Combination Plan Document & Summary Plan Description
Construction Industry Laborers Welfare Fund

To All Participants:

We are pleased to provide you with the Construction Industry Laborers Welfare Fund Combination Plan Document & Summary Plan Description booklet. It can also be found online at http://www.cilfunds.com/health. This booklet summarizes the Benefits available to you under your Welfare Plan.

The contents and provisions of the Plan as of July 1, 2020, include a description of your Comprehensive Medical, Dental, Vision, Loss of Time, Death, and Accidental Death and Dismemberment Benefits. This booklet includes eligibility rules, description of the Benefits available, as well as limitations and exclusions. Benefit amounts are summarized on the Schedule of Benefits.

This booklet also contains information concerning your rights as a participant under the Plan and your rights to continue coverage after it has been cancelled. The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be provided to participants. That information is included here, as well.

You and your Dependents should read this booklet carefully and retain it in a safe place for future reference. If you should have any questions concerning the Benefits available to you, please feel free to write or call the Fund Office at (816) 777-2669 or toll-free at (833) 479-9429.

The Fund is maintained and administered by an unpaid Board of Trustees on which the Union and Employers are equally represented. The Board of Trustees has the primary responsibility for decisions regarding eligibility rules, time and manner of payment of Benefits, administrative policies, management of Fund assets, and interpretation of Plan provisions. Only the Trustees are authorized to interpret the Plan and not any Employer or Union representative.

If you wish to contact the Board of Trustees, write the Fund Administrator at the Fund Office.

Construction Industry Laborers Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500

Office Hours: 8:00 A.M. to 5:00 P.M.
Monday through Friday

Telephone: (816) 777-2669
Toll Free: (833) 479-9429

Website: http://www.cilfunds.com/

Statement Regarding Status as a Grandfathered Health Plan

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

Questions regarding which protections apply and which do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Contact Information

In order to assist you, we have placed the following "contact" information on this page:

FUND OFFICE

Wilson McShane Corporation
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2669
(833) 479-9429 (toll-free)

Website: http://www.cilfunds.com/

PREFERRED PROVIDER ORGANIZATION (PPO)
For the most up-to-date PPO Provider information, contact BlueCross BlueShield of Kansas City (BlueKC):

- Online at www.bluekc.com
- By phone at (800) 810-2583 (BLUE)

BLUE KC NURSE LINE
Any participant can call and speak to a clinical nurse for any healthcare concern 24 hours a day / 7 days a week / 365 days a year.

- Toll-Free (877) 852-5422

BLUE CROSS BLUE SHIELD OF KANSAS CITY PRIOR AUTHORIZATION
You must receive authorization prior to any in-patient Hospital stay. If you use an In-Network provider, the provider will get the authorization. If you use an Out-of-Network provider, you must request the authorization. The contact number is on your ID card and listed below:

- (816) 395-3989
- Toll-Free (800) 892-6116

PRESCRIPTION BENEFIT MANAGER (PBM)

SavRx
224 North Park Avenue
Fremont, NE 68026
Toll-Free: (800) 228-3108
www.SavRx.com

DENTAL BENEFIT
For up-to-date Connection Dental Network provider information, contact Preferred Health Professionals (PHP):

- Online at www.connectiondental.com
- By phone at (800) 544-3014

VISION BENEFIT

Wilson-McShane Corporation
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2669
(833) 479-9429 (toll-free)

NEW DIRECTIONS EMPLOYEE ASSISTANCE PROGRAM (EAP)
The EAP is a voluntary and confidential program that was established to help participants and Dependents with personal problems, including alcohol or drug abuse and dependency, depression and many other issues that may create difficulties on the job or at home. The EAP offers services nationwide at no cost to the participant or Dependent. For more information about the program, contact:

- Online at www.ndbh.com
- By phone toll-free at (800) 624-5544

HEARING NETWORK

Amplifon
Toll-Free: (866) 861-4369
https://www.amplifonusa.com/cilfunds

TELEHEALTH AMWELL
The Telehealth Amwell program allows you to visit with a doctor through your computer (with a webcam) or by using your smartphone. The doctors are available 24 hours a day / 7 days a week and will be able to answer questions, make diagnosis and in some cases prescribe basic medications, when needed. There is no cost to you for this program but prior to using the program you must download the Amwell app and complete your enrollment

WRAP NETWORK - EPLAN
Out-of-Network claims greater than $5,000 incurred by the Participant will be submitted to EPlan as a potential cost control method for potential savings to the Plan and the Participant. Not all claims submitted to EPlan will be eligible for savings.

Table of Contents

Article I - Schedule of Benefits

Section 1.01 – COMPREHENSIVE MEDICAL BENEFITS:

Calendar Year Individual Deductible.....$400
Amounts paid towards the Calendar Year Individual Deductible from October 1 through December 31 each year will be credited towards both the current calendar year and the next calendar year.

Calendar Year Family Deductible

Per Family per year.....$800

Amounts paid towards the Calendar Year Individual Deductible from October 1 through December 31 each year will be credited towards both the current calendar year and the next calendar year.

Coinsurance
(Amount the Plan Pays After Deductible Until Out-of-Pocket Maximum is Met)
After the Out-of-Pocket Maximum is met, the Plan pays 100% of covered UCR Charges for the remainder of the calendar year.
BCBSKC Preferred Care Blue PPO Network..... 90%

Blue Card PPO Network..... 90%
BCBSKC and Blue Card Participating Providers..... 85%
BCBSKC and Blue Card Traditional Providers..... 60%
Out-of-Network, Non-Participating Providers..... 60%

Out-of-Pocket Maximum (After Deductible)
Per Individual Per Calendar Year $3,000

Comprehensive Medical Benefits
Subject to deductible and Coinsurance. Applies to the out-of-pocket maximum

Chiropractic Care Benefit (Covered Employee and Spouse Only)
Subject to deductible and Coinsurance
Applies to the out-of- pocket maximum
Calendar Year Maximum.....$250

Routine Physical Exam
Covered Employee, Spouse and Dependent Children over age 21 and under age 26
Subject to Coinsurance
Applies to the out-of-pocket maximum
In Network Benefits only

Emergency Room Benefit
After the Emergency Room Co-Payment, subject to deductible and Coinsurance
Applies to the out-of-pocket maximum

Emergency Room Co-Payment.....$70
(waived if admitted to Hospital)

Urgent Care Benefit
Subject to deductible and Coinsurance
Applies to the out-of-pocket maximum

Telehealth Amwell Benefit
No Co-Payment
Not subject to deductible or Coinsurance
In-Network Benefit only

This Benefit only applies to the Telehealth Amwell Program. No other programs are covered.
No out-of-pocket cost to use Telehealth Amwell Program.

Hospice Care Benefit
Subject to deductible and Coinsurance
Applies to the out-of-pocket maximum
Benefit limited to six months every three years

Organ and/or Tissue Transplant
Subject to deductible and Coinsurance
Applies to the out-of-pocket maximum
Must be Blue KC Designated Treatment Provider

Hearing Aid Benefit (Active Plans Only)
Subject to Coinsurance
Not subject to deductible
Applies to the out-of-pocket maximum
In Network Benefit only

Benefit payable for testing and hearing devices
once every five Consecutive Calendar Years ..... up to $750

Colonoscopy
Subject to Coinsurance
Not subject to deductible
Applies to the out-of-pocket maximum
In Network Benefit only

Limit to one every ten years for Members age 50 and older.
Screenings earlier than age 50 for family history of colon cancer.

Qualified Alcohol & Drug Treatment
Subject to deductible and Coinsurance
Applies to the out-of-pocket maximum

Mental Health Care
Subject to deductible and Coinsurance
Applies to the out-of-pocket maximum

Pediatric Preventive Care
Dependent Children through age 21
In-Network Benefit only. Out-of-Network expenses will not be covered.
Not subject to deductible, Coinsurance or out-of-pocket limits
Coinsurance..... 100%

Prescription Drug Benefit

Retail Pharmacy (up to 30–day supply)
Coinsurance 80%

Mail Order or Walk-In Mail Order Option
Coinsurance 87%

There are certain classes of prescriptions that are offered at a discounted price; however, you must pay 100% of the Coinsurance. *See page 31 for more information.*

Loss of Time Benefit

(Active Employee Only)
Weekly Benefit $300
Maximum Benefit ..... 13 Weeks

Dental Expense Benefit

Coinsurance of UCR charges 80%
up to the maximum below

Maximum Per Individual
- Routine Preventive Visits ..... 2 per calendar year
- Orthodontia-Lifetime Maximum $2,500
- Temporomandibular Joint - once every 5 years $1,000
- All Other Charges – Calendar Year Maximum* $2,000

* Calendar Year Maximum will not apply to Dependents under age 19 for preventive dental care services.

Vision Expense Benefit

Complete Examination* $50

Lens, Pair*
Single Vision RX $60
Contact Lens RX $100
Bi-Focal RX $100
Tri-Focal/Progressive RX $125
Lenticular RX $130

Frames* $90

* Dependents under age 19 are limited to one examination and one set of glasses or contacts per calendar year. Currently for adults 19 years and older, lenses may be replaced each calendar year, but frames every other calendar year.

