

**Greater Kansas City Laborers  
Welfare Fund**

*Summary Plan Description/Plan Document  
2005 Edition*

## **Greater Kansas City Laborers Welfare Fund**

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*This booklet has been prepared for active and retired Participants of the Greater Kansas City Laborers Welfare Fund and serves as the Plan's legal document that establishes the Plan. The Trustees have the sole discretion and authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the Participant or Beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Trustees reserve the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment.*

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# Introduction

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## About This Booklet

The Board of Trustees of the Greater Kansas City Laborers Welfare Fund (or Plan) is pleased to provide you with this updated Summary Plan Description (SPD), which contains current health and welfare information for active and Retired Employees and their Dependents. This booklet also serves as the Plan's official Plan Document. The benefits described in this booklet are effective as of May 1, 2005.

In this booklet, we've organized the information in an easy-to-understand format. These are some of the sections included in the booklet:

- **Schedule Of Benefits**—An at-a-glance summary of Plan benefits.
- **Important Contact Information**—This tells you who to call when you have a question about your benefits.
- **Life Events**—Details how your benefits are affected by different events that can occur in your life.
- **Detailed Benefit Information**—In-depth explanations about the Plan's medical, prescription drug, vision, disability and death benefits.
- **How To File A Claim**—Gives you a step-by-step process for filing Claims, including what you need to do if a Claim is denied.
- **Definitions**—Defines important terms used throughout the booklet. You can recognize defined terms because the first letter of the term is capitalized.

## Benefits Provided By The Fund

The Fund offers comprehensive health care coverage to help you and your Dependents stay healthy. This coverage can also help provide financial protection against catastrophic health care bills. In addition to medical benefits, the Plan provides active and Retired Employees and their eligible Dependents with:

- Dental benefits;
- Prescription drug coverage;
- Vision benefits; and
- Death benefits.

Active Employees are also eligible for weekly accident and sickness benefits and accidental death and dismemberment (AD&D) benefits. In addition, the Fund offers a Member Assistance Plan (MAP) administered through Employee Health Services, Inc. The MAP offers assistance with substance abuse, family/marital conflicts, financial problems, mental health concerns, and other personal issues. For more information about the MAP, contact Employee Health Services, Inc. (see page 7 for contact information).

## Your Role

It is the Trustees' goal to maintain a financially stable Fund while providing comprehensive health care coverage to you and your family. This becomes more challenging as health care costs

continue to rise annually at double-digit rates. The Fund has implemented some cost-saving measures such as medical deductibles, out-of-pocket maximums and a medical Preferred Provider Organization (PPO) to ensure that the Fund can meet your current and future health care needs.

You can help the Fund manage health care costs by:

- **Visiting PPO providers**—PPO providers, including Hospitals, Physicians and other health care providers, may charge negotiated rates that are often less than non-PPO providers' rates. Also, the Plan pays a higher percentage when you use PPO providers.
- **Fill prescriptions at preferred pharmacies**—The Fund has contracted with a network of pharmacies that have agreed to charge negotiated rates for prescription drugs. Using a preferred pharmacy will save you and the Fund money.
- **Consider emergency treatment alternatives**—In the event of an emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can receive the same level of care at a Physician's office or an urgent care facility as in an emergency room. Keep your Physician's telephone number easily accessible and locate the urgent care facility nearest your home so you'll be prepared in case of an emergency.
- **Review receipts and explanations of benefits (EOBs) carefully**—Sometimes providers incorrectly bill for their services. It's important to review all receipts and EOBs to ensure that charges are correct and that you are receiving PPO or preferred rates when appropriate.

Please take some time to review this booklet. If you're married, share this booklet with your spouse. We recommend that you keep this booklet with your important papers so you can refer to it when needed. If you have questions about the benefits described in this booklet, contact the Fund Office at (913) 236-5490.

Sincerely,

The Board of Trustees

## Schedule Of Benefits

<b><i>Comprehensive Medical Benefit</i></b>	
<b>For Active Employees, Retired Employees And Dependents</b>	<b>Coverage</b>
<b>Calendar year deductible</b>	
In-network	\$300 per person; \$500 per family
Out-of-network	\$400 per person; \$800 per family
<b>Hospital non-notification deductible</b>	
	\$200 for each failure to notify the Fund of planned inpatient hospitalization or emergency hospital admissions
<b>Copayment</b>	
In-network	Plan pays 81% of covered charges
Out-of-network	Plan pays 70% of covered charges
<b>Calendar year out-of-pocket maximum (includes deductibles and copays)</b>	
In-network	\$2,000 per person; \$4,000 per family
Out-of-network	\$3,000 per person; \$6,000 per family
<b>Lifetime maximum</b>	
	\$500,000
<b>Mental and nervous disorder treatment<sup>1</sup></b>	
In-network	Plan pays 81% of covered charges
Out-of-network	Plan pays 70% of covered charges
Outpatient treatment maximum	52 visits per calendar year
<b>Alcoholism and substance abuse treatment<sup>2</sup></b>	
First course of treatment in a three calendar-year period:	
In-network	Plan pays 81% of covered charges
Out-of-network)	Plan pays 70% of covered charges
Subsequent courses of treatment in a three calendar-year period:	
In-network	Plan pays 51% of covered charges
Out-of-network)	Plan pays 40% of covered charges
Maximum days per course of treatment	90
Maximum inpatient days per course of treatment	21
Maximum outpatient visits per course of treatment	45
Lifetime maximum <sup>3</sup>	\$25,000
<b>Chiropractic treatment<sup>4</sup></b>	
Daily limit	\$20
Calendar year maximum	\$240

<sup>1, 2 & 4</sup> You must satisfy the Plan's calendar year deductible before the Plan begins to pay benefits for covered services. Not subject to the out-of-pocket maximum.

<sup>3</sup> Subject to the \$500,000 comprehensive medical lifetime maximum.

**Comprehensive Medical Benefit (continued)**

For Active Employees, Retired Employees And Dependents

Coverage

<b>Laser eye surgery</b>	
Lasik surgery if you are farsighted and have astigmatism (active Employees only)	\$1,500 maximum lifetime allowance per eye
Radial keratotomy (RK), photorefractive keratectomy (PRK), and automated lamellar keratoplasty (ALK) if your nearsightedness cannot be corrected by glasses or contact lenses to at least minus 1 diopter (active Employees, Retired Employees, and Dependents)	
<b>Wellness physicals</b> (active Employees and their spouses only)	Plan pays 100% once each calendar year through the Health Promotion Division of Employer Health Services. See 24 for more information.
<b>Outpatient speech therapy<sup>5</sup></b>	
For restoration of lost speech	
In-network	Plan pays 81% of covered expenses
Out-of-network	Plan pays 70% of covered expenses
For developmentally-related speech therapy for Dependents up to age 12	
Coinsurance	Plan pays 50% of covered expenses
Calendar year maximum	\$1,000
Lifetime maximum	\$5,000
<b>Member assistance program</b>	Plan pays 100%
<b>Prosthetic devices</b>	
In-network	Plan pays 81% after deductible
Out-of-network	Plan pays 70% after deductible
Lifetime maximum <sup>6</sup>	\$25,000 per person
<b>Hearing benefit<sup>7</sup></b>	
In-network	Plan pays 81% of covered expenses
Out-of-network	Plan pays 70% of covered expenses
Maximum benefit per instrument	\$1,000
Hearing instrument limitation	One instrument for each five-year period for adults, including maintenance (every three years up to age 19 for Dependents)
Hearing test maximum	\$75 every 24 months

<sup>5</sup> Charges do not apply to the out-of-pocket maximum.

<sup>6</sup> Subject to the \$500,000 comprehensive medical lifetime maximum.

<sup>7</sup> All hearing tests and aids must be performed and dispensed by a Physician or licensed audiologist. Covered charges are not subject to a deductible or out-of-pocket maximum, but are subject to the comprehensive medical lifetime maximum.

**Comprehensive Medical Benefit (continued)**

For Active Employees, Retired Employees And Dependents Coverage

**Dental expense benefit<sup>8</sup>**

In-network	Plan pays 81% of covered expenses
Out-of-network	Plan pays 70% of covered expenses
Maximum calendar year benefit	\$1,000 per person

**Prescription Drug Benefit**

For Active Employees And Dependents Coverage

Retail pharmacy (up to a 34-day supply or 100-unit dose)	You pay 20% copay (for brand name or generic medications)
Mail order program (up to a 90-day supply)	You pay 20% copay (for brand name or generic medications)

**Prescription Drug Benefit**

For Retired Employees And Dependents Coverage

Retail pharmacy (up to a 34-day supply or 100-unit dose)	You pay 40% copay (for brand name or generic medications)
Mail order program (up to a 90-day supply)	You pay 40% copay (for brand name or generic medications)

**Vision Benefit**

For Active Employees, Retired Employees And Dependents

Plan pays up to \$200 per person per calendar year for covered expenses

**Weekly Accident And Sickness Benefit**

For Active Employees Only

Non-occupational	\$250 per week for up to 13 weeks <sup>9</sup>
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**Death Benefit**

For Active Employees, Retired Employees And Dependents

Employee	\$3,000
Dependent spouse	\$1,500
Dependent children:	
14 days but less than 6 months of age	\$150
Six months or older	\$750
Retired Employee	Benefit equal to number of pension credits earned, to a maximum of 10, times \$100 (i.e., maximum benefit = \$1,000)

**Accidental Death And Dismemberment Benefit<sup>10</sup>**

For Active Employees Only

Loss of life	\$3,000
Loss of two limbs, sight of both eyes or one limb and sight of one eye	\$3,000
Loss of one limb or sight of one eye	\$1,500

<sup>8</sup> Subject to the comprehensive medical calendar year deductible.<sup>9</sup> The actual benefit is greater; the amount shown is after deduction for Social Security tax.<sup>10</sup> If more than one of the losses listed is suffered as the result of any one accident, not more than \$3,000 will be payable.

## Important Contact Information

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If You Need Information About...	Contact...
<ul style="list-style-type: none"> <li>■ Comprehensive medical benefits</li> </ul>	<p><i>For free information about PPO providers in the greater Kansas City area:</i>            Freedom Network Select            P.O. Box 25938            Shawnee Mission, Kansas 66225-5938            Telephone: (913) 685-6300 or toll-free (800) 544-3014  <a href="http://www.phpkc.com">www.phpkc.com</a></p> <p><i>For free information about PPO providers in out-state Missouri:</i>            HealthLink            P.O. Box 411640            St. Louis, MO 63141            Telephone: (314) 989-6300 or toll-free(800) 624-2356  <a href="http://www.healthlink.com">www.healthlink.com</a></p> <p><i>For free information about PPO providers in western Kansas:</i>            Health Partners of Kansas (HPK) c/o PHP            P.O. Box 25938            Shawnee Mission, Kansas 66225-5938            Telephone: (913) 685-6300 or toll-free (800) 544-3014  <a href="http://www.phpkc.com">www.phpkc.com</a></p> <p><i>For Non-PPO provider Claims/questions:</i>            Greater Kansas City Laborers Welfare Fund Office            6405 Metcalf, Suite 200            Overland Park, KS 66202            Telephone: (913) 236-5490            Facsimile: (913) 236-5499</p> <p><i>For pre-notification of planned inpatient hospital admissions and notification of emergency or other urgent admissions within 48 hours of admission:</i>            Preferred Health Professionals (PHP)            Telephone: (913) 685-6300 or toll-free (800) 544-3014</p>
<ul style="list-style-type: none"> <li>■ Wellness physicals (for active Employees and their spouses)</li> </ul>	Employer Health Services 4500 W. 107 <sup>th</sup> St. Overland Park, KS 66207 Telephone: (913) 649-7433, extension 233
<ul style="list-style-type: none"> <li>■ Dental benefits</li> <li>■ Vision benefits</li> <li>■ Weekly accident and sickness benefits</li> <li>■ Death benefits</li> <li>■ Accidental and dismemberment (AD&amp;D) benefits</li> </ul>	Greater Kansas City Laborers Welfare Fund Office 6405 Metcalf, Suite 200 Overland Park, KS 66202 Telephone: (913) 236-5490 Facsimile: (913) 236-5499

If You Need Information About...	Contact...
<ul style="list-style-type: none"> <li>■ Retail prescription drug program</li> </ul>	CaremarkRx 9501 E. Shea Blvd. Scottsdale, AZ 85260 Telephone: (800) 966-5772 Web site: <a href="http://www.caremark.com">www.caremark.com</a>
<ul style="list-style-type: none"> <li>■ Mail order prescription drug program</li> </ul>	CaremarkRx P.O. Box 961066 Fort Worth, TX 76161-0066 Telephone: (800) 966-5772 Web site: <a href="http://www.caremark.com">www.caremark.com</a>
<ul style="list-style-type: none"> <li>■ Member assistance program</li> </ul>	Employee Health Services, Inc. 423 NE 69 Highway Claycomo, MO 64119 Telephone: (816) 455-2224 or toll-free (800) 332-6283

# Eligibility

## Initial Eligibility

### For Active Employees

You become eligible for coverage on the first day of a quarter (January 1, April 1, July 1 or October 1) based on the number of hours of contributions made on your behalf to the Fund, as shown in the chart below.

When you become eligible for coverage, you need to complete an enrollment card. Be sure to complete both sides of the card, provide information about your eligible Dependents, sign, date and return the card to the Fund Office.

From time to time, you'll be asked to provide updated information.

Eligibility Contribution Requirements				
To be eligible for benefits during this benefit period:	You must have contributions made on your behalf in <i>one</i> of the following amounts...			
	250 hours of contributions during this work period:	500 hours of contributions during this work period:	750 hours of contributions during this work period:	1,000 hours of contributions during this work period:
January 1 - March 31	September 1 - November 30	June 1 - November 30	March 1 - November 30	December 1 - November 30
April 1 - June 30	December 1 - February 28	September 1 - February 28	June 1 - February 28	March 1 - February 28
July 1 - September 30	March 1 - May 31	December 1 - May 31	September 1 - May 31	June 1 - May 31
October 1 - December 31	June 1 - August 31	March 1 - August 31	December 1 - August 31	September 1 - August 31

If you are not actively at work due to disability on the date on which your benefits would otherwise become effective, you will not be eligible for weekly accident and sickness benefits until you return to active employment. All other benefits become effective as explained above.

### For Dependents

Dependents become eligible for coverage on the same date that you do. If you acquire a Dependent while eligible for coverage, your Dependent becomes eligible for benefits automatically and immediately, however, you will be required to provide notice within 30 days after acquiring a Dependent. You may also be required to provide documentation concerning your Dependents before Claims are paid on their behalf.

