthCare.gov.

More Information about Individuals who may be Qualified Beneficiaries
If you are an Eligible Employee and you have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add the child to your coverage. To have this child added to your coverage, you must provide written notification to the Fund Office within 30 days of the birth, adoption, or placement for adoption of the child.

Children born, adopted, or placed for adoption as described above, have the same COBRA continuation coverage rights as a Dependent who was covered by the Plan before the event that triggered COBRA continuation coverage. Like all Qualified Beneficiaries with COBRA continuation coverage, continued coverage for these children depends on timely and uninterrupted payments being made on their behalf.

If You have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site).

Keep Your Plan Informed of Address Changes
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.

Plan Contact Information
You may obtain information about the Plan and COBRA continuation coverage from:

MO-Kan Teamsters Trust Funds
COBRA Department
3100 Broadway, Suite 805
Kansas City, MO 64111

Amendment No. 44 to the
Mo-Kan Teamsters Health and Welfare Fund

Restated Plan Rules and Regulations
As of June 1, 1995

Effective March 1, 2020, Article III Section 5, "General Plan Exclusions and Limitations," is amended to add a new item to the end of the list, which reads as follows:

Section 5. General Plan Exclusions and Limitations.

No benefits shall be payable under this Plan for any of the following:

Expenses related to gene therapy, which typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems, whether the gene therapy has received approval from the U.S. Food and Drug Administration (FDA) or is considered experimental or investigational. Gene therapy is excluded from both medical and prescription drug coverage.

* * *

The preceding amendment was adopted at the Trustees meeting on the 6th day of Feb 2020.

Greg Davey, Chairperson

Mike Keeran, Secretary

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