Death Benefit – Active Employees	
Covered Employee	$5,000
Spouse	$3,000
Natural, Legally Adopted and Stepchildren	
10 days to 6 months	$ 500
6 months to 25 years	$3,000

Death Benefit – Retirees Not Eligible for Medicare	
Covered Employee	$2,500
Spouse	$2,500
Natural, Legally Adopted and Stepchildren	None

Accidental Death & Dismemberment Benefit - Actives Only	
Covered Employee	$5,000
Spouse	$3,000
Natural, Legally Adopted and Stepchildren	
10 days to 6 months	$500
6 months to 25 years	$3,000

Section 1.02 – RETIREES AND/OR DEPENDENTS ELIGIBLE FOR MEDICARE

Death Benefit Retiree.....$2,500
Death Benefit Spouse.....$2,500
Death Benefit Children .....None

Medicare Benefit

Medicare Part A
Deductible per spell of Illness..... 100%
Daily Co-Payment from 61st –90th day of Hospital confinement 100%
Daily Co-Payment from 21st-100th day of nursing home confinement for Rehabilitation purposes only..... 100%

Medicare Part B
Annual Deductible 100%
Then 20% of remaining Covered Expenses

Prescription Drug Benefit.....None

Pediatric Preventive Care
Dependent Children through age 21
In-Network Benefit only. Out-of-Network expenses will not be covered.
Not subject to deductible, Coinsurance or out-of-pocket limits
Coinsurance..... 100%

Dental Expense Benefit
Coinsurance..... 80%
Maximum Per Individual
Routine Preventive Visits..... 2 per calendar year
Orthodontia-Lifetime Maximum.....$2,500
Temporomandibular Joint - once every 5 years.....$1,000
All Other Charges – Calendar Year Maximum* $2,000

* Calendar Year Maximum will not apply to Dependents under age 19 for preventive dental care services.

Vision Expense Benefit
Complete Examination *.....$50

Lens, Pair *
Single Vision RX $60
Contact Lens RX.....$100
Bi-Focal RX $100
Tri-Focal/Progressive RX $125
Lenticular RX.....$130

Frames*.....$90

* Dependents under age 19 are limited to one examination and one set of glasses or contacts per calendar year. Currently for adults 19 years and older, lenses may be replaced each calendar year, but frames every other calendar year.

Article II – Eligibility

The following topics are discussed under this Article on Eligibility Rules:

Section 2.01 – Establishing Employee Coverage and Effective Date

You can establish eligibility and receive Benefits by working sufficient hours for a Contributing Employer who pays the required contribution to the Fund subject to the following conditions:

(a) having worked for a Contributing Employer a minimum of 275 hours during a qualifying period; or

(b) having worked for a Contributing Employer a minimum of 1,100 hours during four consecutive qualifying periods; or

(c) having worked for an Employer, who is accepted by the Trustees, and obligated by written agreement to make contributions to the Fund on behalf of Employees.

In any case, your effective date of coverage (and that of your Dependents') will not occur until the first day of the next coverage quarter, January 1, April 1, July 1, or October 1, following the qualifying period, provided contributions have been received by the Fund.

Qualifying Period	**Coverage Quarter**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August	October, November, December

Example: If you begin work in Covered Employment on June 1, 2019 and work 275 hours during the Qualifying Period of June – August 2019, your coverage is effective October 1, 2019 and you will have coverage during the Coverage Quarter of October – December 2019.

Note: If you work in "Disqualifying Employment" as defined in this document, any and all hours worked before the date of Disqualifying Employment WILL NOT be used as a basis for eligibility.

Section 2.01.A – Immediate Eligibility
Immediate Eligibility may be offered to a newly organized Employer or to an individual Employee engaged in organizing activities. Immediate Eligibility must be requested in writing and will be effective in accordance with the Fund's Policy. Eligibility in accordance with the Fund's Policy will terminate at the end of five months, or if the Employee's employment is terminated, or if the Employee satisfies initial eligibility in accordance with Section 2.01 above, whichever occurs first. A copy of the Immediate Eligibility Policy is available by request to the Fund Office.

Section 2.02 – Continuing Eligibility as an Active Employee
After establishing eligibility, you can continue your eligibility by working sufficient hours in qualifying periods as stated above.

Section 2.03 – Continuing Eligibility during Disability
If you are a Covered Employee who is Totally Disabled because:

- of an occupational or non-occupational Illness or Accident; and
- are under the treatment of a legally licensed Physician (does not include a Chiropractor) or Qualified Outpatient Alcohol and Drug Treatment Agency;

you will be allowed a weekly credit of 40 hours, for continuation of coverage, not to exceed 400 hours (10 weeks), with no allowance for split weeks.

Credit hours will be calculated:

- from the first day of Total Disability due to an Accident; or
- from the eighth day of Total Disability due to Illness;

after you are first treated by a legally licensed Physician, or an outpatient alcohol and drug treatment agency.

If, before the eighth day, you are confined to a Hospital or Free Standing Residential Alcohol or Drug Treatment Agency or undergo surgery, credit hours will be calculated from the date of the confinement or surgery.

The 40-hour weekly credit allowance does not apply to:

- Retirees
- Employees who are not employed by an Employer obligated under a collective bargaining agreement
- Employees who are deceased
- Employees who are not eligible for Loss of Time Benefit

If you have qualified for continued coverage for two consecutive calendar quarters by credit under Loss of Time Benefit, you cannot be covered again through credit under Loss of Time Benefit, unless you have qualified for coverage under reinstatement of eligibility.

Section 2.04 – Reciprocal Agreements
Any other welfare fund that enters into an agreement with the Construction Industry Laborers Welfare Fund to allow the transfer of contributions between funds will be known as a reciprocating welfare fund.

If you work outside the jurisdiction of this Fund, you should contact your local Union representative or the Fund Office to determine if there is a reciprocal agreement between the funds and the requirements for the transfer of contributions to your "home fund." If there is a reciprocal agreement and you want the contributions transferred to your "home fund," you must obtain and complete a proper transfer authorization form as required under the reciprocal agreement.

Section 2.05 – Reinstatement of Eligibility
If you lose your eligibility for Benefits, as defined under paragraphs (a) and (b) of Benefit Eligibility in Section 2.01, you will have your Benefits reinstated on the first of January, April, July, or October provided:

(a) a minimum of 275 hours of contributions have been made into the Fund during the qualifying period preceding the coverage quarter; or

(b) 1,100 hours of contributions have been made into the Fund for four consecutive qualifying periods preceding the coverage quarter.

Section 2.06 – Family and Medical Leave Act
Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits must be extended to you and your Dependents if you are an active participant and if you have been granted leave by your Employer pursuant to the FMLA and if your Employer makes the required contributions to the Fund.

The FMLA requires your Employer to inform you of your rights and obligations under this new law. You may contact the local Wage and Hour Division of the United States Department of Labor if you have questions regarding the FMLA.

If you have been granted FMLA leave, your Employer must notify the Fund Office to prevent a loss of eligibility. You may wish to notify the Fund Office yourself when you are granted FMLA leave, but you are not required to do so. Your Employer will be required to complete an administrative process to verify your eligibility for Benefits while on leave. **Your Employer must pay for your extended eligibility.**

Your eligibility will not be extended during the FMLA leave if your Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if your Employer does not make the required timely contributions and a loss of eligibility will result. Please contact the Fund Office for more information.

Section 2.07 – Military Leave
If you are inducted into the Armed Forces of the United States, or enlist in the military service during a national emergency, or who because of membership in a reserve component of the Armed Forces are called into active federal service, you will immediately lose all welfare Benefits for yourself and your Dependents, if such service in the Armed Forces is for more than 31 days.

When such service in the Armed Forces is for more than 31 days, the amount of your eligibility that is remaining at the time of activation for service may be frozen or suspended until you return from such service and elect to reinstate coverage under the Plan. You may make self-payments to continue coverage for yourself and your Dependents for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act (USERRA). However, you will not accumulate any additional eligibility during the time you are absent for such service, and an election to make self-payments to continue coverage during the time of such service (for a period of up to 24 months) will not result in the accumulation of any additional eligibility.

YOU MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN YOU KNOW YOU ARE ENTERING SERVICE IN THE ARMED FORCES.

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into service in the Armed Forces and a retroactive payment to that date may be charged. You have an obligation to notify the Fund Office, as soon as you know you are entering such service **if you wish to take advantage of contribution coverage. Failure to notify the Fund Office may be taken as an indication that you do not wish to purchase coverage for you or your Dependents; so your coverage may not be frozen, and therefore your coverage will not be available when you return.**

For service in the Armed Forces of 31 days or more, but less than 181 days, an application for re-employment with a Contributing Employer must be filed within 14 calendar days (not work days) after your release from such service. For service in the Armed Forces over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge from such service.

Upon discharge from service in the Armed Forces, frozen Benefits (if any) for you and your Dependents will be reinstated on the date that you return to work with a Contributing Employer, provided such return to work is within the deadline stated in the previous paragraph.

If you do not return to work with a Contributing Employer within 90 days of your separation from such service, you may regain eligibility upon meeting the initial eligibility requirements as stated in Section 2.01. If you do not return to work with a Contributing Employer, and do not intend to regain eligibility under the requirements stated in Section 2.01, the reinstatement of your frozen eligibility (if any) will be reviewed and determined by the Trustees upon your request.

Section 2.08 – Waiver of Coverage and Reenrollment Rights

A participant eligible through a Non-Bargained Employee Participation Agreement with the Fund may waive benefits under this Plan and decline active coverage for the participant and the participant's Dependents if the participant has other retiree group health care coverage available. In order to waive coverage under this Section, said participant must submit a waiver form which may be obtained from the Fund Office. Proof of other retiree group health care coverage must accompany this form when submitted. Failure to provide supporting documentation will deem this form to be incomplete and the waiver denied.

If a participant, eligible through a Non-Bargained Employee Participation Agreement with the Fund, waives coverage under this Section, such participant will have a right to apply for coverage under the Plan for the participant and Dependents within 30 days after the termination or loss of the participant's other retiree group health care coverage. Other retiree coverage is not deemed to have "ceased" or been "lost" if the participant voluntarily terminates coverage, loses coverage because of failure to pay premiums or because of fraud. In order to reenroll under this Section, the Participant must submit a form for enrollment which may be obtained from the Fund Office within the 30 days after loss of the other retiree group health care coverage.