Eligible Dependents include:

- Your spouse.
- Unmarried children under age 19.
- Unmarried children age 19, but younger than 23, provided they:
  - Are registered students in regular full-time attendance at an accredited college or university or a vocational, technical, vocational-technical or trade school or institute, or secondary school; and
  - Depend upon you for over 50% of their financial support.

A child who is a registered full-time student in the fall semester will be considered a Dependent from September 1 of that year until August 31 of the next year, provided the child remains a registered full-time student.

In general, Dependents include your spouse and children under age 19 or under age 23 if a full-time student. Under certain circumstances, you may be able to cover disabled children beyond age 19.

If you have a Dependent who is between the ages of 19 and 23 whose full-time student status changes, it is your responsibility to notify the Fund Office. You are responsible for reimbursing the Fund for Claims paid on behalf of such a Dependent who is no longer a full-time student.

- Unmarried Dependent children incapable of self-sustaining employment because of physical handicap or mental retardation provided:
  - They are dependent upon you for support;
  - Their incapacity started before reaching age 19; and
  - Proof of their incapacity is provided to the Fund Office not later than 31 days after reaching age 19 (proof of continued incapacity may be requested by the Fund Office from time to time).

Under the Plan, children include those children for whom you have an obligation to support, including:

- Natural children;
- Stepchildren;
- Legally adopted children;
- Children placed for adoption (which means you are legally obligated for the children in anticipation of the adoption before the children's 18<sup>th</sup> birthday);
- Children for whom you have been appointed legal guardian by a court of competent jurisdiction; and
- Children for whom coverage must be provided because of a Qualified Medical Support Order (QMCSO).

If you *and* your spouse are eligible Employees, both of you may cover your children and each other as covered Dependents. However, you may not cover Dependent children who are eligible as Employees.

#### *For Retired Employees*

You become eligible for retiree benefits under the Plan if you:

- Accrued 10 or more benefit credits with the Greater Kansas City Laborers Pension Fund; and
- Had been eligible for active Plan coverage under the Greater Kansas City Laborers Welfare Fund **12 out of the last 20-consecutive quarters** immediately before retirement; and
- Are receiving regular, early, disability, deferred, partial or pro rata benefits from the Greater Kansas City Laborers Pension Fund (or for any other reason for the first 18 months following retirement).

The Fund Office will notify you when your active eligibility, based on contributions, will end and inform you of your option to elect retiree coverage or COBRA Continuation Coverage as well as the self-payment amounts for each. For more information about COBRA Continuation Coverage, see page 15. If you want to continue coverage as a Retired Employee, you must elect retiree coverage by notifying the Fund Office of your election in writing within 60 days of when you lose coverage under the Plan as an active Employee or the date of the notice.

The first self-payment for retiree benefits is due in the Fund Office within 45 days of the election and must include payments for all months through the month in which the election is made.

Benefits payable to eligible Retired Employees under this Plan are the same as those for active Employees, except that weekly accident and sickness and accidental death and dismemberment benefits are *not* available to Retired Employees. In addition, active and Retired Employees are eligible for different death benefit amounts. The Trustees establish and adjust the required self-payment from time to time on the basis of the cost of the benefits provided.

The Fund coordinates coverage with Medicare for Retired Employees and their spouses who are age 65 or older or eligible for Medicare due to disability. Therefore, if you are retired or disabled, you and your spouse should apply for Medicare Parts A *and* B before reaching age 65 or upon disablement.

If you and your spouse are age 65 or older and retired, your coverage will be coordinated with Medicare Parts A and B whether or not you applied for that coverage. If you are retired, it's very important that you apply for Medicare before you or your spouse reach age 65 since the Fund will begin paying a lower amount of covered expenses because your benefits will be coordinated with Medicare.

When you are making retiree self-payments, if one of your dependent children loses dependent status or you and your spouse are divorced, your spouse or dependent children may continue to make self payments at a rate established by the Trustees for 36 months from the loss of coverage of the dependent child or spouse.

You can discontinue coverage and self-payments for yourself, but maintain coverage for your spouse as long as you are covered for three months before such discontinuance. However, you will not be eligible to reinstate retiree coverage at a later date, unless you satisfy the Plan's initial eligibility requirements.

When you retire your spouse may not be eligible for retiree coverage under this Plan if he or she has coverage under another group health plan. However, you may add your spouse to your retiree coverage the first month immediately following the month your spouse loses coverage under another Employer plan, provided your spouse was continually eligible for that Employer's coverage from the date you retired under this Plan.

## **Continuing Eligibility**

### *For Active Employees*

Once you become eligible for benefits under the Plan, you continue to be eligible for benefits from one benefit period to the next, provided you meet the hours requirement during the corresponding work period. See page 8 for more information.

### *Reciprocal Agreements*

The Fund recognizes that you may work at jobs that require contributions to other laborers' funds. Therefore, the Fund has reciprocal agreements with other funds to help prevent you from losing eligibility when you work outside the jurisdiction of this Fund.

A laborers welfare fund that enters into an agreement with the Greater Kansas City Laborers Welfare Fund to transfer contributions from that fund to the Greater Kansas City Laborers Welfare Fund is a reciprocating fund. You must meet the hours of work requirements explained above based on contributions to this Fund.

This Fund has a reciprocal agreement with the Construction Industry Laborers Welfare Fund of Jefferson City and the Kansas Building Trades Open End Health and Welfare Fund in Topeka. To find out if a particular Employer is contributing to the Kansas City Fund, or whether a job in a particular area will result in transferred contributions toward your continued eligibility in this Fund, you may contact the Fund Office.

### *For Retired Employees*

Your coverage will continue on a month-to-month basis, provided you make the required self-payment. After your first self-payment is made for retiree coverage, self-payments for subsequent months must be received in the Fund Office by the 30<sup>th</sup> day of the month for which you are seeking retiree coverage.

**Important!** Retiree self-payments are due in the Fund Office by the 30<sup>th</sup> of the month for which you are electing coverage. If payment is not received, your retiree coverage will end and coverage cannot be reinstated at a later date.

If you stop making self-payments at any time, you will lose eligibility for retiree coverage and will not be able to reinstate retiree benefit coverage.

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*Example:*

*John is retired and pays for retiree coverage by making self-payments. To continue coverage for the month of September, the Fund Office must receive his self-payment by September 30. If the Fund Office doesn't receive his payment by that date, his coverage will end and he will not be able to reelect retiree coverage under the Plan.*

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### **When Coverage Ends**

#### *For Active Employees*

If you do not meet the continuing eligibility requirements, your eligibility for benefits will end on the last day of the benefit period (December 31, March 31, June 30, or September 30) following the work period in which your contribution hours fall below the minimum requirement to continue coverage. For more information about the hours required during work periods to continue coverage, see the chart *Eligibility Contribution Requirements* on page 8.

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*Example:*

*Bob is eligible for coverage during the July 1 to September 30, 2004 benefit period. However, Bob does not have sufficient contributions made on his behalf during the work period that corresponds to the October 1 to December 31, 2004 benefit period. Therefore, Bob's eligibility for benefits will end as of September 30, 2004.*

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Your coverage under the Plan could also end if the Welfare Fund is terminated.

Before your eligibility for coverage will end, the Fund Office will notify you in writing and explain how you can continue coverage. If you lose eligibility for lack of hours, you may continue coverage under COBRA Continuation Coverage. If you had hours in the immediately preceding quarterly work period, they will be used to reduce your required COBRA self-payment for that quarterly benefit period.

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*Example:*

*If Bob worked only 200 hours between June 1 and August 31, 2004, he will have met only 80% of the hours requirement to maintain eligibility from October 1 through December 31, 2004. For Bob to continue eligibility from October 1 through December 31, 2004, he will have to pay 20% of the required self-payment amount for that period. For the next benefit period (January 1 through March 31, 2005), Bob will have to pay 100% of the self-payment amount to continue coverage.*

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For more information about COBRA Continuation Coverage, see page 15.

### *For Your Dependents*

Your Dependent's eligibility for coverage will end when:

- Your eligibility under the Plan ends;
- They no longer meet the definition of a Dependent;
- The Plan's eligibility rules change in any way that terminates or limits Dependent benefits; or
- The Welfare Fund is terminated.

### *For Retired Employees*

You or your Dependents will lose eligibility for retiree benefit coverage if any one of the following events occurs:

- You become eligible for active Employee benefits because you return to work in covered employment;
- The Welfare Fund is terminated;
- A self-payment, election, or required notice is not made on a timely basis; or
- The Fund discontinues retiree benefits.

If you do not make timely self-payments for retiree coverage, your coverage will terminate and you will not be able to reelect retiree coverage.
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### *Certificate Of Creditable Coverage*

When your coverage under the Plan ends, the Fund Office will provide you and/or your Dependents with a Certificate of Creditable Coverage. The certificate indicates the period of time you and your Dependents were covered under the Plan and additional information required by federal law. The Fund Office will send you the certificate by first class mail within 45 days after coverage under the Plan ends. If you or your Dependents elect COBRA Continuation Coverage (see page 15) or coverage under USERRA (see page 19), another certificate will be provided within 60 days after the COBRA Continuation Coverage or USERRA coverage ends.

In addition, a certificate will be provided within 45 days after you request one from the Fund Office. The Fund Office must receive your request within two years after the later of the coverage under the Plan ended or the date COBRA Continuation Coverage or USERRA coverage ended.

### **Reinstatement Of Eligibility**

If your coverage ends, you can reinstate your eligibility by satisfying the Fund's initial eligibility requirements again (see page 8).

### **Changes In Eligibility Rules**

The Trustees reserve the right, at their discretion, to change, modify or discontinue all or part of the eligibility rules or the benefits provided under the Plan at any time. The Trustees have the authority to establish contribution rates and self-payment rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

## Life Events

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Your benefits are designed to meet your needs at different stages of your life. This section describes how your benefits are affected when different lifestyle changes occur.

### Buying A New Home Or Moving

When you buy a new home or move, it's important to contact the Fund Office to update your address. This will help ensure you receive important benefit information in a timely manner.

### Getting Married (For Active Employees)

When you get married, your spouse is eligible for medical, dental, prescription drug, vision and death coverage. Once you provide any required information, coverage for your spouse begins on the date of your marriage. At this time, you may also want to update your Beneficiary information for your death and accidental death and dismemberment benefits.

If your spouse is covered under another group medical plan, you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage; benefits for your spouse under this Plan will be paid after any benefits are payable from your spouse's plan.

### Adding A Child

Your natural born child is eligible for coverage on their date of birth. If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage. You may cover stepchildren under the Plan as of your date of marriage. In addition, you may cover children for whom you have been appointed the legal guardian. Regardless of the type of Dependent you are covering, they must meet the Plan's definition of Dependent described on page 8. You must notify the Fund Office within 30 days after acquiring a Dependent. You may also be required to provide documentation concerning your Dependents before Claims are paid on their behalf.

*When you add a child, provide the Fund Office with:*

- The birth date, effective date of adoption or placement for adoption or the date of your marriage (for stepchildren).
- A copy of the birth certification, adoption papers, court order or marriage certificate (for stepchildren).
- A copy of your child's other medical insurance information, if he or she is covered under another plan.

### Getting Divorced

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must** notify the Fund Office within 60 days of the divorce date for your spouse to receive COBRA Continuation Coverage. At this time, you may also want to review your Beneficiary designation for your death and accidental death and dismemberment benefits, if eligible.

This Fund recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for eligible Dependents, as determined by the order. A QMCSO is a court order, decree or administrative order relating to child support that must:

- Contain specific information as stipulated by the Fund Office;
- Be submitted to the Plan Administrator, who will determine whether the order is qualified as a QMCSO under federal law; and
- Be approved by the Board of Trustees.

The Fund Office has the authority to determine if a National Medical Support Notice constitutes a QMCSO. A copy of the procedures that the Fund follows to make this determination is available at no charge at the Fund Office.

### **Child Losing Eligibility**

In general, your child is no longer eligible for coverage when he or she marries or reaches age 19 (or 23 if a full-time student). You must notify the Fund Office within 60 days of when your child is no longer eligible for coverage. Your child may elect to continue coverage under COBRA for up to 36 months.

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA Continuation Coverage. Within 60 days of losing eligibility for coverage, he or she must:

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.

### **When You Are Out Of Work Due To Disability (For Active Employees)**

If you are out of work due to a non-work related disability, you may receive weekly accident and sickness benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first.

If you are receiving weekly accident and sickness benefits under the Plan or workers' compensation benefits, you will receive 40 hours of work credit for each week, or eight hours for each day, you are entitled to receive these benefits. No more than 250 hours will be credited during a 12-consecutive month period unless your disability is work-related, in which case the maximum number of credited hours in a 12-consecutive month period is 500. No further hours will be credited after your benefits end. These hours may be used to continue your eligibility under the Plan.

During your disability, you will periodically be asked to complete a form called a *Status Report for Continuing Loss of Time*. This form must be completed by your Physician.

If you become disabled due to an Injury that is covered by the AD&D benefit, you may also be eligible for an AD&D benefit.

If you are out of work due to a work-related disability, you may be eligible for workers' compensation benefits. Contact your local or state workers' compensation office. The Fund does not provide coverage for work-related disabilities.

***If you are out of work due to a non-work related disability:***

- Notify your Employer and the Fund Office.
- Provide the Fund Office with proof of your disability.
- Apply for weekly accident and sickness benefits.

***If you are out of work due to a work-related disability:***

- Notify your Employer and the Fund Office.
- Contact your local workers' compensation office and apply for workers' compensation benefits.

### **Extending Comprehensive Medical Benefits When You Become Totally Disabled (For Active Employees)**

If you are out of work due to a total disability, you should notify your Employer and the Fund Office. If you are unable to work due to a non-work related total disability, you may be eligible for weekly accident and sickness benefits and your medical benefits may continue. For

Employees, totally disabled means that you cannot engage in your usual occupation because of Illness or Injury. For Dependents, totally and permanently disabled means not being able to engage in all normal activities of a person of like age and sex in good health because of Illness or Injury.

If your eligibility for coverage ends while you or your Dependent is totally disabled, your Comprehensive Medical Benefits may continue during the calendar year in which you or your Dependent's eligibility ended and through the next calendar year provided that:

- Eligibility terminated while you or your Dependent were totally disabled;
- The expenses are incurred in connection with the same disability;
- You or your Dependent are totally and continuously disabled on the date each expense is incurred; and
- You or your Dependent are not entitled to benefits under any other group policy or program, whether insured or self-insured, which provides benefits similar to those provided here.

Payments after the calendar year in which your eligibility ends will be subject to a new deductible.

### **In The Event Of Your Death**

If you are eligible for coverage on the date of your death, your Beneficiary will receive a death benefit (and an AD&D benefit, for active Employees only, if your death is caused by an accident). See pages 37 and 38 for more information about these benefits.

#### *For Active Employees*

If you die while an active Employee (whether employer contributions are being made on your behalf or you're making self-payments), medical and vision benefits for your eligible Dependents will be continued for the period of time that eligibility would be maintained based on your accumulated hours, but not less than 90 days. No self-payments will be required during the 90-day period.

Your spouse and/or eligible Dependents may then continue coverage for up to an additional 33 months by electing COBRA Continuation Coverage and making the necessary self-payments (see below).

#### *For Retired Employees*

If you are a Retired Employee and die after age 55 (or a disabled Retired Employee who dies at any age), your surviving spouse and eligible Dependents can continue coverage by making self-payments. Your surviving spouse can continue coverage through self-payments determined by the Trustees until the later of the date he or she remarries or 36 months after your death. If the self-payments are discontinued for any month, or if your surviving spouse does not elect to make self-payments when first eligible, your spouse will not be eligible to continue coverage by making self-payments.

### **COBRA Continuation Coverage**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of plan benefits to Employees and eligible Dependents ("Qualified Beneficiaries") who would otherwise lose coverage under a plan. Qualified Beneficiaries include you and each Dependent who was covered under the Plan on the

day before a qualifying event occurs and who would lose coverage as a result of a “Qualifying Event” (see below). Children born, adopted or placed for adoption have the same COBRA rights as a spouse or Dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage.

Under certain circumstances, you can continue coverage by making self-payments to the Plan for COBRA Continuation Coverage. You will *not* be eligible to continue coverage for weekly accident and sickness, death or accidental death and dismemberment benefits. By making self-payments, you may continue medical, dental, prescription drug and vision benefits.

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan. If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing as soon as possible, but not later than 30 days after the birth, adoption, or placement, to have this child added to your coverage.

Like all Qualified Beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

### ***Qualifying Events***

If you or your Dependents lose coverage as a result of your reduction in hours, termination of employment or certain other events (called qualifying events), you and/or your Dependents have the right to elect to continue health care coverage by making premium payments to the Plan.

### ***For Employees***

COBRA Continuation Coverage will be offered to you if your coverage under the Plan ends for the following reasons:

- Your hours of employment are reduced; or
- You are terminated from employment for any reason other than your gross misconduct.

### ***For Your Spouse***

COBRA Continuation Coverage will be offered to your spouse if coverage under the Plan ends for the following reasons:

- Your hours of employment are reduced;
- You are terminated from employment for any reason other than your gross misconduct;
- You die;
- You become enrolled in Medicare; or
- You and your spouse divorce.

### ***For Your Dependents***

COBRA Continuation Coverage will be offered to your eligible Dependents if coverage under the Plan ends for the following reasons:

- Your hours of employment are reduced;
- You are terminated from employment for any reason other than your gross misconduct;

- You die;
- You become enrolled in Medicare; or
- Your Dependent ceases to be an Eligible Dependent as defined under the terms of the Plan.

When the Fund Office has been notified that one of these events has occurred, you and your eligible Dependents will be notified of the right to elect COBRA Continuation Coverage. Upon notification, the Fund Office will send you a COBRA application and *Notice of Health Continuation Procedures*.

### *Notifying The Fund Office*

You or your Dependent must inform the Fund Office of a legal separation, divorce or a child losing Dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such an event, you and/or your Dependents will lose your right to elect COBRA Continuation Coverage.

Your Employer will notify the Fund Office of your termination of employment, reduction in hours, enrollment in Medicare, or death. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of **any** qualifying events as soon as they occur. ***If you do not notify the Fund Office within 60 days of a qualifying event, you and your Dependents will lose your right to elect COBRA Continuation Coverage.***

When the Fund Office is notified that one of these events has occurred, you and your Dependents will be notified of your right to elect COBRA Continuation Coverage. Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Dependents have the option to elect coverage independently from you.

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any preexisting condition limitation under a new group medical plan.

### *Electing To Continue Coverage*

When the Fund Office is notified that coverage will end due to a qualifying event, the Employee and eligible Dependent(s) will be notified of their right to choose the Continuation Coverage. The Fund Office will send you and your family a COBRA Election Notice containing information on how to continue your health care coverage and the applicable COBRA premiums. The Employee and eligible Dependent(s) will then have **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from receipt of the Election Notice to elect the Continuation Coverage. If the Employee or eligible Dependent(s) do not elect the Continuation Coverage within the 60-day election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the 60-day election period.

Each eligible Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their eligible Dependents.

If an Employee or the Spouse of an Employee has a newborn child, or adopts a child, or has a child placed with him or her for adoption during the COBRA continuation period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified in writing as soon as possible, but not later than 30 days, after the birth, adoption or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Plan is the same coverage provided under the Plan at the time of termination except for the Weekly Accident and Sickness Benefit, Death Benefit and Accidental Death and Dismemberment Benefit.

### *Period Of Coverage*

Coverage continues for a maximum of:

- 18 months if your coverage ends due to your termination of employment or your reduction in hours.
- 29 months if you or one of your Dependents is disabled when your coverage ends or if you become disabled within 60 days of the date your coverage ends. To continue coverage for up to 29 months, you must notify the Fund Office in writing of your determination of disability by the Social Security Administration within 60 days of the determination and before the expiration of the initial 18-month period of COBRA Continuation Coverage. Such notice will allow up to an additional 11 months of COBRA Continuation Coverage for a maximum of 29 months of COBRA Continuation Coverage.
- 36 months if your spouse or other Dependent's coverage ends because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Eligible Dependent child no longer qualifying for Dependent coverage under the Plan.

It's important to notify the Fund Office within 60 days of a qualifying event. If you do not do this, you and your Dependents will lose your right to elect COBRA Continuation Coverage.
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### *Loss Of COBRA Continuation Coverage*

COBRA Continuation Coverage will end if any of the following occur after the initial qualifying event:

- A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;
- You or your Dependent becomes covered under another group health plan;
- You or your Dependent becomes entitled to Medicare;
- The Plan no longer provides group health care coverage; or
- The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

### *Paying 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 a yearly basis, and will not exceed 102% of the cost to provide this coverage. The amount you owe for your first COBRA self-payment may be reduced by hours you worked in the immediately preceding work period.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your Dependents' coverage under the Plan ended. The Fund Office will notify you of the first payment due date, which is no later than 45 days after your election. Subsequent payments are due the first of the month and are considered timely if made within 30 days after the first day of the month. If a payment is late, coverage will be terminated if the payment is not received by the last day of that month.

## **Serving In The Uniformed Services (For Active Employees)**

The Fund provides benefits to you and your covered Dependents during your military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Please contact the Fund Office before you enter military service to receive details about how and to what extent your coverage and that of your Dependents can be maintained.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you must pay your share, if any, of the cost of coverage. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by making monthly self-payments. To continue coverage, you or your Dependent must pay the required self-payment.

Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24-consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former Employer no longer provides any health plan coverage to any Employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your eligible Dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage.

You need to notify the Fund Office in writing when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

### ***Reinstating Your Coverage***

Following discharge from military service, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your Employer. According to USERRA

#### **Reemployment**

Following your discharge from service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in health care coverage provided by your Employer.

guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a contributing Employer.

When you are discharged, if you are Hospitalized or recovering from an Illness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a contributing Employer. The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

### **Family And Medical Leave (For Active Employees)**

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption or placement with you for adoption of a child;
- The care of a seriously ill spouse, parent or child; or
- Your own serious Illness.

During your leave, you will maintain all the coverage offered under the Plan. You will remain eligible until the end of the leave, provided your contributing Employer properly grants the leave and makes the required notification and payment to the Fund. See your Employer to learn about your rights and obligations under FMLA.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

If you have been granted FMLA leave, your Employer must notify the Fund Office at least 14 days before the leave begins, except in an emergency, and then no later than seven days after the leave begins. You may wish to notify the Fund Office when you are granted FMLA leave, but you are not required to do so. Your Employer will be asked to complete some forms to verify your eligibility for benefits while you are on leave. To be eligible for coverage during FMLA leave, your Employer must pay the cost of coverage in an amount determined by the Fund for each week you are on FMLA leave.

### **When You Retire**

When you retire, coverage for you and your Dependents will end under the active Plan on the last day of the benefit period for which contributions were made on your behalf. When you retire, you may be eligible for retiree coverage if you meet the eligibility requirements described on page 9, or you can elect COBRA Continuation Coverage. However, if you elect retiree coverage, you are not eligible to elect COBRA Continuation Coverage when your retiree coverage ends.

Retiree benefits coverage for non-Medicare eligible Retired Employees under age 65 is the same as the coverage for active Employees, except that Retired Employees are:

- Not eligible for weekly accident and sickness benefits;
- Not eligible for accidental death and dismemberment benefits;
- Prescription drug copayments are different as shown in the **Schedule Of Benefits** on page 5; and
- Lower death benefit (unless disabled before you retire).

Benefits for Medicare-eligible retirees are coordinated with Medicare.

If you are an active Employee and lose eligibility for active coverage due to retirement and do not meet the eligibility requirements for retiree coverage, you may be eligible for COBRA Continuation Coverage.

## **Returning To Work**

### *For Active Employees*

If your eligibility ended and you start working again for an Employer who contributes to the Fund, you must once again meet the initial eligibility requirements described on page 8 before you will be eligible for Plan benefits.

If you return to work following a military leave of absence, your coverage will be reinstated as described on page 19.

### *For Retired Employees*

If you are a Retired Employee and return to work, you may continue to self-pay for retiree coverage until you have earned enough hours to qualify for active coverage. Once you subsequently retire, you may return to retiree coverage as provided under the Plan

# Comprehensive Medical Benefits

(For Active Employees, Retired Employees And Eligible Dependents)

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The Fund offers comprehensive health care coverage to help you and your Dependents stay healthy and to provide financial protection against catastrophic health care expenses.

## How The Plan Works

### *Preferred Provider Organization (PPO)*

To help manage certain health care expenses, the Plan contains a cost management feature—a Preferred Provider Organization (PPO) network. A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a PPO provider, you save money for yourself and the Plan because the PPO provider has agreed to charge a negotiated dollar amount.

It's your decision whether or not to use a PPO provider. You always have the final say about the Physicians and Hospitals you and your family use. To encourage you to use PPO providers whenever possible, the Plan pays a higher percentage of covered expenses when you use a PPO provider. Also, there are lower deductibles and out-of-pocket maximums if you use PPO providers. For a listing of Physicians and Hospitals that participate in the PPO network, contact the Fund Office or the PPO (see page 6). This information is provided to you free of charge.

The Plan pays different levels based on whether you use a PPO or non-PPO provider as listed in the **Schedule Of Benefits** beginning on page 3. Once your copayment amounts for covered expenses (excluding the deductible) reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of remaining Reasonable and Customary Charges for the rest of that year up to the annual maximum.

Note some expenses may be covered differently or subject to different benefit maximums. See the **Schedule Of Benefits** beginning on page 3 for more information.

### **Preferred Provider Organization (PPO)**

A PPO is a network of health care providers who have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use PPO providers.

### *When you need to see a Physician...*

- Call to make an appointment.
- Write down any health-related questions you have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you're taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment to ensure your Physician knows where to file your Claim.
- Make sure your Physician's office has your current address on file.

Please keep in mind that when you visit a PPO Hospital, the Physicians and other health care providers in the Hospital may not belong to the PPO network and vice versa.

Here's an example of how using a PPO provider can save you money.

*Let's look at what Steve would pay at a PPO Hospital compared to a non-PPO Hospital. This assumes that he has not satisfied his calendar year deductible.*

	PPO Hospital*	Non-PPO Hospital
Covered Expenses	\$1,700	\$2,000
Deductible	- <u>\$300</u>	- <u>\$400</u>
Expenses For Reimbursement	\$1,400	\$1,600
Plan Pays	x 81% = <u>\$1,134</u>	x 70% = <u>\$1,120</u>
Steve Pays	\$566 (19% plus \$300 deductible)	\$880 (30% plus \$400 deductible)

In the above example, using a PPO Hospital saves Steve \$314 .

\* This example assumes a PPO savings rate of approximately 15%. The actual savings may vary.

### *Calendar Year Deductible*

The calendar year deductible is the amount of covered expenses that you pay each year (January 1 - December 31) before the Plan begins to pay benefits for PPO and non-PPO provider services.

The deductible applies to each Eligible Person each calendar year. The family deductible is met once two or more covered members of a family meet the individual deductible. Once the individual and/or family deductible is met, no further deductibles are required for that year. Deductibles cannot be carried over from one calendar year to the next.

Out-of-pocket expenses for covered medical services are limited. The out-of-pocket maximum does not include your annual deductible.

### *Common Accident Deductible*

Normally, the individual deductible is applied to each member of the family. However, if two or more covered members of a family are Injured in the same accident, the medical expenses that result from the accident will be combined and only one deductible will apply to all expenses incurred as a result of that accident (regardless of the number of family members Injured).

### *Copayment*

Once you or your family meet the annual deductible, the Plan pays a percentage of covered expenses, called a "copayment." The amount the Plan pays depends on the type of covered expense as listed in the **Schedule Of Benefits** beginning on page 3. Your payment is the remaining percentage of covered expenses and any amounts not covered by the Plan.

***If you need to be Hospitalized:***

- Ask your Physician to refer you to a PPO Hospital.
- Inform your supervisor that you'll be away from work.
- Bring your medical ID card to the Hospital.

### *Calendar Year Out-Of-Pocket Maximum*

The out-of-pocket maximum limits the amount you pay out-of-pocket in a calendar year for covered expenses. If your copayments toward covered expenses reach the out-of-pocket maximum (excluding the deductible), the Plan pays 100% for most additional covered expenses for the rest of the calendar year, up to the annual maximum shown in the **Schedule Of Benefits**. There are separate out-of-pocket maximums for PPO and non-PPO provider covered expenses.

Your copayment amounts toward the out-of-pocket maximum do not include amounts you pay toward meeting your annual deductible.