Section 2.09 – Dependent Waiver

A Dependent of an active or retired participant may waive coverage if other group health care coverage is available. In order to reenroll under this Section, a Dependent of an active or retired participant must submit a HIPAA Certificate of Creditable Coverage to the Plan demonstrating there was no break in coverage under the other Plan. This documentation must be submitted within 30 days after the loss of the other group health care coverage.

Section 2.10 – Dependent Eligibility

Dependent includes the individuals defined in Section 17.17, and that provided documented proof of dependency is on file with the Fund Office. Documented proof may include, but is not limited to: marriage license, birth certificate, legal separation document, divorce decree, property settlement agreement, Qualified Medical Child Support Order (QMCSO) or other documentation, as required.

A Covered Employee has 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If a Covered Employee has a child, that child must be added as a Dependent within 60 days of the child's birth. If the new Dependent is added in a timely manner, the new Dependent will be eligible effective the date of the life event.

If a Dependent is not added in a timely manner (more than 30 days after the life event or more than 60 days after birth), the new Dependent will be eligible beginning with the first of the month after the receipt of all documented proof of dependency.

If a person who is your Dependent is also a Covered Employee and eligible for Benefits under this Plan, the Plan will pay benefits as a Covered Employee and then pay benefits as a Dependent. . Benefits will not exceed a total payment of 100% of the UCR Charge.

If a person is a Dependent child where both parents are Covered Employees and are eligible for Benefits under this Plan, the Plan will pay as the primary parent's benefit as determined in Section 13.01 and then pay as the secondary parent's benefit. Benefits will not exceed 100% of the UCR Charge.

See Section 13.01 for further information on Coordination of Benefits.

Section 2.11 – Initial Retiree Eligibility

To be eligible for retiree coverage, the retiree or surviving Spouse that is not re-married must:

- be receiving monthly benefits under the Construction Industry Laborers Pension Plan or other labor plan (not applicable to surviving Spouse); and

- have had coverage under this Welfare Plan for at least 12 out of 20 calendar quarters before the effective date of benefits under the Construction Industry Laborers Pension Fund; and

- have 10 or more pension credits with the Construction Industry Laborers Fund (Reciprocal Pension Credits earned under St. Louis Laborers Pension Fund, the Kansas Construction Trades Open End Pension Fund, or the Greater Kansas City Laborers Pension Fund may be used to satisfy this requirement). LIUNA National Plan service or other evidence satisfactory to the Trustees may be submitted to prove ten years of service as a laborer (not applicable to surviving Spouse); and

- have elected coverage at the time of retirement.

You must pay a monthly cost as established by the Board of Trustees to maintain Retiree coverage elected.

Retirees and their Dependents are eligible for Dental and/or Vision Benefits, if elected at the time of retirement. If you subsequently discontinue Dental and/or Vision Benefits, you will not be allowed to re-elect these Benefits at a later date.

Retirees and their Dependents are eligible to purchase coverage for Dental and/or Vision Benefits under the Plan as a self-payment option only as established by the Board of Trustees. Each Retiree must elect coverage for Dental and/or Vision Benefits at open enrollment on a form approved by the Board of Trustees.

Section 2.12 – Retirees Who Return to Work for a Contributing Employer
There are two rules for establishing initial eligibility when you return to work for a Contributing Employer after at least three consecutive months following the date on which your annuity start date:

Rule 1
If you intend to return to **active** status, you may establish initial eligibility, provided Employer contributions have been received by the Fund, as follows:

(a) Complete an election form to notify the Plan that you intend to return to active status and file the form with the Fund Office; and

(b) Complete one of the following hours requirements:

(1) you must work for a minimum of 480 hours during a calendar year; or

(2) you must work for a minimum of 1,200 hours during the four consecutive qualifying periods within the first 12 months after you return to work,

Rule 2

If you intend to **return to work temporarily but do not intend to return to active status**, you may establish initial eligibility, provided Employer contributions have been received by the Fund, as follows:

(a) You must work for a minimum of 480 hours during a qualifying period; or

CAUTION: If you are retired and then work at least 475 hours for a Contributing Employer during a Plan Year, your pension benefits may be suspended by the Construction Industry Laborers Pension Fund.

(b) You must work for a minimum of 1,920 hours during the four consecutive qualifying periods,

then you will be covered for Benefits for three months beginning on the January 1st, April 1st, July 1st or October 1st following the qualifying period, provided contributions have been received by the Fund.

Qualifying Period	**Coverage Period**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August	October, November, December

Once you establish eligibility, you maintain your eligibility under the rules listed in Section 2.02.

If you return to work in Disqualifying Employment as defined in this document, any and all hours worked before the date of Disqualifying Employment will not be used as a basis of eligibility.
If you are a Retiree and are eligible under Section 2.11 by making the required self-payments, you must continue to make self-payments to maintain coverage until you have worked enough hours as stated above to regain eligibility by hours.

Section 2.13 – Spouse or Dependent of Retiree - Right to Waive Coverage

If you are a Retiree, your Spouse or Dependent may waive coverage if other group health care coverage is available. To waive coverage, your Spouse or Dependent must submit a waiver which may be obtained from the Fund Office. Proof of other group health care coverage form must be submitted with the waiver. If the other group health care coverage ends for any reason, your Spouse or Dependent may reenroll in the Plan. To reenroll in the Plan, your Spouse or Dependent must submit a HIPAA Certification of Creditable Coverage or other statement from the group health plan that coverage was terminated to the Fund Office within 30 days after the loss of the other group health care coverage.

If you failed to select coverage for your Spouse at the time of your initial retirement and your retirement effective date was before January 1, 2012, then your failure may be treated as a request to waive coverage for your Spouse. You may request coverage:

1. if your Spouse was married to you on your initial retirement effective date; and

2. if your Spouse has maintained coverage under another group health plan; and

3. your Spouse lost coverage no later than 30 days prior to your request to elect spousal coverage; and

4. you provide proof of the other group health coverage for at least five years prior to the loss of that coverage.

Section 2.14 – Termination of Employee Coverage
Your coverage as a Covered Employee will immediately terminate:

1. On the date the Plan is terminated.

2. On the date you commence active duty in any military force of any country or state (see Military Leave Section 2.07).

3. On the date you cease to be eligible for coverage according to the rules for eligibility established by the Trustees.

4. On the date you are employed in "Disqualifying Employment."

5. On the date you cease to be eligible for a pension benefit under the Construction Industry Laborers Pension Fund.

6. On the date you cease to make timely payments for Retiree Coverage.

7. On the date you cease to make timely payment for COBRA Continuation Coverage.

Section 2.15 – Termination of Dependent Coverage
The coverage of your Dependent will immediately terminate:

1. On the date the Covered Employee's coverage terminated;

2. On the last day of the month that your natural, adopted or stepchild ceases to be a Dependent as defined in Section 17.17;

3. On the date your Totally Disabled child or any other child who is not your natural, adopted or stepchild ceases to be a Dependent as defined in Section 17.17;

4. On the date your Dependent child commences active duty in any military force of any country or state;

5. On the last day of the month for an ex-spouse;

6. On the date the coverage period ends following the remarriage of your surviving Spouse who is eligible for Retiree coverage;

7. On the date timely payment is not made for Retiree Dependent coverage;

8. On the date timely payment is not made for COBRA Dependent coverage.

Section 2.16 – Right to Continuation of Coverage

Federal law requires that sponsors of group health plans such as the Construction Industry Laborers Welfare Fund offer Covered Employees and their families a temporary extension of their health care coverage under the Plan, (called "COBRA Continuation Coverage") in exchange for self-contribution payments to the Plan. The right to an extension of health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and to other members of your family (you and your Dependents under the terms of the Plan) who are covered by the Plan when you would otherwise lose your group health coverage, referred to as "Qualified Beneficiaries."

What is COBRA Continuation Coverage?

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

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

    a. Your hours of employment are reduced, or

    b. You are terminated from employment for any reason other than the Covered Employee's gross misconduct.

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

    a. Your hours of employment are reduced;

    b. You are terminated from employment for any reason other than your gross misconduct;

    c. You die;

    d. You become enrolled in Medicare; or

    e. You and your Spouse become legally separated or divorce.

3. COBRA Continuation Coverage will be offered to your Dependent child if coverage under the Plan ends for the following reasons:

    a. Your hours of employment are reduced;

    b. You are terminated from employment for any reason other than the Covered Employee's gross misconduct;

c. You die;

d. You become enrolled in Medicare;

e. You and your Spouse become legally separated or divorced; or

f. Your Dependent child ceases to be a Dependent as defined under the terms of the Plan.

How long will COBRA Continuation Coverage last?

1. 18 months
   If you or your Dependent lose coverage due to a reduction in your hours or due to the end of your employment, COBRA Continuation Coverage is available for a maximum of up to 18 months.

2. 29 months
   If you and/or your Dependent is disabled (as determined under Titles II or XVI of the Social Security Act) at the time coverage would otherwise terminate because of a reduction of hours or termination of employment, or who becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, you or your Dependent can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months of COBRA Continuation Coverage.

3. 36 months
   COBRA Continuation Coverage lasts up to a maximum of 36 months if your Dependent's health care coverage ends due to:

   a. You and your Spouse become legally separated or divorce;

   b. You become enrolled in Medicare;

   c. You die; or

   d. Your Dependent child ceases to be a Dependent as defined under the terms of Section 17.17.

4. Second Qualifying Event
   COBRA Continuation Coverage may also be extended for up to 36 months if your family experiences another event, called a "qualifying event" while receiving COBRA Continuation Coverage. If, while receiving COBRA Continuation Coverage, one of the following events occur, a Dependent is eligible for an extension of COBRA Continuation Coverage up to a maximum period of 36 months:

   a. You and your Spouse become legally separated or divorce;

b. You become enrolled in Medicare;

c. You die; or

d. Your Dependent child ceases to be a Dependent as defined under the terms of Section 17.17.

Keeping the Fund Office Informed of Changes

In order to protect your family's rights, the Fund Office should be informed of any changes concerning your family. You and any of your Dependents have the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or a Dependent child's loss of dependent status**. Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in your hours, termination of employment, enrollment in Medicare or death, you or your Dependent should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

In the event you or your Dependent become Totally Disabled during the initial 60-day COBRA Continuation Coverage period, it is the responsibility of you or your Dependent to notify the Fund Office of the determination of disability. **Failure to notify the Fund Office of a Total Disability determination may affect your right to extend the COBRA Continuation Coverage period due to Total Disability.**

Electing to Continue Coverage

When the Fund Office is notified that coverage will end due to a qualifying event, you and your Dependent(s) will be notified of your right to choose the COBRA 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. You and your Dependent(s) will then have the **later** of **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from the postmarked date of the Election Notice to elect the COBRA Continuation Coverage. If you or your Dependent(s) do not elect the COBRA 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 Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their Dependents.

If you or your Dependent has a newborn child, or adopts a child, or has a child placed with him or her for adoption during the COBRA Continuation Coverage period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except that the Death and Accidental Death and Dismemberment Benefits are not available.

Payments
The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees. For the first Benefit Period payments for COBRA Continuation Coverage, you will be given credit for the actual hours contributed on your behalf during the qualifying period. If you have at least 75% of the required work hours reported, the second subsequent benefit quarter's self-payment rate will be equal to 50% of the current quarterly COBRA payment rate. The full COBRA rate will be required for the remaining period of time you are eligible for COBRA continuing coverage.

After you or your Dependent elect to receive COBRA Continuation Coverage, the first premium must be made within 45 days of the election. Failure to make the required premium payments within the initial 45-day period will result in the loss of the COBRA Continuation Coverage.

There may be a reduction in COBRA rates based on previous work hours. Please call the Fund Office for more information.

Termination of COBRA Continuation Coverage
COBRA Continuation Coverage will end if any of the following occur:

1. A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;

2. You or your Dependent becomes covered under another group health plan;

3. You or your Dependent becomes entitled to Medicare;

4. The Fund no longer provides group health care coverage; or

5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

Section 2.17 – Special Enrollment Rights
The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 added the following special enrollment rights applicable to group health plans like this one. By law, the Plan must provide the following description of special enrollment rights to anyone who is not enrolled in the Plan but later becomes eligible for coverage, even though it is doubtful these rights would affect you or your Dependents since coverage under this Plan is automatic for you and your Dependents once you establish eligibility:

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

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

Article III - Comprehensive Medical Benefits

The following topics are discussed under this Article on Comprehensive Medical Benefits:

Section 3.01 – Calendar Year Individual Deductible

The individual deductible is the amount of Covered Expenses incurred in a calendar year that must be paid by you before you or your Dependents are eligible to receive Comprehensive Medical Benefits. The Comprehensive Medical deductible amount is shown in the Schedule of Benefits.

The deductible runs between January 1 and December 31 every year. Any amount that an individual pays towards his or her deductible in the fourth quarter of a calendar year (between October 1 and December 31) is credit towards that current calendar year deductible and the following year deductible.

Section 3.02 – Calendar Year Family Deductible

If the Covered Expenses applied to the individual deductibles for all eligible family members reach the Family deductible as shown in the Schedule of Benefits, then no additional deductible will be required for the remainder of the calendar year. No single member of the family can satisfy more than the individual deductible amount as shown in the Schedule of Benefits.

The deductible runs between January 1 and December 31 every year. Any amount that an individual pays towards his or her deductible in the fourth quarter of a calendar year (between October 1 and December 31) is credit towards that current calendar year and the following year.

Section 3.03 – Coinsurance

Coinsurance is the percentage of Covered Expenses paid by the Plan. The Coinsurance percentage is shown in the Schedule of Benefits. There are different Coinsurance levels that apply to the various networks and to out-of-network providers.

Section 3.04 – Co-Payment

Co-Payment is the flat dollar amount of Covered Expenses that you are required to pay after the calendar year deductible has been satisfied.

Section 3.05 – Out-of-Pocket Maximum
The maximum dollar amount you are required to pay for Covered Expenses incurred in any calendar year. When this amount is reached for an individual in any calendar year, certain Covered Expenses are payable at 100% for the remainder of the calendar year. The out-of-pocket maximum is shown in the Schedule of Benefits. The deductible is not included in the Out-of-Pocket Maximum.

The out-of-pocket maximum does not apply to the following medical expenses:

- Ineligible charges;
- Prescription drug charges; or
- Charges in excess of Plan maximums.

Section 3.06 – Participating Provider Network
You are covered by the BlueCross BlueShield Kansas City Network. For the most up-to-date provider information for BlueCross BlueShield Kansas City (BCBSKC), you can visit BKBSKC's website at www.bluekc.com or contact the Provider Finder at (800) 810-BLUE (2583). You may also call the Fund Office at (816) 777-2669 or toll-free at (833) 479-9429.

Section 3.07 – Prior Authorization for In-Patient Admission
Prior Authorization is the process used to confirm whether a proposed service or procedure is Medically Necessary, covered for the proposed care, and covered for the proposed length of stay prior to your in-patient admission. The network providers are responsible for contacting Blue KC with the information regarding the "elective" or "planned" medical services that will be performed. This process will be mandatory for all providers to follow for all "elective" or "planned" in-patient care services. This process is typically done behind the scenes between your Physician and the Hospitals by a licensed registered nurse to ensure the care you are receiving is cost efficient, high quality and appropriate for the medical services being rendered. However, in the event you use an out-of-network provider it will be your responsibility to contact Blue KC for prior authorization. The contact information is on your insurance card and in the Contact Information located in the front of this Combination Plan Document & Summary Plan Description.

Without prior authorization, your claim might not be approved and you would be responsible to pay the charges.

Section 3.08 – Covered Medical Expenses
If a Covered Employee or eligible Dependent receives Medically Necessary treatment as a result of a non-occupational Accidental Injury or Illness, the Fund will pay the UCR Charges for Covered Expenses for any such medical treatment or service. Payment is subject to the deductible amount, Coinsurance and maximum amounts shown in the Schedule of Benefits.

UCR Charges are those charges made for Medically Necessary services and/or supplies essential to the care of a Covered Person if:

1. The charges are the amount normally charged by the service provider for similar services and supplies.

2. The charges do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services and supplies are received.

Covered Charges include expenses incurred by a Covered Person for the following services, supplies and types of treatment:

1. Hospital Room and Board and other Hospital services and supplies required for purposes of treatment. The maximum Covered Charge for Hospital Room and Board is the PPO negotiated rate or the most frequent room rate per day being charged by the Hospital for confinement in other than the Intensive Care Unit. After 23 observation hours, a confinement will be considered an inpatient confinement;

2. Services or treatment (for minor surgical procedures, performed in an outpatient setting) which may include a Hospital, Ambulatory Surgical Care Center, or Physician's office;

3. The professional services of a Physician or psychologist as defined in this Plan;

4. A routine Annual Physical Exam for the covered Employee, legal Spouse and Dependent Children over age 21 and under age 26. This includes, but is not limited to, pap smear, mammogram, gynecological exam and prostate exam subject to the limits stated in the Schedule of Benefits;

5. Services of a legally licensed physical therapist, occupational therapist, registered nurse, or a licensed practical nurse provided that these services are not rendered by a member of the person's family. (Does not include Private Duty Nursing);

6. Surgical dressings, splints, casts (and other devices used in the reduction of fractures and dislocations), artificial eyes;

7. Anesthesia, blood, blood plasma and oxygen (including rental of equipment for its administration);

8. X-ray and laboratory examination or x-ray, radium and radio-active isotope therapy;

9. Medically Necessary transportation rendered by a Hospital or licensed ambulance service to or from a local Hospital or the nearest Hospital equipped to furnish necessary treatment not available at a local Hospital;

10. Purchase, repair and replacement of hearing aids incurred by any Covered Person subject to the Plan maximums stated in the Schedule of Benefits. Please contact Amplifon Hearing Health Care at (866) 861-4369 for locations of a Hearing Network Provider**;**

11. The initial purchase, fitting and replacement of orthotic appliances such as braces, splints or other appliances which are required for support of an injured or deformed part of the body as the result of a disabling congenital condition or an Accident or Illness;

12. Rental, not to exceed, the purchase price of Durable Medical Equipment as defined in Section 17.19. These items may be bought, rather than rented, subject to Medical Policy;

13. Cosmetic Surgery, if:

    - performed within 90 days and as a result of a non-occupational Accidental Injury; or

    - a treatment plan is established and on file with the Fund within 90 days of a non-occupational Accidental Injury.

    Covered Expenses must be incurred while coverage is in effect for the Covered Person.

14. The Room and Board and nursing care by a Convalescent Facility (Skilled Nursing Facility/Extended Care Facility/Rehabilitation Facility), due to confinement during a Convalescent Period solely for recovery from a Non-Occupational Accident or Illness, will be payable if and when:

    - the patient is confined as a bed patient within the facility and confinement starts within 14 days of a Hospital confinement of at least three days;

    - the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement and the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

    Covered Charges, for a Covered Person's care, in these facilities is limited to the semi-private room rate.