### *Calendar Year And Lifetime Maximums*

You and each eligible Dependent can receive medical benefits up to the calendar year and lifetime maximums specified in the **Schedule Of Benefits** beginning on page 3. Certain services have separate calendar year and/or lifetime maximums.

### *Pre-notification*

Pre-notification of medical treatment helps you know in-advance whether a particular treatment or service will be covered and at what level. You should seek medical care when necessary. However, you must notify the Fund of planned inpatient hospital admissions. In addition, you must notify the Fund of emergency or urgent admissions within 48 hours of admission to the hospital. If you do not notify the Fund of this type of treatment, you will have to pay an **additional** \$200 deductible for each failure to notify.

**Important!** Call Preferred Health Professionals (PHP) at (913) 685-6300 or (800) 544-3014 to:

- Pre-notify all planned inpatient hospital admissions; and
- Notify of emergency hospital admissions within 48 hours of admission.

If you or a dependent is Medicare-eligible, this pre-notification provision does not apply to you, unless this Plan is the primary payer.

### *Large Case Management*

In cases of catastrophic illness or long-term care (for example, cancer, stroke, transplants, severe disability, and other serious afflictions), treatment is typically needed from several health care specialists and expenses often exceed what is expected or necessary. If you need treatment for a catastrophic illness, you may work with a PHP case management coordinator to coordinate health care activities to facilitate proper and timely care, while eliminating duplication of services, unnecessary services and excessively expensive treatments when an appropriate alternative method exists.

Case management services provided by PHP include:

- Coordination of alternative care, such as comprehensive inpatient and outpatient care, rehabilitation, skilled nursing facility care, home health and hospice care;
- Referral to appropriate in-network and out-of-network providers; and
- Ongoing monitoring and management of long-term cases.

A case management coordinator will contact you in the event of a catastrophic Injury or Illness. Participation in this program is voluntary.

### *Wellness Physicals*

Understanding the importance of preventive health care, the Plan provides active Employees and their spouses with a wellness physical once a year. For information about the types of services covered under this benefit, see page 30. If you would like additional information about this benefit, you may call HealthPlus at (913) 649-7433, extension 233.

### *Member Assistance Program*

The Member Assistance Program (MAP) is a free counseling service that provides professional and *confidential* assistance to help you solve personal and work problems. The MAP is a

voluntary program that can assist you and your family members in improving the quality of your life and resolving many different types of personal concerns including:

- Substance abuse;
- Family issues such as parent-child conflicts, serious illness of a family member, aging parents, or single parenting;
- Marital issues such as separation and divorce and domestic violence;
- Financial issues such as household finances and over-extended credit; and
- Emotional and mental health issues such as stress, anxiety, depression, and grief and loss.

If you have a question or an issue you would like to discuss, call Employee Health Services, Inc. at (816) 455-2224 or toll-free at (800) 332-6283 to arrange an appointment with a MAP counselor in your area. You and your family members may meet with a counselor for up to three sessions or you may be referred to others for further assistance.

### *Reasonable And Customary Charges*

The Plan pays benefits only to the extent that they are “Reasonable and Customary.” In general, this is the amount providers most frequently charge for the same service or procedure in a geographic area. Reasonable and Customary Charges are determined by the Trustees who may rely on the advice of medical professionals.

The negotiated rates charged by PPO providers are considered Reasonable and Customary by the Plan. For charges incurred by a non-PPO provider, the Plan Administrator determines Reasonable and Customary Charges.

### *Medically Necessary*

The Plan pays benefits only for services and supplies that are Medically Necessary. In general, “Medically Necessary” means a service or supply ordered by a Physician that:

- Is consistent with the symptoms of diagnosis and treatment of your Injury or Illness;
- Is appropriate with regard to good medical practice and recognized by an established medical society in the United States; and
- Could not have been omitted without adversely affecting the Eligible Person’s condition or the quality of medical care.

The fact that a Physician prescribes services or supplies does not automatically mean the services or supplies are Medically Necessary and covered by the Plan.

### *Your Responsibility*

It is important to remember that the medical Plan is not designed to cover every health care expense. The Plan pays charges for covered expenses, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

## Choosing A Physician

You save money for yourself and the Plan when you use a Physician who participates in the Plan's PPO.

One way to find a Physician is to ask around. Ask a family member, friend or co-worker if they have the name of a Physician they would recommend. Before visiting a Physician, you should contact the PPO (see page 6 for PPO contact information) to ensure your Physician is in the PPO.

Here are some questions you may want to ask the Physician(s) you're thinking about making an appointment with:

- Are you accepting new patients?
- What's your treatment style?
- Are you board certified? If so, in what specialties? (Any Physician with a license can practice in any specialty. Board certification is your assurance that the Physician has appropriate training for the specialty.)
- At which Hospitals do you admit patients for major health care needs? Does the Hospital belong to the PPO network? Do the Hospital technicians (for example, for laboratory tests and X-rays) belong to the PPO network?
- What are your office hours?
- On average, how long do patients have to wait to make an appointment?
- During an appointment, on average, how long is the wait in your waiting room?

## Covered Expenses

Covered expenses are the Reasonable and Customary charges that you and/or your Dependent(s) are required to pay for the following Medically Necessary services and supplies ordered by a licensed Physician for treatment of non-occupational Injuries and diseases. These expenses are payable up to the amounts shown in the **Schedule Of Benefits**.

1. Hospital expenses for room and board charges while Hospital-confined, not to exceed the semi-private room rate or, if the Hospital does not provide semi-private room accommodations, the private room rate.
2. Hospital expenses for confinement in an intensive care unit in excess of the amount of the Hospital's regular rate for room and board accommodations.
3. Hospital miscellaneous charges for Medically Necessary services and supplies furnished by the Hospital and not included in the room and board charges, while you are Hospital confined. These charges include:
  - a. Meals and special diet;
  - b. General nursing services;
  - c. Use of operating room including cystoscopic room and cast room;
  - d. Complete anesthetic charges, whether administered by an authorized outside anesthetist or an employee of the Hospital;
  - e. Blood transfusions, including administration and blood typing;
  - f. Oxygen;
  - g. Medicines;

- h. Laboratory services;
  - i. X-rays and the use of radium and radioactive substances;
  - j. Basal metabolism test;
  - k. Electrocardiograms and electroencephalograms;
  - l. Physical therapy;
  - m. Dressings and casts, including preparations or use of gauze, cotton fabrics, solutions, plasters and other material in dressings or casts;
  - n. X-rays and radiation treatment; and
  - o. Ambulance service to and from the Hospital.
4. When Hospital confinement is not required, benefits are payable for Hospital expenses incurred in connection with:
    - a. A surgical procedure resulting from accidental bodily Injury or Illness; or
    - b. Emergency first-aid treatment resulting from accidental Injury or Illness.
  5. Charges for inpatient or outpatient surgical procedures performed as a result of a non-occupational accidental bodily Injury or Illness. The operation must be recommended and performed by a legally qualified Physician or Surgeon.
  6. Charges for the organ transplant procedures listed below up to the maximum benefit amounts listed below:

Transplant Procedure	Maximum Benefit Amount
Bone Marrow	\$200,000
Cornea	\$7,000
Heart	\$220,000
Heart/Lung	\$230,000
Kidney	\$90,000
Kidney/Pancreas	\$140,000
Liver	\$230,000
Lung	\$220,000
Pancreas	\$75,000

The above per procedure maximum benefits will be the total of all medical benefits otherwise payable under the Plan that are incurred:

- a. As the result of your or your Dependents undergoing one of the above procedures; and
- b. During the five-day period before the date of first transplant surgery and ending 12 months after such date.

Charges incurred for services and supplies provided to the organ donor are included in the above limits. The maximums listed above are subject to the Plan's Comprehensive Medical Benefit \$500,000 lifetime maximum benefit.

7. Charges for professional treatment as a result of a non-occupational bodily Injury or Sickness from a licensed Chiropractor during a visit made to the Chiropractor's office.
8. Speech therapy for the restoration of lost speech.
9. Charges incurred by a Dependent child through age 12 for developmentally-related speech therapy treatment that is prescribed by a legally qualified Physician or Speech Therapist and rendered on an outpatient basis by a:
  - a. Duly constituted and lawfully operated Hospital;
  - b. Licensed speech therapy institute or center; or
  - c. Licensed Physician or Speech Therapist, other than one who ordinarily resides with you or is a member of your immediate family.

Payment is limited to the amounts shown in the **Schedule Of Benefits** beginning on page 3.

10. Charges for private duty nursing services of a registered graduate nurse, other than one who ordinarily resides with you or is a member of your immediate family (comprised of your spouse, and the children, brothers, sisters, and parents of you or your spouse).
11. Charges for treatment by a physiotherapist, other than one who ordinarily resides with you or who is a member of your immediate family (comprised of your spouse, and the children, brothers, sisters, and parents of you or your spouse).
12. Charges for dental work or treatment, or dental X-rays, as required for the treatment of an accidental Injury to the jaw or sound natural teeth occurring within one year of such accident.
13. Charges for treatments and medical visits by a Physician while you are Hospital-confined.
14. Charges for lasik surgery for active Employees only who are farsighted and have an astigmatism, up to the limits shown in the **Schedule Of Benefits**.
15. Charges for radial keratotomy (RK), photorefractive keratotomy (PRK) and automated lamellar keratoplasty (ALK) for active and Retired Employees and their eligible Dependents if nearsightedness cannot be corrected by glasses or contact lenses to at least minus one diopter.

16. Coverage is provided for Durable Medical Equipment for:

- a. Rental up to the allowed purchase price of the device;
- b. Purchase of standard models at the option of the Plan;
- c. Medically Necessary repair, adjustment or servicing of the device; and
- d. Medically Necessary replacement of the device due to a change in the Eligible Person's physical condition or if the device cannot be satisfactorily repaired.

Durable Medical Equipment is covered only when ordered by a Physician. Purchase of Durable Medical Equipment and the cost of maintenance agreements are covered only when the Plan determines that it is cost-effective for the Plan. The amount of Plan benefits payable for the purchase of Durable Medical Equipment will be reduced by any benefits paid by the Plan for the rental of such equipment.

**Durable Medical Equipment (DME)**

DME is equipment that:

- Can withstand repeated use and is not a consumable or disposable item;
- Is exclusively and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of Injury or Illness; and
- Is appropriate for use in the home.

17. Prosthetic devices, including necessary supplies, repairs and servicing as shown in the Schedule Of Benefits on page 4.
18. Cochlear implants are covered as a prosthetic device. Surgery to implant the device and auditory rehabilitation are also covered expenses.
19. Charges for anesthesia (including administration thereof) in a Hospital by a Physician.
20. Charges for blood, plasma, and oxygen (including rental of equipment for its administration).
21. Charges for radiation therapy treatments including treatment with X-ray, radium, cobalt, or other radioactive material.
22. Charges for local ambulance service.
23. Charges for inpatient and outpatient treatment of mental and nervous disorders and/or alcoholism and substance abuse by a psychiatrist, psychologist, a certified mental health or substance abuse counselor, or a social worker who has a masters degree and who:
  - a. Is legally licensed and/or legally authorized to practice or provide service, care or treatment of mental and nervous disorders and/or alcoholism and substance abuse under the laws of the state or jurisdiction where the services are rendered;
  - b. Acts within the scope of his or her license; and
  - c. Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

A course of treatment for alcoholism and substance abuse is limited to any combination of up to 21-consecutive days of inpatient care and up to 45 outpatient visits within a 90-day period. All treatment must be at a licensed facility and under the supervision of a licensed Physician. A treatment plan must be submitted to the Fund Office by the attending Physician before payment can be made and you (or your Dependent) must complete the full treatment program.

24. Routine colonoscopies once every five years for active and Retired Employees and their Dependents age 50 or older.
25. Well-child examinations and routine childhood immunizations for eligible Dependents up to age 18. Routine childhood immunizations are covered based on guidelines recommended by the American Academy of Pediatrics and include DPT, polio, MMR, HIB, Hepatitis, Chicken Pox, and Tetanus.
26. Wellness physical for active Employees and their spouses once each year through the Health Promotion Division of Employer Health Services. The physical includes:
  - a. Lab work including:
    - Lipid profile (includes cholesterol, HDL, LDL, and triglycerides);
    - Glucose (blood sugar);
    - Complete blood count (CBC);
    - Chemistry profile;
    - TSH (thyroid) for females;
    - PSA (prostate) for males; and
    - Colorectal cancer screen hemocult kit (on request).
  - b. History and physical examination including medical history, body composition, resting blood pressure and heart rate.
  - c. Cardiovascular stress test including resting EKG, exercise stress EKG and individual consultation with Physician. Or, in lieu of the exercise stress EKG, females can choose to have a pelvic/pap exam and screening mammogram.
  - d. Strength and flexibility test.
  - e. Education including coronary risk factor analysis, goal setting and individualized wellness education and instruction.

For more information about this benefit, you may contact the Wellness Department at HealthPlus at (913) 649-7433, extension 233.

27. Charges incurred for pregnancy and pregnancy-related conditions of active Employees, their Dependent spouses, or their Dependent children. Benefit payments for a Dependent child will be limited to one pregnancy only up to a maximum of \$3,000. For benefits to be payable, the person must be eligible under the Plan at the time the expenses are incurred.
28. Charges due to an elective abortion of an active Employee, Dependent spouse or Dependent child only if performed on an outpatient basis. Benefit payments for charges incurred for a Dependent child will be limited to one abortion only up to a maximum of \$3,000.
29. Charges for diagnostic X-ray and laboratory services.
30. Charges incurred for routine pap smear on an annual basis.
31. Charges incurred for routine mammogram every two years up to age 50 and annually after age 50.
32. Charges for hearing instruments and hearing tests, up to the amounts shown in the **Schedule Of Benefits**.