15. Treatment of a nervous, mental or emotional condition while not Hospital confined will be payable as stated in the Schedule of Benefits;

16. Surgical Expenses in connection with sterilization of the reproductive system, or voluntary abortion;

17. A second opinion for a proposed surgical operation. The second opinion, must be given by a Board Certified Specialist, in the medical field relating to the proposed surgical procedure. The surgeon giving the second opinion must not be practicing in the same group with the surgeon giving the original opinion as to the proposed surgery;

18. Hospice charges incurred by the Covered Person must be for services provided by a licensed hospice facility, for inpatient or in home care. To be eligible for the Hospice Benefit, a Physician must certify that a Covered Person's condition is terminal. Terminal is defined as having six months or less to live. The Benefit payment is subject to the limit stated in the Schedule of Benefits. There is no coverage for respite care;

19. Chiropractic charges for manipulations, physical therapy, x-ray and laboratory test **for the Covered Employee and Spouse only, subject to the Plan limits stated in the Schedule of Benefits;**

20. Any Expenses incurred as a result of pregnancy and delivery while a Covered Person is covered under these Comprehensive Medical Benefits will be eligible for the same Benefits as any other Illness;

21. The following are Covered Expenses in connection with a mastectomy:

    - Reconstruction of a breast on which a mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce symmetrical appearance;
    - Expenses for prosthesis and physical complications of all stages of a mastectomy, including lympheodemas.

    Coverage for these items will be for procedures as determined by consultation with the attending Physician and patient.

22. Human Organ and Tissue Transplant charges incurred for the Covered Person during a transplant period, which begins while a recipient is covered, for these Benefits. The transplant period begins five days before the date of the organ or tissue transplant and ends 12 months after the organ or tissue transplant is completed. Transplant services must be received from a Blue KC Designated Treatment Provider;

23. Speech Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (1) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a Frenectomy) of a person; (2) an Accident; or (3) an Illness that is other than a learning or mental disorder;

24. Charges associated with the initial purchase of a wig, after chemotherapy, up to a lifetime maximum of $250.00;

25. Diagnosis and treatment of infertility except for services and supplies specifically excluded in General Limitations and Prescription Drug Benefit;

26. Any human organ and tissue transplant donor expenses related to the donor when the transplant recipient is a Covered Person under the Plan and transplant services are received from a Blue KC Designated Treatment Provider;

27. Charges for Medically Necessary surgical interventions for treatment of Temporomandibular Joint Benefit (Temporomandibular Pain-Dysfunction Syndrome);

28. Telehealth Amwell Program. The Telehealth Amwell Program is designed to give Covered Persons the capability to speak with a certified Physician online (with a webcam) or through a smartphone to get quick access to certain prescriptions or other advice regarding a medical situation. The Telemedicine Benefit is available 24 hours a day, seven days a week. This Benefit is not meant for emergency situations, but it can help in deciding whether a medical situation is an emergency. There is no member Co-Payment per call as reflected in the Schedule of Benefits and it is not subject to deductible or Coinsurance;

29. Services and supplies related to growth hormone therapy to treat Turner Syndrome and congenital Panhypopituitarism.

30. Services and supplies related to dental anesthesia for a Dependent child when Medically Necessary.

31. Services and supplies related to breast pumps received from In-Network providers (including mail order). One breast pump per pregnancy is covered at 100% of allowable charges with a prescription from your Physician. Covered breast pumps can be manual or electric and double or single pump.

Section 3.09 – Pediatric Preventive Care Benefit

Benefits for Pediatric Preventive Care for Dependent Children through age 21, as detailed below, will be paid at 100% when received from an In-Network Provider without application of the Deductible Amount or Coinsurance. **Preventive care services received from an Out-of-Network provider will NOT be paid under the Plan.**

The Plan will rely on established techniques and relevant evidence to determine the frequency, treatment or setting for which a recommended preventive service will be available without cost-sharing requirements. For immunizations, the Plan will follow the schedule recommended by the Center for Disease Control (CDC). The current recommendations can be found at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf. The listing may change from time to time based upon the recommendation of the CDC and BlueKC policy.

In addition, if preventive pediatric services are received as a part of a regular office visit, the Plan can require you to pay a portion of the costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your provider bills you for the preventive services separately from the office visit.

Covered Charges for Pediatric Preventive Care are as follows:

Routine preventive Physician Examinations limited to the age ranges recommended by the American Academy of Pediatrics. The listing may change from time to time based upon the recommendation of the American Academy of Pediatrics and BlueKC policy.

Newborn hearing screening, audiological assessment and follow-up, and initial amplifications

Childhood Immunizations

- At least 5 doses of vaccine against diphtheria, pertussis, tetanus;
- At least 4 doses of vaccine against polio, Haemophilus Influenza Type b (Hib);
- At least 3 doses of vaccine against Hepatitis B;
- 2 doses of vaccine against measles, mumps, and rubella;
- 2 doses of vaccine against varicella;
- At least 4 doses of vaccine against pediatric pneumococcal (PCV7);
- 1 dose of vaccine against influenza;
- At least one dose of vaccine against Hepatitis A;
- 3 doses of vaccine against Rotavirus;
- Such other vaccines and dosages as may be prescribed by the State Department of Health

Section 3.10 – Qualified Alcohol and Drug Treatment Benefit
Any Covered Expenses incurred by any Covered Person for the treatment of alcoholism, drug addiction, drug dependency or drug overdose will be paid according to the Schedule of Benefit provided that treatment is provided in a Hospital, Free Standing Residential Alcohol or Drug Treatment Center or by an outpatient alcohol and drug treatment agency.

However, no Benefit will be payable for:

- Any treatment or service that is specifically excluded under the sections entitled "Limitations Applicable to All Comprehensive Medical Benefits" or "General Limitations."

- Any charges in connection with a court ordered alcohol or drug treatment.

This is the only Benefit payable for the treatment of alcoholism, drug addiction, drug dependency or drug overdose.

Addiction to the use of tobacco will not be considered drug addiction and charges for smoking cessation programs or other treatment of addiction to tobacco will not be considered Covered Charges under this Benefit.

Section 3.11 – Comprehensive Medical Benefits for Active Employees and Dependents Eligible for Medicare
If you are an active Covered Employee, and you or your Dependent **are eligible for Medicare**, you are entitled to Benefits under this plan on the same basis as active Covered Employees and Dependents not eligible for Medicare.

Section 3.12 – Comprehensive Medical Benefit Limitations and Exclusions
Please read this Section carefully.

The Plan will **not** pay any of the following medical expenses:

1. Any treatment or service not prescribed by a Physician, as defined in this Plan;

2. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, the following charges will be covered:

    a. services or supplies provided for or in connection with an accidental injury to sound natural teeth provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch, and

    b. services and supplies related to dental anesthesia for a Dependent child when Medically Necessary;

3. Loss caused by Accidental Injury, disease or Illness which arises out of or occurs in the course of any occupation or employment for wage or profit; loss caused by any Accidental Injury, disease or Illness for which the Covered Employee claims to be, or may claim to be, or is entitled to any benefits under any Worker's Compensation or occupational disease law; and the Fund retains the option to withhold payment of Benefits for treatment of any Accidental Injury, disease or Illness which may be compensable under a Worker's Compensation or occupational disease law;

4. Any charges you or your Dependents are not, in absence of this coverage, legally obligated to pay, or that are furnished without charge, paid for through any governmental agency, unless specifically billed for by such agency as provided by law;

5. Any glasses, contact lens or eye examination for the correction of vision or fitting of glasses;

6. Any treatment or service while on active duty in any military force of any country or state;

7. Any speech therapy except as specifically provided for in these Comprehensive Medical Benefits;

8. Any expense related to an organ and/or tissue transplant which is provided by an out-of-network provider;

9. Any human organ and tissue transplant donor expenses related to the donor when the transplant recipient is not a Covered Person under the Plan, when transplant is not received from a Blue KC Designated Treatment Provider;

10. The following minor surgical procedures are **<u>not</u> covered unless:**

    - they are performed in an outpatient setting, which may include a Hospital, Ambulatory Surgical Care Center or Physician's office; or
    - the Physician certifies that it is necessary to perform the procedure on an in-patient basis.

    Adenoidectomy – Removal of adenoids
    Blepharoplasty – Removal of excess skin of the eyelids
    Breast Biopsy: Needle – Collection of small tissue sample of breast tumor for laboratory exam
    Carpal Tunnel Decompression – Relief of pressure on wrist nerve
    Cervical Lymph Node Biopsy – Excision of small piece of tissue from node in neck
    Closed Reduction of Nasal Fractures – Repairing nasal fractures without a cutting procedure
    Colonoscopy – Exam of large intestine by scope
    Cystourethroscopy – Exam of bladder by scope
    D & C – Dilation and curettage – Scraping of uterus
    Esophagoscopy- Exam of esophagus by scope

Excision of Small Lesions – Removal of small tumors, cysts, or scars
Extraction of Teeth
Ganglionectomy – Removal of wrist tumor
Gastroscopy – Exam of stomach by scope
Hammertoe operations – Straightening of toe
Laparoscopic Tubal Ligation – Female sterilization
Laparoscopy – Exam of abdominal organs by scope
Myringotomy – Creation of small opening in the ear, drum
Nail Procedures – Operations on fingernails and toenails
Puncture Aspiration of Breast Cyst –Needle drainage of breast cyst
Skin, Muscle, or Bone Biopsy – Excision of small tissue sample for laboratory exam
Small Skin Grafts – Covering a wound with tissue
Vasectomy – Male sterilization
Voluntary abortion

11. Services and supplies related to genetic testing;

12. Any Expenses related to medical contraceptives, except for diaphragm, injectables, drug-releasing intrauterine contraceptive device (IUD) and implantable contraceptive;

    Please see Article V for contraceptives covered under the Prescription Drug Benefits.

13. Any item listed in "Article X – General Limitations."

Group health plans and health insurance issuers offering group health insurance coverage 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 (e.g., your Physician, nurse midwife or physician's assistant), 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, set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour, as applicable) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer many not, under federal law, require that a provider obtain prior authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on pre-certification, contact your PPO.

Article IV - Prescription Drug Benefit

The following topics are discussed under this Article on Prescription Drug Benefit:

Prescription Drug charges are payable only under this Benefit and not under any other provision of the Plan. Prescription Drug charges **do not apply** to the annual deductible or out-of-pocket maximum under the Comprehensive Medical Benefit. **The Prescription Drug Benefit is not available to Medicare Eligible Retirees.** Prescription drug means a drug which by law must say "Caution: Federal Law Prohibits Dispensing Without Prescription" and is prescribed for an FDA approved use on well documented standard of medical treatment. The Plan will pay for prescription drugs, subject to the applicable Coinsurance, exclusions and limitations.

You may purchase prescriptions at either a retail pharmacy or through mail order. The appropriate use and duration of prescription drugs may be reviewed from time to time through the drug utilization review program. A preferred medications list is available upon request to SavRx.

Section 4.01 – Retail Pharmacy

To purchase a prescription at a participating retail pharmacy, present your prescription drug card, not your Welfare eligibility card, and prescription to the pharmacist. Your responsibility will be 20% (after the Plan's 80% Coinsurance) per covered prescription purchased at a participating pharmacy.

To purchase a prescription at a non-participating retail pharmacy, you must pay 100% of the cost of each covered prescription and then submit the receipts, with a claim form to the Prescription Benefit Manager listed on page iii. They will process your claim and, if the prescription is a covered prescription, will reimburse you for 80% of the cost of each prescription.

A retail pharmacy allows for up to a 30-day supply of your prescription.

Section 4.02 – Mail Order or Walk-In Mail Order

If you are taking a maintenance prescription (a prescription that you can expect to take on a long-term, ongoing basis, i.e., for treatment of high blood pressure or high cholesterol), your initial prescription and two refills of that medication may be obtained through a retail pharmacy. After the limited allowed fills at the retail pharmacy, you **must utilize the Mail Order or Walk-In Mail Order Service**. Your responsibility through the Mail Order or Walk-In Mail Order Service will be 13% (after the Plan's 87% Coinsurance) of the cost of each covered prescription. The Mail Order or Walk-In Mail Order Service allows for a 90-day supply or 300 units, whichever is greater. To purchase a prescription through the Mail Order Service, you must contact the Plan's prescription benefit manager identified on the back of your insurance card. To purchase a prescription through the Walk-In Mail Order Service, you must visit a participating pharmacy.

Section 4.03 – Step Therapy Program
The Plan participates in the PBM's Step Therapy Program in an effort to maintain and preserve a high quality and cost-effective program for you. This program is mandatory for certain medication classes. The Step Therapy Program is designed to help you receive the most cost-effective medications to treat certain conditions. The program promotes the use of generic medications because they are proven to be as safe and effective as brand name medications for most patients, but cost much less.

The Step Therapy Program groups certain medications into "steps". Generic medications, which are the most cost effective, fall into the "first-step" category, preferred brand-name medications fall within the "second-step" category and non-preferred brand-name medications, which are the least cost effective, fall into the "third-step" category. The Step Therapy Program steers you to take first-step medications prior to coverage of a second step medication and to take a second step medication prior to coverage of a third step medication.

The medication classes which qualify for the enhanced Step Therapy Program include: Antidiabetics, Antihypertensive, Asthma, Cholesterol Reducers, Proton Pump Inhibitors, Acne and Oral Antidiabetics.

If you or your Physician have any questions about this program, call SavRx's Customer Service Center at the phone number listed on page iii.

You have the option to take any medication that your Physician prescribes. However, it may not be covered under the Plan if the above proper steps are not taken first.

Section 4.04 – Prescription Drug Limitations
Certain prescription drugs or items in the following classes are eligible for a discounted price through the Plan's prescription benefit manager. Your responsibility will be 100% of the discounted prescription purchase. The cost of the following classes of prescription drugs are NOT COVERED (will not be paid by or reimbursed to you by the Plan). However, you can purchase prescription drugs from these classes at 100% of the discounted price:

- Weight control,
- Cosmetic drugs (example skin pigmentation),
- Sexual dysfunction,
- Smoking deterrents,
- Diaphragms.

Section 4.05 – Prescription Drug Exclusions
No Benefit will be payable for the following:

- Fertility drugs; infertility drugs,
- Items lawfully obtainable without a prescription-excluding insulin,
- Devices and Appliances,

- Prescriptions covered without charge under Federal, State or Local programs, to include Worker's Compensation,
- Drugs used for cosmetic purposes [e.g. Rogaine (monoxidil) for hair restoration],
- Any charge for the administration of a drug or Insulin,
- Experimental, Investigative or Inappropriate Drugs,
- Unauthorized refills such as attempting to refill a prescription prior to using 75% of the prescribed dosage,
- Genetically Engineered drugs [e.g. Growth Hormones], except as covered under Comprehensive Medical Benefits for treatment of Turner Syndrome and congenital Panhypopituitarism,
- Drugs used for the treatment of addiction to tobacco products, i.e., nicotine gum, Nicoderm patches,
- Drugs used for weight control (appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamin supplements containing fluoride),
- Drugs used for hormone therapy, except as otherwise provided in Comprehensive Medical Benefits to treat Turner Syndrome.
- Any Expenses related to prescription contraceptives, except for oral, vaginal ring, and transdermal contraceptives;

  Please see Article III for contraceptives covered under the Comprehensive Medical Benefits.

Section 4.06 – Prescription Benefit Manager Contact Information

If you have questions or need help determining if a pharmacy is a participating pharmacy for Sav-Rx or if you have questions regarding the drug formulary, you will need to contact Sav-Rx. Their contact information can be found on your drug card and is as follows:

Call: 24-hour Customer Care Call Center: (800) 228-3108

Website: www.SavRx.com

Article V - Dental Expense Benefits

The following topics are discussed under this Article on Dental Expense Benefit:

If a Covered Person is treated by a legally licensed dentist, the Plan will pay the Coinsurance percentage of the UCR Charges not to exceed the maximum amount shown in the Schedule of Benefits for each individual each calendar year. Covered Persons may use any dentist that they choose. However, using a dentist in the Connection Dental Network through PHP, may result in a lower out-of-pocket expense. See page iii for information on how to find a Connection Dental Network dentist. A charge shall be deemed to have been incurred on the date the applicable care or service is rendered.

Section 5.01 – Routine Oral Examination Benefit

The following procedures are included in this Routine Oral Examination Benefit for "check-up" purposes. A Covered Person can receive two routine oral examinations and cleanings each calendar year including but not limited to:

(a) Cleaning (prophylaxis)
(b) Oral examination
(c) Bitewing x-rays
(d) Diagnosis
(e) Fluoride and sealants
(f) Preparation of a complete treatment plan

Section 5.02 – Basic Dental Benefit

These Benefits may be part of a treatment plan or in connection with dental disease, a defect or Accident, but are not limited to:

(a) Fillings
(b) Crowns and bridges
(c) Partial and full dentures
(d) Extractions and other oral surgery
(e) Panoramic and full mouth x-rays
(f) Periodontal treatment
(g) Root canal therapy
(h) Anesthesiology

Section 5.03 – Denture Replacement Benefit

This Denture Replacement Benefit (full or partial) applies to Covered Charges for dental expenses arising from the replacement of dentures which is not the result of theft, breakage or loss of the previous dentures.

In addition, no charges will be paid for any replacement of a denture, which was previously covered under the Plan unless replacement is separated by five years from prior placement. All other provisions and limitations apply to this Benefit.

Section 5.04 – Orthodontic Benefit
This Benefit is payable for necessary orthodontic treatment which begins while the individual is covered, subject to the Coinsurance and the maximum amount shown in the Schedule of Benefits for each individual for their lifetime.

The insert date of the appliance will be considered the date the Covered Expense is incurred. The Fund will require certification from your dentist for continuation of orthodontic treatment.

If eligibility terminates after a course of orthodontic treatment has begun, payments will not continue past the eligibility termination date.

Section 5.05 – Temporomandibular Joint Benefit (Temporomandibular Pain-Dysfunction Syndrome)
This Benefit will be payable for Temporomandibular Pain-Dysfunction Syndrome therapy, rendered by a licensed dentist, for non-cutting surgical or non-surgical treatment including, but not limited to:

- Removable or non-removable occlusion altering appliances;
- Fixed or removable prosthesis;
- Any appliance or device used in or about the mouth designed to alter or restrict the movement of the jaw.

In addition to all other provisions and limitations of the Dental Expense Benefit, the Coinsurance and benefit maximum provisions apply as shown in the Schedule of Benefits.

If eligibility terminates after a course of Temporomandibular Pain-Dysfunction Syndrome therapy has begun, payments will not continue past the eligibility termination date.

Section 5.06 – Dental Expense Benefit Limitations
No Dental Expense Benefits will be payable for services or treatment:

1. Resulting from an Occupational Accidental Injury or Disease arising out of and during you or your Dependent's employment whether or not payment in whole or in part is received under any Workers' Compensation laws or similar federal or state laws. No claim will be considered or paid based on a denial by the Worker's Compensation Insurance Company or so long as a Worker's Compensation or similar law claim is pending, or has not been finally adjudicated as to coverage under the Act;
2. While on active duty in any military force of any country or state;
3. For any charges you or your Dependents are not, in absence of this coverage, legally obligated to pay, or that are furnished without charge, paid for through any governmental agency, unless specifically billed for by such agency as provided by law;
4. Provided, for cosmetic purposes, unless as a result of Accidental Injuries (Covered Expenses must be incurred while your coverage is in effect); or
5. For oral hygiene instruction or supplies;

6. For behavioral management or supplies;

7. Paid by the Fund under any other part of the Plan.

8. Provided before or after you or your Dependents are eligible for Benefits.

Section 5.07 – Dental Expense Benefit Opt-Out Option

A Covered Person may decline the Dental Expense Benefit by opting out of such coverage. To opt-out of the Dental Expense Benefit, please contact the Fund Office.