33. Charges incurred for the following dental services and supplies:

- a. Oral examinations including scaling and cleaning of teeth, but not more than two examinations, scalings and cleanings in any calendar year. The treatments must be separated by a period of six consecutive months;
- b. Topical application of sodium or stannous fluoride, once in each period of 12 consecutive months, but only for an Eligible Person who has not yet attained age 19;
- c. Dental X-rays if professionally indicated, but for full-mouth X-rays, not more often than once in each period of 36 consecutive months;
- d. Extractions;
- e. Amalgam, synthetic porcelain, and plastic restoration;
- f. Gold restorations when the teeth cannot be restored with another filling material;
- g. Crowns and jackets when the teeth cannot be restored with a filling material;
- h. General anesthetics administered in connection with oral surgery;
- i. Space maintainers;
- j. Treatment for relief of pain;
- k. Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- l. Endodontic treatment, including pulpal therapy and root canal therapy;
- m. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework;
- n. The replacement or alteration of full or partial dentures or fixed bridgework that is necessary because of oral surgery:
  - Resulting from an accident;
  - For repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue, but only if the replacement or alteration is completed within 12 months after such surgery;
- o. The replacement of a full denture that is necessary because of:
  - Structural change within the mouth, but only if more than five years has elapsed since the initial placement;
  - The initial placement of an opposing full denture;
  - The prior installation of an opposing full denture;
  - The prior installation of an immediate temporary denture, but only within 12 months of the installation of the temporary;
- p. Replacement of, or addition of, teeth to an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, but only if the existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable;

- q. The replacement of a crown restoration provided the original crown was installed more than five years prior to the replacement;
  - r. Repair or recementing of crowns, inlays, bridgework or dentures or relining of dentures; and
  - s. Orthodontia, including initial and any subsequent installation of orthodontic appliances; provided however, that orthodontic treatment must begin while you or your Dependent is Eligible. If you or your Dependent's eligibility terminates while receiving orthodontic care, benefits will continue until the first to occur of completion of the treatment or payment of the annual maximum benefit.
34. Charges incurred for treatment of tumors or cysts of the mouth, excision of malignant tissue and treatment of fractures of the jaw and facial bones. Oral surgery that is necessary due to a medical condition.

Coverage for surgical treatment of temporomandibular joint (TMJ) will be provided if the procedure is determined to be Medically Necessary, appropriate and effective for the treatment of the patient's condition; and if the patient has one or more of the following conditions:

- a. Bony or cartilaginous tumor of the mandibular condyle;
  - b. Hypomotility and ankylosis;
  - c. Persistent dislocation; or
  - d. Radiographically demonstrable arthropathic changes in the temporomandibular joint, with intractable pain.
35. Charges for birth control implants every three years or sooner if Medically Necessary.

### **Expenses Not Covered**

Not every medical expense is covered by the Plan. For a list of expenses not covered by the Plan, see **General Plan Exclusions** beginning on page 40.

# Prescription Drug Benefits

(For Active Employees, Retired Employees And Eligible Dependents)

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For many participants, prescription drug benefits are one of the most important and utilized benefits. Recognizing the importance of this coverage, the Plan has contracted with a network of preferred pharmacies through the prescription drug provider listed in **Important Contact Information** on page 7. When you have your prescriptions filled at a preferred pharmacy, you save money for yourself and the Plan.

The Plan offers coverage for your short-term prescription needs as well as your long-term prescription needs. When you have prescriptions filled at a retail pharmacy, benefits are payable for up to a 34-day supply or 100-unit dose, whichever is greater. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail order program (see below). When you use the mail order program, you can have prescriptions filled for up to a 90-day supply.

The mail order program allows you to get up to a 90-day supply of a prescription at one time.

You do not need to meet a deductible before your prescription drugs are covered. If you are covered under another plan, prescription drug benefits provided by this Plan will *not* be coordinated with the other plan.

## Prescriptions Filled At Preferred Pharmacies

You should present your ID card when you have prescriptions filled at a preferred pharmacy. When you present your ID card at a preferred pharmacy, all you need to do is pay the applicable copayment. You do not have to complete any Claim forms.

*When you have a prescription filled at a non-preferred pharmacy or do not present your ID card...*

- Pay the full cost of the prescription.
- Submit a Claim form.

You can obtain a prescription drug Claim form from the Fund Office or by contacting the prescription drug provider listed on page 7.

## Prescriptions Filled At Non-Preferred Pharmacies

If you have a prescription filled at a non-preferred pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You will then need to submit a Claim form to the prescription drug provider listed in **Contact Information** on page 7. You will be reimbursed only the amount the Plan would pay for the drug at a preferred pharmacy, minus the applicable copayment.

## Prescriptions Filled Through The Mail Order Program

You should use the mail order program when you need to have prescriptions filled for maintenance medications. When you order by mail, you can get up to a 90-day supply at one time. The mail order program copayments are listed in the **Schedule Of Benefits** on page 5. You can pay by credit card or call the prescription drug provider in advance of submitting your order to confirm the price of your medication and then send in a check.

Because the price of prescription drugs changes frequently, the price of your prescription may change from the time you mail in your copayment until the time your prescription is dispensed. If the price of your prescription changes, the mail order program provider will send you a bill for any balance due.

Maintenance medications are prescription drugs that are used on a long-term or on-going basis. These prescriptions can be used to treat chronic illnesses like:

- Arthritis;
- Diabetes;
- Emotional distress;
- Heart disorders;
- High blood pressure; or
- Ulcers.

### *How To Use The Mail Order Program*

When you need to order medication through the mail order program, follow these steps:

- Ask your Physician to prescribe a 90-day supply of medication with refills.
- Mail the original prescription along with a completed order form, envelope, patient profile and your copayment to the mail order program. You can obtain forms and envelopes from the Fund Office or by contacting the provider as listed on page 7.
- Allow about 14 days from the time you mail in your order to receive your prescription(s).

Note: If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions: a short-term supply, which you can have filled right away; and a 90-day supply for the mail order program.

- After you have had your first prescription filled you can obtain refills via:
  - **Internet**—Have your prescription number, zip code and credit card information ready.
  - **Mail**—Mail your refill slip and copayment.
  - **Telephone**—Have your prescription number, zip code and credit card information ready.

See Contact Information on page 7 for the Web site address, mailing address and telephone number of the prescription drug provider.

### **Generic Equivalents And Brand Name Medications**

Almost all prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness.

When you or your Dependent need a prescription, you may want to ask your Physician whether a generic medication can be substituted for a brand name medication. Your pharmacist can also assist you in substituting generic medications when appropriate.

In general, using generic medications will help control the cost of health care while providing quality medications—and can be a significant source of savings for you and the Plan. Since your copayment is a percentage of the cost of the medication, you can save money by receiving generic medications, which typically cost less than brand name medications; you'll pay a percentage of a smaller amount.

Most prescription medications have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness – and the generic medication generally costs less. You should ask your Physician if a generic equivalent is available for any prescriptions you need filled.

## **Covered Expenses**

The Prescription Drug Benefit is administered by a prescription drug provider selected by the Plan. The Plan's prescription drug benefit is designed to cover the major portion of prescription drug costs an Eligible Person incurs. Covered prescription drug expenses include:

1. Federal Legend Drugs.
2. Drugs that require a prescription under state law but not under federal law.
3. Compound drugs.
3. Injectable insulin.
4. Diabetic supplies, including test stripes, needles and syringes.
5. All prescribed forms of birth control including oral contraceptives, birth control devices, and birth control patches.

## **Expenses Not Covered**

In addition to the General Plan Exclusions beginning on page 40, prescription drug benefits are not payable for:

1. Drugs or medicines lawfully obtainable without a prescription order of a Physician or Dentist, except insulin.
2. Therapeutic devices or appliances, support garments and other non-medical substances, regardless of their intended use.
3. Any charge for the administration of prescription legend drugs or injectable insulin.
4. Medication that is taken by or administered to the individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
5. Refilling of a prescription in excess of the number specified by the Physician or Dentist, or any refill dispensed after one year from the order of a Physician or Dentist.
6. Prescription drugs that may be properly received without charge under local, state or federal program, including workers' compensation.
7. Fertility drugs.
8. Injectable drugs, except insulin.
9. Smoking deterrents.
10. Vitamins and nutritional supplements.
11. Weight-loss drugs.
12. Cosmetic drugs.

# Vision Benefits

(For Active Employees, Retired Employees And Dependents)

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Vision care can play an important role in your overall health. Recognizing this, the Plan covers charges for eyeglasses and vision care provided by a legally qualified ophthalmologist or optometrist.

If you or your eligible Dependent incurs covered vision care expenses, you will be reimbursed up to \$200 per person per calendar year.

To be covered under the Plan, you must receive vision care and services from a legally qualified ophthalmologist or optometrist.

## Covered Expenses

The Plan covers these vision expenses:

1. Charges for complete examination including dilation of pupils and/or relaxing of focusing muscles by drops, refraction for vision and examination for pathology.
2. New or replacement frames and/or lenses including fitting and verification of lens accuracy.
3. Contact lenses.

Under certain circumstances, eye surgery to correct vision impairments is covered under the Comprehensive Medical Benefit. See page 28 for more information.

## Expenses Not Covered

In addition to the General Plan Exclusions beginning on page 40, the Plan does not cover these expenses under the Plan's vision benefits:

1. Medical or surgical treatment of the eyes.
2. Services or materials provided as a result of any workers' compensation law, or similar legislation, or obtained through or required by any government agency or program whether federal, state or subdivision thereof.
3. Any services or materials provided by any other group benefit plan containing benefits for vision care.

### *When you need vision care:*

- Schedule an appointment with an ophthalmologist or optometrist of your choice.
- Pay the full cost of services or supplies received.
- File a completed Claim form with the Fund Office.

## In The Event Of Disability Or Death

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Weekly accident and sickness, death and accidental death and dismemberment (AD&D) benefits help provide financial protection to you and/or your family in the event you become Injured, die or become totally disabled. This section describes these benefits. Retired Employees are eligible for death benefits only.

### **Weekly Accident And Sickness Benefit (For Active Employees)**

If you become totally disabled while you are covered under this Plan and while you are employed by a contributing Employer, you may be eligible for weekly accident and sickness benefits.

You must be an eligible, active Employee under the Plan to receive weekly accident and sickness benefits and the disability must:

- Be a non-occupational Injury;
- Be a Sickness not entitling you to benefits under any workers' compensation or occupational disease law; and
- Require the care of a legally qualified Physician.

#### *Benefit Amount*

The amount of weekly accident and sickness benefits is listed in the **Schedule Of Benefits** on page 5. Benefits are payable for up to a maximum of 13 weeks for any one continuous period of disability due to the same or related cause(s). These benefits will be payable to you as of the:

- Eighth day of disability, if it is due to Sickness; or
- First day of disability if it is due to an accident.

No disability will be considered as beginning more than three days before the first visit to a Physician.

Payment will be made at the daily rate of one-fifth (1/5) of the weekly benefit during partial weeks of continuing disability. Successive periods of disability separated by less than two weeks of continuous active employment will be considered as one continuous period of disability unless they arise from different and unrelated causes.

Weekly accident and sickness benefits are subject to Social Security, federal income and unemployment taxes and may be included in your gross income for tax purposes. If you have questions about including your benefits in your gross income or about exclusions in the law, you should consult your tax advisor or legal counsel.

*If you can't work because of a non-work related Injury or Sickness:*

- Call your Employer and the Fund Office.
- See a Physician as soon as possible.
- File a Claim with the Fund Office for weekly accident and sickness benefits.

### **Death Benefit (For Active Employees, Retired Employees And Dependents)**

The Plan provides a death benefit in the event of the death of an active Employee, Retired Employee and Dependent(s).

### *Benefit Amount*

The amount of the benefit is shown in the **Schedule Of Benefits** on page 5. For the death benefit to be payable, written notice of your or your Dependent's death must be provided to the Fund Office ***within one year of the death***. Death benefits are payable even if the cause of death is work-related.

In the event of your Dependent's death, benefits will be paid to you. In the event of your death, benefits will be paid to the Beneficiary you have on file at the Fund Office. If a Partial Pension or Pro-Rata Pension is being paid to the Retired Employee, the amount of the death benefit will be determined by multiplying the number of pension credits earned by the Retired Employee under the Greater Kansas City Laborers Pension Fund, to a maximum of 10, by \$100.

For information about naming a Beneficiary, see page 39.

### *Continuation Of Death Benefit During Disability*

If you become totally and permanently disabled while eligible and before age 65, your death benefits will remain in force as long as you remain disabled provided proof of disability is submitted as required. You must provide initial proof of disability to the Fund Office within three months after your total disability has continued for nine months. Subsequent evidence of disability must be provided each year.

### **Accidental Death And Dismemberment (AD&D) Benefit (For Active Employees)**

The AD&D benefit is payable for the loss of life, the loss of limbs or the loss of sight of one or both eyes as shown in the **Schedule Of Benefits** on page 5. Benefits are payable for losses through external, violent and accidental means on or off the job. Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

These benefits are paid in addition to any other benefits payable under the Plan, including the Plan's death benefit. Loss must occur within 90 days from the day of the accident. Benefits are paid directly to you for an Injury or to your Beneficiary in the event of your death.

### *Limitations And Exclusions*

No payment will be made for death or any loss resulting from or caused directly, entirely or partly by:

1. Bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms which will occur with and through an accidental cut or wound), or disease or Illness of any kind.
2. Intentional self-destruction or intentional self-inflicted Injury, while sane or insane.
3. Participation in the committing of a felony.
4. War or an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.
5. Travel or flight in any aircraft, except as a fare-paying passenger on a licensed passenger aircraft.

## Naming A Beneficiary

You may designate anyone you wish as your Beneficiary for death and AD&D benefits (if you are eligible for AD&D benefits). To change or designate a Beneficiary(ies), you need to file a form with the Fund Office. You can change your Beneficiary at any time, without the consent of your previous Beneficiary. If you divorce, the Beneficiary you designated before your divorce will no longer apply and you will be required to file a new Beneficiary designation.

A Beneficiary is the person(s) you designate to receive your death and AD&D benefits. You may change your Beneficiary at any time. Contact the Fund Office for a Beneficiary designation form.

It is very important that you designate a Beneficiary. If you do not designate a Beneficiary, your death and AD&D benefit (if applicable) will be paid to:

- Your legal spouse, if living;
- If no surviving spouse, to any children in equal shares;
- If no surviving spouse or children, to your parents in equal shares; or
- If no surviving spouse, children or parents, to your estate.

## General Plan Exclusions

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The Plan does not pay benefits for these expenses:

1. Any treatment or service not prescribed as Medically Necessary by a legally qualified Physician or Surgeon. In the case of inpatient admissions, the diagnosis or symptoms must require inpatient treatment for the admission to be considered Medically Necessary.
2. Any Sickness resulting from an occupational disease covered under a workers' compensation law (except for death and AD&D benefits).
3. Any accidental bodily Injuries arising out of and in the course of a person's employment (except for death and AD&D benefits).
4. Hospitalization, surgical or medical treatment provided or paid by the local, state or federal government or any instrumentally thereof, except for hospitalization or surgical or medical treatment provided by the Veterans Administration when services are provided due to a disability that is not service-connected.
5. Any Sickness or Injury resulting from war or any act of war, declared or undeclared, including armed aggression, or from military, naval, or air service.
6. Confinement, professional fees, services or supplies for which no charge is made or that the Employee or any of his/her Dependents are not required to pay.
7. Except as specifically provided under the Plan:
  - a. Hearings aids or their fitting.
  - b. Transportation, except local ambulance service.
  - c. Eye refractions, eyeglasses or their fitting.
  - d. Chiropractic services and supplies.
  - e. Speech therapy.
  - f. Charges for treatment of temporomandibular joint dysfunction.
  - g. Radial keratotomy and any other Experimental eye surgery for vision correction.
  - h. Organ transplants.
  - i. Treatment of substance abuse (alcoholism or chemical dependency).
8. Cosmetic surgery for medical treatment to improve or preserve physical appearance (including tattoo removal, breast augmentation or other medical or surgical treatment intended to restore or improve physical appearance as determined by the Plan Administrator), except for:
  - a. Surgery required because of an accidental Injury; and

- b. The treatment of birth defects of a Dependent child provided the child continues to be eligible at the time of treatment;
9. Treatments, Procedures, Drugs, Devices, services or supplies that are Experimental, Investigative or Inappropriate and do not meet accepted standards of medical practice.
10. Custodial care, which includes services and supplies, room and board and other institutional services provided to an individual primarily to assist him/her in activities of daily living, and where such care is not reasonably expected to cure the person of any Illness or Injury.
11. Failure to keep a scheduled visit or charges for completion of a Claim form.
12. Special home construction to accommodate a disabled individual.
13. Experimental, Investigative or Inappropriate Drugs, drugs that may be dispensed without a prescription (such as aspirin), over-the-counter products unless specifically included (i.e., insulin) and contraceptives except those requiring a prescription.
14. The reversal of a voluntary sterilization procedure.
15. Expenses for the diagnosis and treatment of infertility and complications including, but not limited to, services, prescription drugs procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant and infertility donor expenses.
16. Supplies or equipment for personal hygiene, comfort or convenience such as air conditioners, humidifiers, physical fitness and exercise equipment, waterbeds, etc.
17. Orthopedic shoes or supportive devices for flat-footed conditions and services and supplies for routine foot care.
18. Therapeutic devices or appliances such as hypodermic needles, syringes, pumps, support garments or other non-medical substances except where required for insulin injection, regardless of their intended use.
19. Dental work or treatment of any kind, or dental X-rays, except as specifically provided in the Plan or except as required because of accidental Injury to sound natural teeth.
20. Any claim, expense or service, caused by, resulting from, or for which a contributing cause was an attempt to commit or the commission of a felony as defined under state or federal law.
21. Expenses for an autopsy and any related expenses.
22. Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an Injury, Illness or disability of an Eligible Person.
23. Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by a contributing Employer, or if benefits are otherwise provided under this Plan or any other plan that a contributing Employer contributes to or otherwise sponsors, such as an HMO.

24. Expenses that exceed any specific Plan benefit limitation, annual maximum or overall (lifetime) maximum as described in this Summary Plan Description/Plan Document.
25. Any portion of the expenses for covered medical services or supplies that exceed the Reasonable and Customary Charge as defined on page 68.
26. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. See **Subrogation** on page 55 for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
27. Expenses for services rendered or supplies provided before you or your eligible Dependents became covered under the Plan or after the date the Eligible Person's coverage ends, except under those conditions described in **COBRA Continuation Coverage** on page 15. Additionally, orthodontic care benefits will continue for you or your dependent until the first to occur of completion of the treatment or payment of the annual maximum benefit.
28. Expenses for services rendered or supplies provided that are not prescribed by a Physician.
29. Expenses for, and related to, non-Emergency travel or transportation (including lodging, meals and related expenses) of a health care provider, Covered Person or family member of a Covered Person.
30. The use of a private room in a Hospital or other specialized health care facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Physician. If a Hospital has only private rooms, the Plan will pay a percentage of the most common semi-private room rate charged by the Hospital, unless a Physician determines that a private room is required for isolation due to a diagnosis or is required by the Hospital's public health regulations.
31. Expenses for services provided by any Physician or other health care practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or Employee or from someone who ordinarily lives in the patient's home.
32. Expenses for the services of a medical student, intern or resident.
33. Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care practitioner was available to do so on a stand-by basis.
34. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in **Definitions** on page 65 or when you are on temporary work assignment for a contributing Employer at a location outside the United States. Payment will be made to the Employee only once the necessary documentation is received as an out-of-network Claim.
35. Hospital or other specialized health care facility expenses if you leave the facility against the medical advice of the attending Physician.
36. Any and all telephone calls between a Physician or other health care provider and any patient, other health care provider or any representative of the Plan for any purpose whatsoever, including, without limitation:

- Communication with any representative of the Plan for any purpose related to the care or treatment of an Eligible Person;
- Consultation with any health care provider regarding medical management or care of a patient;
- Coordinating medical management of a new or established patient;
- Coordinating services of several different health professionals working on different aspects of a patient's care;
- Discussing test results;
- Initiating therapy or a plan of care that can be handled by telephone;
- Providing advice to a new or established patient; and
- Providing counseling to anxious or distraught patients or family members.

37. Expenses for acupuncture and/or acupressure.

38. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

39. Expenses for prayer, religious healing or spiritual healing.

40. Expenses for naturopathic, naprapathic and/or homeopathic services, treatments or supplies.

41. Expenses for corrective appliances except those specifically covered.

42. Expenses for genetic tests such as obtaining a specimen and laboratory analysis, detecting or evaluating chromosomal abnormalities or genetically transmitted characteristics, including:

- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to the child; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except when those tests are performed using fluid or tissue samples obtained through amniocentesis when Medically Necessary as determined by the Plan Administrator.

43. Expenses for genetic counseling.

44. Expenses for hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription (or non-legend or over-the counter) drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces or hair analysis.

45. Charges for home health care services, other than for private duty nursing services of a registered graduate nurse who ordinarily does not reside with the person or is not a member of the person's immediate family.

46. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant.

47. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, vitamins, weight reduction/control special foods, food supplements, liquid diets, diet plans or any related products, herbs and minerals, whether they can be purchased over-the-counter or

require a prescription (except when provided during Hospitalization and except for prenatal vitamins) or minerals requiring a prescription.

48. Medical Foods (as defined in Definitions on page 67).
49. Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, when prescribed or performed for the purpose of:
  - Avoiding the possibility or risk of an Illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
  - Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.
50. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigative, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines.
51. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
52. Expenses for insertion and maintenance of an artificial heart or other organ or related device, except heart valves and kidney dialysis and complications thereof.
53. Expenses incurred for obesity or morbid obesity such as weight reduction programs, drugs, surgical and non-surgical treatments and procedures and reversion of such procedures, including bariatric surgery, gastric bypass, gastric banding, open or laparoscopic vertical banded gastroplasty, laparoscopic adjustable gastric banding (Lap-Band system), or any other such procedure, as well as cosmetic or other surgery for removal of excess fat or skin following weight loss, pregnancy or surgery, regardless of medical necessity or supervision by a Physician. Complications from any excluded expenses are also excluded.
54. Expenses for memberships in, or visits to, health clubs, exercise programs, gymnasiums and/or any facility for physical fitness programs, including exercise equipment.

# How To File Claims And Appeals

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## Filing Claim Forms

When receiving medical treatment, present your medical benefits identification card at the time of treatment. Generally, if you use a PPO provider, the provider will submit a Claim to the Plan Administrator on your behalf. If your provider does not submit a Claim on your behalf, follow the instructions in this section. A Claim is defined on page 47.

You should file your initial Claim for Plan benefits **within one year** after the date you receive services. If a Claim is denied, in whole or in part, there is a process you can follow to have your Claim reviewed by the Trustees.

Follow these steps when submitting Claims:

1. Contact the Fund Office to obtain the correct Claim form and confirm your eligibility for benefits. Whenever possible, do this *before* incurring any health care expenses.
2. Fill out **your** portion of the Claim form completely and accurately. Be sure to provide: your name, date of birth and Social Security number, other group health plans you or a Dependent is covered under, your Dependent's name, date of birth and Social Security number if the Claim is for a Dependent.
3. Have your provider fill out **his/her** portion of the form. It's important that your provider show a diagnosis on the Claim form. If your Physician provides his/her own Claim form, you may submit it in addition to the form provided by the Fund Office, but be sure the provider writes in his/her diagnosis.
4. Attach all bills or receipts relating to the health service provided. Also, make sure the bill clearly identifies what services were performed and the amount charged for each service.
5. Usually, when you use PPO providers, they file Claim forms for you. If your provider does not file your Claim, be sure to attach all itemized Hospital bills or Physician's statements that describe the services rendered and file your Claim with the Fund Office.
6. If you have questions at any point in the Claim filing process, call the Fund Office at (913) 236-5490.
7. *If the Claim you are submitting is the result of an accident*, be sure to complete the separate accident report.
8. If you are applying for the weekly accident and sickness benefits, be sure the Physician has completed his/her portion of the Claim form. Otherwise, payment of the weekly accident and sickness benefit will be delayed.

9. Send the completed Claim form and any supporting documentation to:

Greater Kansas City Laborers Welfare Fund  
c/o TIC International Corporation  
6405 Metcalf  
Cloverleaf Building 3, Suite 200  
Overland Park, Kansas 66202

10. Your Claim will be reviewed by the Fund Office. You will be notified of their decision on your Claim as described below. You may also appeal a Claim decision as described below.

When reviewing and processing Claims, the Fund will:

- Take steps to assure that Plan benefit provisions are applied consistently with respect to similarly situated Plan Participants; and
- Consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or is Experimental or Investigative).

#### *Discretionary Authority Of Plan Administrator*

The Plan Administrator, which is the Board of Trustees, has discretion and authority to interpret the terms of the Summary Plan Description/Plan Document and Agreement and Declaration of Trust and to interpret any facts relevant to a determination, and to determine eligibility and entitlement to Plan benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. The Plan Administrator may delegate any or all of its duties with respect to Claims and Appeals to an Appeal Committee or other third party.

<p><b>Days</b> For the purpose of the Claim and appeal processes, "days" refers to calendar days, not business days.</p>
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#### *Authorized Representative*

An Authorized Representative is the person with authority to act on the Claimant's behalf to file a Claim or appeal in accordance with the Fund's procedures. Subject to the written statement requirement discussed below, the following individuals may be recognized as the Claimant's Authorized Representative:

- Health care provider;
- Legal spouse;
- Dependent child age 18 or over;
- Parents or adult siblings;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

The Plan requires a written statement from the individual that he/she has designated one of the above individuals as the Authorized Representative along with the representative's name, address and phone number. Where the individual is unable to provide a written statement, the Plan will

require written proof (e.g., power of attorney for health care purposes, court order of guardian/conservator) that the proposed Authorized Representative has been authorized to act on the individual's behalf. An assignment for payment to a health care provider is **not** a designation of the provider as an Authorized Representative.

Once the individual names an Authorized Representative, the Plan will route all future Claims and appeals-related correspondence to the Authorized Representative and not the individual. The Authorized Representative of a Claimant will be able to take any action or inaction that could be taken by the Claimant. The Plan will honor the designated Authorized Representative for one year, or as mandated by a court order, before requiring a new authorization. The individual may revoke a designated Authorized Representative by submitting a signed statement.

The Trustees, or its designated representative, have the sole discretion to determine whether a Claimant has properly designated an Authorized Representative. The Plan reserves the right to withhold information from a person who claims to be the Authorized Representative if there is suspicion about the qualifications of the individual claiming to be the Authorized Representative.

### *Definition Of A Claim*

- A Claim is a request for a benefit from the Fund for covered expenses incurred and made by an individual (also referred to as “Claimant”) or that individual’s duly Authorized Representative in accordance with the Fund’s reasonable Claims procedures.
- There is no pre-certification or pre-approval required for any benefit payable under this Plan. Therefore, there are no pre-service, concurrent care or urgent care Claims.
- All Claims under this Fund are post-service Claims. All payment of benefits is for expenses previously incurred by a Claimant. While there is no prior approval required for medical expenses or procedures, individuals or providers may voluntarily telephone or write the Fund Office to ask if certain procedures or individuals are covered under the Plan. Such inquiries are not Claims and answers are not binding on the Fund.

A post-service Claim is a request for benefits under the Plan that is not a pre-service Claim. Post-service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper Claim or electronic bill submitted for payment after services have been provided are examples of a post-service Claim.

### *Claim Elements*

A claim must include the following elements to be processed by the Plan:

- Be written or electronically submitted in accordance with HIPAA's EDI standards;
- Be received by the Fund Office or applicable PPO within one year of the date service was provided;
- Name a specific individual (Claimant/Patient);
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested and an itemized detail of charges;
- Identify the provider's name, address, phone number, professional degree or license, and Federal tax identification number (TIN);
- When another plan is primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement along with the submitted Claim; and
- When accidental injury is involved, details of the accident.

A request is **not** a Claim if it is:

- Not made in accordance with the Fund's benefit Claims filing procedures described in this booklet;
- Made by someone other than the individual or their Authorized Representative;
- Made by a person who will not identify themselves (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- For prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit Claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal; or
- When a prescription is presented to a pharmacy to be filled under the terms of this Plan. However, if the request for a prescription is denied, in whole or in part, a Claimant may file a Claim and appeal with the Fund in accordance with these Claims and Appeals Procedures.

### *Non-Disability Claims*

Typically, non-disability Claims are decided within 30 days from the Fund's receipt of the Claim. The time for deciding the Claim may be extended one time by the Fund for up to 15 days, upon notice to the Claimant. The notice will be sent before the expiration of 30 days. The notice will state the circumstances that are beyond the control of the Fund and require the extension and the date by which the Fund expects to render a decision. This is the "Initial Determination Period."

If a Claim cannot be processed due to insufficient information, the Fund will suspend the Initial Determination Period and notify the Claimant of the information required and the time period for providing the information to the Fund. The Claimant will have 45 days from receipt of the notification to supply the additional information.

The suspension ends at the earlier of the Fund's receipt of the requested information or the end of the 45-day period. The Initial Determination Period then begins to run again. If the information is not provided within the time period required by the Fund, the Claim will be denied. The Fund then has the balance of the original 30 days to make a decision and notify you of the determination. If the Fund has applied the 15-day extension, then the Fund has this additional 15 days to determine the Claim.