Article VI - Vision Expense Benefits

The following topics are discussed under this Article on Vision Expense Benefit:

Section 6.01 – Vision Expense Benefits

Vision Expense Benefits are payable to you and your Dependents as shown in the Schedule of Benefits which are for:

1. Examinations performed by a licensed optometrist or ophthalmologist;
2. Lenses or contact lenses prescribed by such person; and
3. Frames or contact lens fitting.

Vision care services can be obtained from any vision provider.

Section 6.02 – Vision Expense Benefit Limitations

No Vision Expense Benefits will be payable for the following:

1. Examinations in excess of one in any calendar year;
2. Lenses or contact lens fittings in excess of one pair in any calendar year;
3. Frames in excess of one set in any two calendar years;
4. Sunglasses, unless they are prescribed to be worn generally at all times;
5. Cosmetic materials or options having no corrective value, such as tinted or coated lenses, etc.;
6. Routine yearly examinations, lenses or frames required by an Employer in connection with the occupation of the Covered Person;
7. Any treatment or service which is the result of Occupational Accidental Injury or Disease arising out of and in the course of you or your Dependent's employment whether or not payment in whole or in part is received under any Workers' Compensation laws or similar federal or state laws. No claim will be considered or paid based on a denial by the Worker's Compensation Insurance Company or so long as a Worker's Compensation or similar law claim is pending, or has not been finally adjudicated as to coverage under the Act;
8. Any charges you or your Dependents are not, in absence of this coverage, legally obligated to pay, or that are furnished without charge, paid for through any governmental agency, unless specifically billed for by such agency as provided by law.

This Benefit for Dependents under age 19 will be payable at 100% up to the limits listed in the Schedule of Benefits but are limited to one examination and one set of glasses or contacts per calendar year.

Section 6.03 – Vision Expense Benefit Opt-Out Option

A Covered Person may decline the Vision Expense Benefit by opting out of such coverage. To opt-out of the Vision Expense Benefit, please contact the Fund Office.

Article VII - Loss of Time Benefit

(Covered Employees only)

The following topics are discussed under this Article on Loss of Time Benefit:

Section 7.01 – Eligibility for Loss of Time

Only the Covered Employee (including non-bargained employees) is eligible for the Loss of Time Benefit. Dependents, retirees and persons eligible under COBRA are not eligible for this Benefit.

Section 7.02 – Loss of Time Benefit

If you become Totally Disabled by a non-occupational or occupational, Accidental Injury or Illness and are prevented from performing each and every duty of your occupation, a weekly benefit is payable to you in the amount shown in the Schedule of Benefits.

Benefits will be paid up to a maximum of 13 weeks for any one period of Total Disability, regardless of the number of Accidents or Illnesses during that period. Successive periods of Total Disability separated by less than one day of active work on a full-time basis or availability for full time work will be considered one period of Total Disability.

No Benefit will be payable for the first seven days of any Total Disability due to an Illness. The seven-day period begins as of the date the Covered Employee is first treated by a legally licensed Physician, or by an Outpatient Alcohol and Drug Treatment Agency as defined in this Combination Plan Document & Summary Plan Description; unless, within that seven day period, the Covered Employee is:

1. Confined in a Hospital or Free Standing Residential Alcohol or Drug Treatment Center; or

2. Undergoes surgery; because of this Illness.

Benefits will be payable from the date of confinement or surgery.

In the case of an Accident, Benefits will payable, as of the date that the Covered Employee is first treated by a legally licensed Physician.

Loss of Time Benefit payments that are the result of alcoholism, drug addiction, drug dependency or drug overdose will be limited to 13 weeks within three consecutive calendar year periods. The three consecutive calendar year periods will start the first day you:

- are confined in a Hospital or Free Standing Residential Alcohol or Drug Treatment Center; or

- receive treatment as an outpatient by an Outpatient Alcohol and Drug Treatment Agency.

Section 7.03 – Loss of Time Limitations
Please read this Section carefully.

No Loss of Time Benefit will be payable for the following:

1. Any period of Total Disability while only under the treatment of a chiropractor;

2. Any period of Total Disability during which the Covered Employee is not under treatment by a legally licensed Physician (this does not include a chiropractor);

4. Any claim where you commit or attempt to commit a felony and thereby suffer an Accidental Injury or Total Disability as a result of that commission or attempt;

5. Any period of Total Disability which is a result of alcoholism, drug addiction, drug dependency, or drug overdose during which the Covered Employee is not confined in a Hospital or Free Standing Residential Alcohol or Drug Treatment Center or is not under outpatient treatment by an outpatient alcohol or drug treatment agency;

6. Any Total Disability for which coverage is specifically excluded under the sections entitled "Comprehensive Medical Benefit Limitations and Exclusions" or "General Limitations;"

7. Any period of Total Disability during which you are eligible as a Qualified Beneficiary under COBRA;

8. Retirees; or

9. Dependents of the Covered Employee.

Loss of Time Benefits under this Plan will be paid directly to you and cannot be assigned to a third party.

Article VIII - Death Benefit

(Covered Employee, Spouse, Natural, Legally Adopted and Stepchildren)

The following topics are discussed under this Article on Death Benefit:

Section 8.01 – Death Benefit

The amount of your Death Benefit and your Dependent's Death Benefit stated in the Schedule of Benefits will be paid to the Beneficiary as defined herein. Written proof of your death must be furnished to the Fund Office on the Fund's prescribed forms within one year of the death of the Covered Employee.

Section 8.02 – Death Benefit Limitations

The Death Benefit will be limited in the following situations:

- The Death Benefit will not be paid for any claim where you or your Dependent commits or attempts to commit a felony causing death as a result of that commission or attempt.
- In the event of your death or the death of your Dependent who is eligible for this Death Benefit both as a Covered Employee and as a Dependent of a Covered Employee, only the Covered Employee's Death Benefit will be payable for that person.
- Benefits provided to Qualified Beneficiaries under COBRA do not include Death Benefits.

Death Benefits under this Plan are paid to the Beneficiary as defined herein and cannot be assigned to another party.

Article IX - Accidental Death and Dismemberment Benefit (AD&D)

(Covered Employee, Spouse, Natural, Legally Adopted and Stepchildren)

The following topics are discussed under this Article on Accidental Death and Dismemberment Benefit (AD&D):

Section 9.01 – Accidental Death and Dismemberment (AD&D) Benefit Amount

If you or your Dependent loses his life, hand, feet, or eyesight as a direct result of and within 90 days of an Accident, independent of all other causes, Benefits will be paid as follows:

Type of Loss	**Benefit**
Life or both hands, both feet, both eyes or any combination of hand, foot, or eye	Full Benefit amount
Single hand, foot or eye	50% of the Benefit amount

Benefits will be paid to you, in the case of your dismemberment or the dismemberment of your Dependent, or to the Beneficiary as explained in Section 17.04.

Loss of hands or feet means complete severance at or above the wrist or ankle joint, and loss of eyesight means permanent loss of the entire sight of one or both eyes.

Section 9.02 – Accidental Death and Dismemberment (AD&D) Benefit Limitations

The AD&D Benefit will be limited in the following situations:

- If you or your Dependent suffers more than one of the above losses as the result of one Accident, no more than the full Benefit amount will be paid.

- Certain losses, such as those caused by war, while on active duty in any military force of any country or state, suicide, disease or ptomaines are not covered.

- Losses as a result of an Occupational Accidental Injury or Sickness arising out of and in the course of the your employment or your Dependent's employment, whether or not payment in whole or in part is received under any Workers' Compensation laws or similar federal or state laws. No claim will be considered or paid based on a denial by the Worker's Compensation Insurance Company or so long as a Worker's Compensation or similar law claims is pending, or has not been finally adjudicated as to coverage under the Act.

- Any claim where the you or your Dependent commits or attempts to commit a felony and thereby suffers an Accidental Injury, causing death, as a result of that commission or attempt will not be paid.

- In the event of a claim for you or your Dependent if you or your Dependent are eligible both as a Covered Employee and as a Dependent of a Covered Employee, only the Covered Employee Benefits will be payable for that person.

- Benefits provided to Qualified Beneficiaries under the COBRA do not include Accidental Death and Dismemberment Benefits.

Accidental Death and Dismemberment Benefits under this Plan are paid to you (in the case of dismemberment) and to your Beneficiary (in the case of death) as explained in Section 17.04 and cannot be assigned to another party.