### *Disability Claims*

A disability claim is a claim for weekly accident and sickness benefits or accidental death and dismemberment benefits.

A disability Claim is a Claim for weekly accident and sickness benefits and AD&D benefits due to dismemberment.
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The Fund will make a decision on Disability Claims and notify you of the decision within 45 days of the Fund's receipt of the Claim. The time period for deciding the Claim may be extended by the Fund for two periods of 30 days each, upon notice to the Claimant. The notice for the first extension, if necessary, will be sent before the expiration of the initial 45-day period. The notice for the second extension, if necessary, will be sent before the expiration of the first 30-day extension. The notice(s) will state the circumstances that are beyond the control of the Fund that require the extension and the date by which the Fund expects to render a decision. This is the "Initial Determination Period."

If a Claim cannot be processed because of insufficient information from the Claimant, the Fund will suspend the Initial Determination Period and notify the Claimant of the information required

and the time period for providing the information to the Fund. The Claimant will then have 45 days to provide the additional information. The suspension ends at the earlier of the Fund's receipt of the requested information or the end of the 45-day period. The Initial Determination Period then begins to run again. If the information is not provided within the time period required by the Fund, the Claim will be denied. The Fund will notify the Claimant of the determination no later than the end of the Initial Determination Period.

For disability Claims, the Fund reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while a Claim for benefits is pending.

### **Notice Of Adverse Benefit Determination**

You will be provided with written notice of a denial of a Claim (whether denied in whole or in part). Ordinarily, this "Adverse Benefit Determination" will be in the form of an explanation of benefits (EOB). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific benefit provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review or appeal;
- If an internal rule, guideline or protocol was relied upon in deciding your Claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your Claim, or a statement that it is available upon request at no charge.

### **Requesting A Review Of A Denied Claim**

If your Claim is denied, in whole or in part, or if you disagree with the decision made on a Claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of a denial.

### **Appeal Process**

You have the right to review documents relevant to your Claim. A document, record or other information is relevant if it:

- Was relied upon by the Fund in making the decision;
- Was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);
- Demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
- Constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your Claim, without regard to whether their advice was relied upon in deciding your Claim.

The Board of Trustees or Appeal Committee designated by the Board of Trustees will review your Claim. The Board of Trustees or Appeal Committee will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your Claim was denied on the basis of a medical judgment (such as a determination that the Treatment or service was not Medically Necessary, or was Investigative or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the professional originally consulted in the denial of your Claim, or the subordinate of that professional.

### *Hearing Procedures*

- The Claimant and/or a duly Authorized Representative will be afforded an opportunity to appear before the Board or Appeal Committee and will have the right and opportunity to examine witnesses, produce documents, and other evidence material to the Claim.
- The proceedings of the hearing will be preserved by means of tape recordings, stenographic or court reporter's records.
- In conducting the hearing, the Board or Appeal Committee will not be bound by the usual common law or statutory rules of evidence.
- The Claimant or his or her Authorized Representative will have the right to review the tape recording of the hearing and obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to.
- There will be copies made of all documents and records introduced at the hearing and same will be attached to the record of the hearing and made a part thereof. In lieu of attaching copies of the documents and records, reference may be made to them on the tape recording and same will be retained in the Claimant's Claim file.
- All information upon which the Board or Appeal Committee bases its decision will be disclosed to the Claimant or his or her Authorized Representative at the hearing.
- In the event that additional evidence is introduced by the Board that is not made available to the Claimant before the hearing, the Claimant will be granted a continuance of so much time as he or she desires, not to exceed 30 days provided that the Claimant agrees in writing to such extension. (For the purposes of this section, evidence discovered upon examination of the Claimant's own witnesses will not be considered "new evidence.")
- The Claimant will be afforded the opportunity of presenting any evidence in his or her behalf. If the Claimant offers new evidence, the hearing may be adjourned with the written consent of the Claimant for a period of not more than 30 days so that the Board or Appeal Committee may investigate and determine whether additional evidence or the accuracy of the Claimant's new evidence will be considered.

You or your Authorized Representative may appear before the Board of Trustees or Appeal Committee and will have the right and opportunity to examine witnesses, produce documents and other evidence that is material to your Claim.

### *Timing Of Notice Of Decision On Appeal*

Ordinarily, decisions on Claims on appeal (non-disability and disability Claims) will be made at the next regularly scheduled meeting of the Board of Trustees or Appeal Committee of the Board of Trustees after receiving your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting after receiving your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary.

You will be advised in writing in advance if an extension will be necessary. You will be advised of the specific reason for the delay and the timing of the expected decision on the Claim.

Once a decision on the review of your Claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

### *Notice Of Decision On Review*

The decision on any review of your Claim will be given to you in writing. The notice of a denial of a Claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific benefit provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your Claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review or appeal;
- If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on Medical Necessity, or because the Treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your Claim, or a statement that it is available upon request at no charge.

### *Limitation On When A Lawsuit May Be Started*

You may not start a lawsuit to obtain benefits until after you have requested an appeal and a final decision has been reached on appeal, or until the appropriate time frame described above has elapsed since you filed a request for appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

## Administrative Information

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### Coordination Of Benefits

When members of a family are covered under more than one group benefit plan, there may be instances of duplication of coverage—two plans paying benefits for the same medical expenses. This Plan takes into account benefits coverage you and your Dependents have under other plans to ensure that benefits payable are not more than the actual medical expenses incurred. The Plan's Coordination of Benefits (COB) provision coordinates the medical, dental and vision benefits (*but not prescription drug benefits*) payable by this Plan with similar benefits payable under other plans.

If you and/or your Dependents are covered by this Plan and by another plan(s) that provides medical, dental or vision benefits, benefits will be coordinated between the plans. This Plan can never pay more on any Claim than it would have if it did not coordinate benefits with another plan.

Benefits are coordinated with other plans, which include:

- Group, blanket or franchise insurance coverage;
- Group Blue Cross or Blue Shield coverage and other group Hospital service equipment coverage, medical service prepayment coverage, group practice and other prepayment coverage (except if you pay the subscription charge or premium payment directly to the organization providing coverage);
- Coverage under labor-management trustee plans, union welfare plans, employer organizational plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group; and
- Coverage under governmental programs, including Medicare when legally possible and any coverage required or provided by any statute (except Public Medical Assistance Programs).

The plan that pays benefits first is called the "primary plan," and the plan that pays benefits second, is called the "secondary plan." Special rules are used to determine which plan is primary and secondary, as explained below. When benefits are coordinated, you receive payments from the primary *and* secondary plan.

This Plan could be the primary *and* secondary plan for your spouse and children if your spouse is covered under this Plan as both an Employee and Dependent.

### *Which Plan Pays First*

These rules determine which plan pays first:

1. A plan without coordination of benefit rules will pay benefits before a plan that contains coordination of benefit rules.
2. A plan that covers a person other than as a Dependent will pay benefits before a plan that covers the person as a Dependent. If you and your spouse are covered as Employees under the Plan, you will both be covered as Dependents of the other.
3. For Claims of Dependent children whose parents are married, the plan that covers the parent whose birthday (month and day) falls first in the calendar year will pay first. If the parents

have the same birthday, the plan covering the parent for the longer period of time will pay first.

4. If one plan uses gender rules and the other plan uses the birthday rule, the rules of the other plan will determine which plan pays first (except in the case of a Dependent child whose parents are separated or divorced).
5. For Claims of Dependent children of separated or divorced parents, these rules determine which plan pays first:
  - If there is a court decree that establishes financial responsibility for health care expenses, the plan covering the Dependent children of the parent who has the responsibility will be primary.
  - If there is no court decree, the plan that covers the parent with custody will be primary.
  - If there is no court decree and the parent with custody has remarried, the order of benefits will be:
    - The plan of the parent with custody;
    - The plan of the step-parent with custody; and then
    - The plan of the parent without custody.
6. If none of the above rules determines order of payment, the plan that has covered the person for the longest continuous time pays benefits first.

### *Coordination With Medicare*

If you and/or your spouse are age 65 or older and retired or otherwise eligible for Medicare where Medicare is your primary coverage, coverage under the Plan will be coordinated with Medicare Parts A and B. **The coverage will be coordinated whether or not you have applied for the coverage from the Social Security Administration. It is important that you apply for Medicare as soon as you are eligible because the benefits provided by the Plan will be reduced according to payments Medicare would make.**

**Coordination with Medicare.** If you are eligible for Medicare, your benefits will be coordinated with Medicare.

*Enroll in Medicare* as soon as you are eligible. When you are eligible, the Plan treats you as if you were enrolled in Medicare, so you should enroll to keep your expenses down.

If you are still eligible for benefits as an active Employee and are performing work for which contributions are paid to the Fund, your benefits will also be coordinated with Medicare. However, if Medicare is not your primary coverage, the Plan will pay first, and Medicare will pay any additional amounts where Medicare coverage is applicable (if you are enrolled in Medicare).

Persons age 65 and older or disabled are eligible to enroll for benefits under Title XVIII of the Social Security Act of 1965 (Medicare). Part A of Medicare, which covers Hospital expenses, generally does not require a premium payment. Part B covers other types of medical expenses and requires you to pay a monthly premium. To be covered under Parts A and B, you need to apply.

When coordinating with Medicare, this Plan and Medicare together will not cover more than 100% of covered expenses for an accident or illness.

### *Order Of Benefit Payment*

This Plan has *primary* responsibility for expenses incurred by you or your Dependent spouse if you meet the following qualifications:

- You are at least age 65;

- You are eligible for Medicare Part A solely because of age; and
- With respect to the Employee only, you are actively employed by an Employer that pays all or part of the required contributions for eligibility.

The Plan has *secondary* responsibility for you and your Dependent spouse if you are:

- Not actively employed by an Employer that pays all or part of the required contributions for eligibility; and
- Eligible for Medicare Part A because of age.

The Plan will have secondary responsibility (even if the Eligible Person is also eligible for Medicare Part A because of age) for expenses incurred by an Eligible Person who is eligible for primary Medicare benefits because:

- Of end-stage renal disease, (after the first thirty months of Medicare eligibility); or
- He or she is disabled and has received Social Security disability benefits for 24 consecutive months.

The Plan will have primary responsibility for the Claims of an Eligible Person who is eligible for secondary Medicare benefits solely because of end-stage renal disease.

### ***General Information About Medicare***

Medicare is a three-part program. The first part is officially called “Hospital Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part A of Medicare. The second part is officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers Hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician’s services, although it, too, covers a number of other items and services. Part C of Medicare is called Medicare Advantage and covers Medicare managed care offerings. If you are covered by a managed care plan, the Plan will presume that you have complied with the managed care program’s rules necessary for your expenses to be covered by the managed care program.

If you do not enroll for Part B coverage within the three months after becoming age 65, and you stop working or lose eligibility for Plan benefits, you may enroll for Part B coverage within seven months of the first day of the first month in which you are no longer covered by the Plan without any penalty or waiting period. If you are such an individual and you do not enroll for Part B coverage within this seven-month period, you may enroll during the “general enrollment period.” This “general enrollment period” occurs between January 1 and March 31 of each year and coverage begins the following July 1.

The monthly premium will be assessed a 10% increase for each full 12 months (after age 65) you are not enrolled in Part B coverage. However, months during which you were covered by the Welfare Plan are not counted.

**It’s your (and your Dependent’s) responsibility to apply for Medicare Part A and Part B.** If you or your Dependent are eligible for Medicare and want information about enrollment, contact your local Social Security Administration Office three months before your 65<sup>th</sup> birthday or when you are otherwise eligible for Medicare. Contact your local Social Security Administration Office if you have questions concerning Medicare eligibility, enrollment or coverage.

## Subrogation

If the Fund provides benefits for Injury, Illness or other loss to any Participant, the Fund is subrogated to all rights of recovery to any funds or monies that person, his or her spouse, Dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Covered Person") may have arising out of said Injury, Illness or other loss. The recovery will not be limited by characterization of loss and will include recovery for personal Injury, lost wages, loss of service, disability and Claims for wrongful death, survivor or other Claims under any state or federal law. The Fund is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Fund is entitled to first dollar reimbursement from any recovery regardless of whether the Covered Person is made whole by the recovery. The Fund will be entitled to assert a lien against third parties, insurers, attorneys and other appropriate persons or entities to protect its right of subrogation.

### Subrogation

If the Plan pays benefits on your behalf as a result of an Injury caused by another party, the Plan has the right to seek payment/repayment of those benefits from the party that caused the Injury.

The Fund's subrogation rights include, without limitation, priority to first dollar recovery from any settlement or judgment and all rights of recovery of a Covered Person to any payments made by or on behalf of a responsible person including, but not limited to, a recovery:

- Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the Injury;
- From any fund or policy of insurance or accident benefit plan providing no fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;
- Under uninsured or underinsured motorist insurance;
- Under motor vehicle medical payment insurance; and
- Under specific risk accident and health coverage or insurance, including, without limitation, premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverage or insurance.

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend will execute and deliver such documents and papers (including, but not limited to, a benefits questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund as the Fund may require. The Covered Person will do whatever else is necessary to protect the rights of the Fund, including allowing the intervention by the Trustees or Fund or the joinder of the Trustees or Fund in any Claim or action against the responsible party or parties.

The Fund Trustees are vested with full discretionary authority to determine eligibility for benefits, to construe subrogation and other Plan provisions and to reduce or compromise the amount of the Fund's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, will be binding on the Fund without the Fund's written approval thereof, and the Fund expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Fund's subrogation interest will be deducted first from any recovery from any entity or source by or on behalf of the Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Fund, pursuant to the subrogation right, will not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common law/state law doctrine purporting to reduce the amount of the Fund's recovery.

The Fund reserves the right to initiate an action in the name of the Covered Person or his or her guardian, conservator or next friend to recover its subrogation interest, and the Covered Person or

his or her guardian, conservator or next friend will cooperate fully with the Fund in such instances.

In the event of any failure or refusal by the Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Fund, or (2) to take any other action requested by the Fund to protect the interest of the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments made from future Claims of the Covered Person.

The Covered Person will not do or engage in any negotiations that would reduce, compromise or prejudice the Fund's rights to first recovery from any third party. In the event the Covered Person recovers any amount by settlement or judgment from any person, corporation, insurance carrier, governmental agency or other responsible party (1) the Fund will be repaid in an amount equal to the full amount of benefits paid by the Fund and (2) no further benefits for treatment or services related to the Injury leading to the settlement or recovery will be paid by the Fund. If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Fund's right to subrogation, the amount of the Fund's Claim will be deemed to be held in constructive trust, and the Fund will be entitled to seek restitution, impose a constructive trust or seek any other legal or equitable remedies available (including recovery of the Fund's attorneys' fees and costs) by instituting legal action against the Covered Person or other party. In addition, the Fund reserves the right to offset and/or deduct any amounts paid as benefits against future Claims submitted by the Participant and his or her Dependents.

The Fund will not pay or be held responsible for any portion of the Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Fund reserves the right to first dollar reimbursement from any recovery to the full amount of benefits paid by the Fund and hereby Claims a first lien against the proceeds of any settlement or judgment and priority over any Claim or lien of legal counsel, insurers or any other third party. The Covered Person will provide all of the above referenced individuals with notice of the Fund's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Covered Person or his/her guardian, conservator or next friend, provided any such agreement is established in writing.

If the Covered Person, or his/her guardian, conservator or next friend does not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Fund will be entitled to institute legal action against the responsible party or parties in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to or on behalf of the Covered Person.

In an action brought by the Fund, the reasonable cost of recovery, including Fund's attorneys' fees, will first be deducted from any recovery by judgment or settlement against the responsible party or parties. The Fund's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the Injury or Illness, will next be deducted with the balance paid to the Covered Person.

### **Use And Disclosure Of Protected Health Information (PHI)**

The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan); and
- Reimbursement to the Plan.

### *Health Care Operations*

Health care operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:

- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
  - Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
  - Resolution of internal grievances; and
  - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
- Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

For purposes of this section, the Board of Trustees of the Greater Kansas City Laborers Welfare Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual or pursuant to a business associate contract;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the Plan Administrator or the staff designated by the Plan Administrator may be given access to PHI. Such persons may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the

persons described in this paragraph do not comply with this Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

***Your Right To File A Complaint With The Plan Or The HHS Secretary***

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Official. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services (HHS):

Hubert H. Humphrey Building  
200 Independence Avenue S.W.  
Washington, D.C. 20201

<p>You have the right to file a complaint if you feel your privacy rights have been violated.</p> <p>The Plan may not retaliate against you for filing a complaint.</p>
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The Plan will not retaliate against you for filing a complaint.

***If You Need More Information***

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the Fund Office:

Privacy Official  
TIC International Corporation  
6405 Metcalf, Suite 200  
Overland Park, Kansas 66202  
(913) 236-5490

***Conclusion***

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

The Plan's Privacy Notice will be issued in paper form to all Participants. Or, upon request, the Privacy Notice may be issued on the Plan's Web site or distributed via e-mail. A revised Privacy Notice will be issued to all Participants within 60 days of material revision to the Privacy Notice or at any time at the request of an individual. At least every three years, the Plan will inform Participants of the availability of the Privacy Notice.

# Important Plan Information

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## *Name Of Plan*

The name of the Plan is Greater Kansas City Laborers Welfare Fund.

## *Board Of Trustees*

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of Employer and Union representatives. If you wish to contact the Board of Trustees, you may send correspondence to the Fund Office or to the address shown below. The Trustees of the Plan, as of May 1, 2005, are:

### *Union Trustees*

Mark E. Adkins  
Laborers Local 1290  
2600 Merriam Lane  
Kansas City, KS 66106

Charles H. Jones  
2560 Pleasant Ridge Road  
St. Joseph, MO 64504

Mark R. Nidiffer  
Laborers Local 1290  
2600 Merriam Lane  
Kansas City, KS 66106

John J. Rider  
7156 Remington Oaks Loop  
Lakeland, FL 33810

Reginald L. Thomas  
Laborers Local 264  
1101 East 87<sup>th</sup> Street, Suite 103  
Kansas City, MO 64131

Leslie W. Williams, Secretary  
Business Manager  
Laborers Local 264  
1101 East 87<sup>th</sup> Street, Suite 103  
Kansas City, MO 64131

Larry Yarnell (Alternate Trustee)  
Laborers Local 264  
1101 East 87<sup>th</sup> Street, Suite 103  
Kansas City, MO 64131

Carlton Young (Alternate Trustee)  
Laborers Local 1290  
2600 Merriam Lane  
Kansas City, KS 66106

### *Employer Trustees*

Jeffrey L. Chaikin, Chairman  
The Builders' Association  
632 West 39<sup>th</sup> Street  
Kansas City, MO 64111

Gregory A. Dunn  
Dun-Par Engineered Form Co.  
9608 Norfleet Avenue  
Kansas City, MO 64138

Dan. R. Meyer  
Rau Construction Company  
9650 Nall Avenue  
Overland Park, KS 66207

### *Plan Sponsor And Administrator*

The Board of Trustees is both Plan Sponsor and Plan Administrator. For address information for the Board of Trustees, please see above.

### *Identification Numbers*

The number assigned to the Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 43-6039074.

### *Agent For Service Of Legal Process*

Ms. Linda N. Winter, Esq. is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Ms. Winter at:

Arnold, Newbold, Winter & Jackson, P.C.  
1125 Grand Boulevard, Suite 1600  
Kansas City, MO 64106

Legal documents may also be served upon any individual Trustee.

### *Source Of Contributions*

The benefits described in this booklet are provided through Employer contributions. Contributions to the Plan are made by Employers in accordance with their Collective Bargaining Agreements. All agreements must be approved and accepted by the Trustees.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreements.

An Employee whose eligibility is to terminate will be allowed under certain circumstances to continue coverage for a limited period of time by making direct contributions to the Plan.

### *Type Of Plan*

The Plan is maintained for the purpose of providing loss of time and health care benefits in the event of Sickness or accident and benefits in the event of death. The Plan benefits are shown in the **Schedule Of Benefits** (see page 3). The Plan is administered through a third party administrator. All benefits are provided on a self-insured basis directly from the Fund's assets.

### *Trust Fund*

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible Participants and defraying reasonable administrative expenses.

### *Eligibility*

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are described fully in this booklet.

### *Claim Procedure*

The procedures to follow for filing a Claim for benefits are explained beginning on page 45 of this booklet. If all or any part of your Claim is denied, you have the right to request that the Board of Trustees review the matter and that the matter be submitted to a hearing.

### *Plan Year*

The Plan year and the fiscal year for the Fund begins on November 1 and ends on October 31 of the following year.

### *Plan Amendment And Termination*

While the Trustees intend to maintain the Plan indefinitely, they have the authority, in their sole discretion and without prior notice to Participants, Employees, contributing Employers, the Union and others affected, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time by execution of an instrument in writing should conditions so warrant. If the Plan is modified or terminated, you will be notified in writing or as required by law.

The Trust may be terminated as a result of the expiration of all Collective Bargaining Agreements requiring payment of contributions to the Fund, or for any other reason deemed necessary by the Trustees.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a plan for dissolution adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any participating Employer, association or labor organization.

### **Statement Of ERISA Rights**

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

#### *Receive Information About Your Plan And Benefits*

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description/Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

## *Continue Group Health Plan Coverage*

You also have the right to:

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ends.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- Under Federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas. However, this coverage is subject to the plans normal annual deductibles and coinsurance provisions.

## *Prudent Actions By Plan Fiduciaries*

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## *Enforce Your Rights*

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Summary Plan Description/Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

### *Assistance With Your Questions*

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

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210

For more information about your rights and responsibilities under ERISA:

- Call (866) 444-3272; or
- Visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Definitions

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**Agreement and Declaration of Trust, Trust Agreement or Trust**—the original Agreement and Declaration of Trust executed on April 1, 1962, including any amendments or modifications.

**Association**—The Builders' Association with principal office at 632 West 39th Street, Kansas City, MO 64111.

**Beneficiary**—a person designated by a Participant or by the terms of the Plan who is, or may become, entitled to receive any type of benefit from the Fund.

**Board of Trustees**—the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees will constitute the “Administrator,” the “Plan Sponsor” and the “Named Fiduciaries” of the Trust and of the Employee benefit plan established and maintained under the authority of the Trust Agreement.

**Chiropractor**—an individual duly trained and licensed to perform chiropractic services by the governmental authority having jurisdiction over such licensing.

**Claim**—See page 47.

**Collective Bargaining Agreement**—the labor agreement, including any amendments, between the Union and the Association, or a labor agreement between the Union and any other Employer.

**Covered Person**—an Employee for whom payments are made to the Fund as provided by a Collective Bargaining Agreement or who meets the definition of "Employee."

**Dependent**—see page 8.

**Dentist**—an individual duly licensed to practice dentistry by the governmental authority having jurisdiction over such licensing.

**Durable Medical Equipment**—equipment that:

- Can withstand repeated use and is not a consumable or disposable item;
- Is exclusively and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of Injury or Illness; and
- Is appropriate for use in the home.

**Eligible Person**—an Employee, Retired Employee and/or their Dependents who are entitled to the benefits payable under the Plan and have fulfilled the Plan's eligibility requirements and any other requirement or restriction provided under any individual benefit under the Plan.

**Emergency**—Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. In the event of a behavioral health disorder, the lack of the treatment

could reasonably be expected to result in the patient harming himself or herself and/or other persons.

**Employee**—includes any:

- Person who is employed by an Employer as that term is defined herein and for whom the Employer is required to make contributions into the Trust Fund;
- Employee of the Union or of a participating Union;
- Employee of the Association;
- Employee of the Trustees; and
- Other Employee of an Employer who has been accepted as such by the parties involved with this Plan and the Trustees.

**Employer**—includes:

- Any member of the Association who is a party to, or otherwise bound by, a Collective Bargaining Agreement with the Union requiring payments to the Trust Fund with respect to Employees represented by the Union;
- Any Employer who is a non-member of the Association who has signed a stipulation agreement with the Union and the Trustees in accordance with the provisions of the Agreement and Declaration of Trust;
- Any other Employer or group of Employers who have been approved by the Union and the Association and accepted by the Board of Trustees; and
- The Trustees of the Trust as to the Employees of the Trust, the Union as to the Employees of the Union, participating Unions as to the Employees of participating Unions and the Association as to the Employees of the Association. Such status of the Union, participating Unions and Association will be solely for the purpose of making the required contributions to the Fund and neither the Union, participating Unions nor the Trustees will participate in the selection of any Association Trustees.

**Experimental, Investigative or Inappropriate Drug, Device, Treatment or Procedure**—a service or treatment on which the consensus of expert medical opinion, based on reliable evidence (i.e., published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment. “Experimental, Investigative or Inappropriate” also means such services or treatments not yet official and not yet recognized as having proven beneficial outcomes, those still primarily confined to a research setting and those that are not appropriate based on medical circumstances and/or given the advanced stage of a Covered Person’s Sickness or the likelihood that the service or treatment will measurably improve the Covered Person’s Sickness or medical condition. It also means:

- A drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has been so approved for marketing at the time the drug or device is furnished;
- A drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function;

- A drug, device, treatment or procedure which Reliable Evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis; or
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocol used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

The Trustees will have the sole authority to determine, in their discretion, whether a service, procedure, drug, device or treatment modality is Experimental, Investigative or Inappropriate. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

**Fund, Welfare Fund or Health and Welfare Fund**—the Trust Fund created pursuant to the Trust Agreement and, in general, means the monies or other things of value that comprise the corpus and additions to the Trust Fund.

**Hospital**—a place that is licensed as a Hospital (if licensing is required by law), that is operated for the care and treatment of resident inpatients, has a laboratory, registered graduate nurses always on duty and an operating room where surgical operations are performed by legally qualified Physicians or Surgeons.

For the purpose of paying benefits for mental or nervous disorders, Hospital means, a place, other than a convalescent, nursing or rest home, that has accommodations for resident bed patients, facilities for the treatment of mental or nervous disorders and a resident psychiatrist always on duty or on call, and that, as a regular practice, charges the patient for the expense of confinement.

For the purpose of paying benefits for the treatment of alcoholism, chemical dependency or drug addiction, Hospital also means a residential primary treatment program as licensed by the appropriate state agency pursuant to a diagnosis or upon the recommendation of a legally qualified Physician or Surgeon.

Hospital also includes a skilled nursing facility that primarily provides rehabilitative services that are intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily functions. A Hospital also includes specialty hospitals, which are licensed to provide acute care.

A Hospital does not include a hospital or institution or part of a Hospital or institution that is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

**Injury**—an accidental bodily injury resulting directly and independently of all other causes.

**Illness or Sickness**—a condition in which a person is unable to function in his or her normal capacity due to bodily organ malfunction or any other temporary ailment, including pregnancy.

**Medical Foods**—Modified low protein foods and metabolic formulas as described here:

- Modified Low Protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract and are processed or formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.
- Metabolic Formulas are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because a person has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.
- Medical Foods are *not* natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders.

**Medically Necessary or Medical Necessity**—a service or supply that:

- Is consistent with the symptoms of diagnosis and treatment of the Eligible Person's Injury or Illness;
- Is appropriate with regard to good medical practice and recognized by an established medical society in the United States; and
- Could not have been omitted without adversely affecting the Eligible Person's condition or the quality of medical care.

The fact that a Physician has prescribed, recommended or approved the treatment, service or supply does not, in itself, make it eligible for payment.

**Osteopath**—a Physician duly licensed to practice osteopathy by the governmental authority having jurisdiction over such licensing.

**Participant**—any Employee or former Employee of an Employer who is, or may become, eligible to receive any type of benefit from this Fund or whose Beneficiaries may be, or may become, eligible to receive any such benefit.

**Physician or Surgeon**—an individual duly licensed to practice medicine and, for a Surgeon, to perform all surgery by the governmental authority having jurisdiction over such licensing. Physicians also include duly licensed Osteopaths, Chiropractors, podiatrists, optometrists, and oral surgeons.

**Plan, Welfare Plan or Health and Welfare Plan**—the schedule of benefits and the rules and regulations of the Plan and Trust Fund including any amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

**Retired Employee**—any person who retires from active employment and meets the retirement requirements explained on page 9.

**Reasonable and Customary (R&C) Charge**—the charge for a service or supply that is not higher than the usual amount charged in the locality for similar services or supplies. The Fund will also consider the complexity of the service in determining R&C.

**Speech Therapist**—an individual duly trained and licensed by the governmental authority having jurisdiction over such licensing in administering speech therapy prescribed by and under the supervision of a Physician.

**Union**—the Laborers Local Unions Nos. 264 and 1290 of the Western Missouri and Kansas Laborers District Council of the Laborers International Union of North America, AFL-CIO.