Article X - General Limitations

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

The following General Limitations apply to all portions of this Plan. In addition to any other limitations, either specific or general, set forth in the Plan, no Benefits will be paid under any Section of the Plan, whether the coverage is for you or your Dependent, for charges related to:

1. Accidental Injury or death resulting from you or your Dependent's engagement in an illegal occupation or in the commission of or attempt to commit a felony;

2. Any treatment or service while on active duty in any military force of any country or state;

3. Any treatment or service which is the result of an Occupational Accidental Injury or Illness arising out of and in the course of the your employment or your Dependent's employment whether or not payment in whole or in part is received under any Workers' Compensation laws or similar federal or state laws; (except Death Benefits). No claim will be considered or paid based on a denial by the Worker's Compensation Insurance Company or so long as a Worker's Compensation or similar law claim is pending, or has not been finally adjudicated as to coverage under the Act;

4. Any treatment or service which is not Medically Necessary (except sterilization of the reproductive system or voluntary abortion), which is Experimental, Investigative or Inappropriate or which is not recommended by a Physician;

5. Expenses relating to reversal or attempted reversal of sterilization of the reproductive system;

6. Non-PPO Provider charges which are in excess of UCR Charges for any services or materials;

7. Custodial Care as defined in Section 17.16;

8. Services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea including radial keratotomy, except in the case of Accidental Injury or Illness of the eye which would require this procedure and the person has vision that cannot be corrected to at least 20/50 by artificial means of glasses or contact lenses;

9. Services or treatment resulting from war, declared or undeclared, or any act of war;

10. Assisted reproductive technology (ART) procedures, including but not limited to, artificial insemination; in vitro fertilization; embryo transfer and Gamete Intrafallopian Transfer; intravaginal insemination; intracervical insemination; intrauterine insemination or services and supplies related to ART procedures, such as sperm banking;

11. Surrogate pregnancy;

12. Transsexual surgery;

13. Cosmetic Surgery, except as provided for in Comprehensive Medical Benefits;

14. Routine physical examinations, well child examinations, immunizations or school physicals for Dependent children, except as provided under Pediatric Preventive Care;

15. Preventative services, including but not limited to, influenza virus or pneumococcal vaccines, except as provided under Routine Physical Exam and Pediatric Preventive Care;

16. Chiropractic services for Dependent children;

17. Marital counseling or family therapy, school related behavioral problems;

18. Services primarily for weight loss, unless treatment is Medically Necessary due to (morbid) obesity;

19. Orthoptics or Vision Training;

20. Hearing aid batteries;

21. The purchase or replacement of a hearing aid for a retiree or Dependent of a retiree;

22. Charges for drugs except as provided through the Comprehensive Medical Benefit or Prescription Drug Program;

23. Smoking cessation programs or any other prescribed medication or therapy designed to treat tobacco addiction;

24. Charges for completion of a claim form, for telephone conversation or online visit with a provider in place of an office visit, for writing a prescription and for medical summaries, except as provided by the Telehealth Amwell Program;

25. Lodging or travel, even though prescribed by a Physician for the purpose of obtaining medical treatment, except as provided by a Blue KC Designated Treatment Provider;

26. Building or remodeling or alteration of a residence; or the purchasing or customizing of vans or other vehicles;

27. Equipment for purifying, heating, cooling or otherwise treating air or water;

28. Exercise equipment, medical supplies, devices or equipment provided for you or your Dependent's convenience or personal use;

29. The cost of maintenance, supplies, repair or modification to any Durable Medical Equipment after it was purchased by the Fund;

30. Services when the primary reason for treatment is the reduction or elimination of snoring;

31. Drugs, devices, supplies, treatments, procedures or services that are considered Experimental, Investigative or Inappropriate;

32. Services for developmental, educational, self-management training or therapy, such as Applied Behavioral Analysis (ABA) Therapy;

33. Breast surgery or reconstruction if original surgery was for cosmetic reasons;

34. Private Duty Nursing;

35. Any treatment or service obtained from a provider that is located outside the United States or its territories; except that emergency treatment will be covered if incurred while the Covered Person is temporarily out of the country, on vacation or temporarily out of the country for educational purposes;

36. Any services which are not the medically accepted standard form of treatment;

37. Any services rendered prior to the effective date of coverage;

38. Any services rendered after termination of coverage;

39. Any services which are not specifically related to an Illness or Accident of the Covered Person to whom the services are being rendered (such as family history of);

40. Employment or school physicals;

41. Court ordered alcohol or drug treatment;

42. Service and supplies for hormone therapy, except as otherwise provided in Comprehensive Medical Benefits to treat Turner Syndrome;

43. Any charges related to a breast pump obtained from an Out-of-Network provider or purchased over the counter, or more than one breast pump per pregnancy, regardless of circumstances;

44. Gene therapy, including any services, supplies and/or drugs related to gene therapy, including CAR T-cell therapy;

44. Any charges for non-emergency air ambulance transportation;

45. Charges related to implantable devices unless Medically Necessary and pre-certified through Blue KC;

46. Any Hospice charges related to respite care; and

47. Contraceptives except as provided through the Comprehensive Medical Benefit and Prescription Drug Benefit.

Article XI - Claims Filing Procedure

The following topics are discussed under this Article on Claims Filing Procedure:

Claim forms for all types of claims under this Plan are available from the Fund Office:

Construction Industry Laborers Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500

The following procedures should be followed to file a claim:

Section 11.01 – Time Limit for Filing Health Care Claims
All claims under this Plan must be filed within 12 months from the date the Covered Expense was incurred. Filings later than this term deadline will not be covered by the Plan.

Section 11.02 – Death and Accidental Death Claims
The Beneficiary should obtain a claim form from the Fund Office. Complete all information on the form. Be sure the form is signed. Your Beneficiary must attach a certified copy of the death certificate.

Section 11.03 – Loss of Time Claims
Obtain Loss of Time claim form from the Fund Office. Have your Physician complete the "Attending Physician's Statement." You complete the Covered Employee's section. Make sure all items are completed. Be sure you sign the form.

For additional payments under the Loss of Time Benefit, obtain a supplementary Loss of Time claim form. You must complete the Covered Employee section, and your Physician must complete the attending Physician's section of the form.

Section 11.04 – Comprehensive Medical, Dental, and Vision Claims
Most medical, dental and vision claims will be electronically filed by the provider of service. If you need to file a claim manually, the procedures to do so are outlined below.

1. A claim cannot be considered for processing without a properly completed claim form on file.

2. Obtain the proper claim form, complete all Covered Employee sections, answer all questions, sign the form and return to the Fund Office.

3. A claim pertaining to an Accident cannot be considered for processing without written details of the Accident.

4. A claim cannot be considered for processing without an Explanation of Benefits from the primary carrier or Medicare showing their payment or denial.

5. Bills from Hospitals, Physicians, anesthesiologists, radiologists, etc. must show:

   (a) Your name and social security number;

   (b) The patient's name and address;

   (c) The diagnosis;

   (d) Date of service;

   (e) Type of service and amount charged;

   (f) The name, degree, address and Tax Identification Number of the provider.

6. All dental, vision and Medicare claims should be submitted directly to the Fund Office.

7. All medical claims (except Medicare) should be submitted directly to the address on the reverse side of the coverage card.

8. A claim cannot be considered for processing until the Fund Office receives a properly completed W-9 from the provider.

Section 11.05 – Prescriptions

If you do not purchase your prescription drugs through a participating pharmacy, you must obtain a direct reimbursement form from the Fund Office, complete the form and submit the form and your paid prescription receipt(s) to the pharmacy benefit manager (PBM) for reimbursement. **Do not submit your receipts for prescription drugs to the Fund Office for reimbursement.**

Article XII – Claims and Appeals Procedures

The following topics are discussed under this Article on Claims and Appeals Procedure:

Section 12.01 – Filing a Claim

A. A Medical or a Disability (Loss of Time) Claim is filed by a Claimant when the claim is received by the Fund Office.

B. A Medical Claim is filed by a service provider, either in writing, or electronically, when received by the appropriate preferred provider organization, as designated by the Fund.

C. A Medical Claim must be filed within one year of the date of service.

Section 12.02 – Initial Benefit Determination

A. Medical Claims:

1. The Fund Office will approve or deny a Medical Claim within 30 days of the Fund's receipt of the Medical Claim. This is the Initial Benefit Determination Period. The Initial Benefit Determination Period may be extended for 15 days if special circumstances require an extension of time. An example of special circumstances is delay of information from a service provider or Physician's office. If an extension of time is needed, the Claimant will receive notice before the Initial Benefit Determination Period that a 15-day extension will be applied. The notice will describe the special circumstances and the date by which an Initial Benefit Determination will be made.

2. If there is insufficient information to decide a Medical Claim, the Fund Office will notify the Claimant before the Initial Benefit Determination Period. The notice will specifically describe the information that is necessary to complete the Claim and will allow the Claimant 45 days to provide the requested information. The Initial Benefit Determination Period will be tolled (suspended) from the date the Fund Office sends notice to the Claimant to the earlier of: 1) the date the Claimant provides the requested information; or 2) the expiration of the 45-day period. **If the Claimant does not provide the requested information, the Claim will be denied.**

B. Disability (Loss of Time) Claims:
Fund Office will approve or deny a Disability (Loss of Time) Claim within 45 days. The Fund may extend this initial determination period up to two times of 30 days each. The Fund shall notify Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the Claim, the Fund will give

Claimant 45 days to provide this additional information. The request for additional information may include notice to the Claimant that the Claim is denied, in whole or in part, if the requested information is not provided within the 45-day period.

C. Death Benefits:
The Fund Office will approve or deny a Death Claim within 45 days of the Fund's receipt of the written application for Benefits. The Fund may extend this initial determination period up to two times of 30 days each. The Fund shall notify Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the Claim, the Fund will give Claimant 45 days to provide this additional information. The request for additional information may include notice to the Claimant that the Claim is denied, in whole or in part, if the requested information is not provided within the 45-day period.

D. Notice of any Claim Denial, in whole or in part, will include:

1. The specific reason(s) for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

5. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, a statement that such a rule, guideline, protocol, or similar criterion was relied on in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge and on request;

6. If the adverse benefit determination is based on a Medical Necessity or Experimental, Investigative or Inappropriate Treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge and upon request.

E. Initial Adverse Benefit Determination for Disability (Loss of Time) Claims

1. The initial adverse benefit determination, concerning a Disability (Loss of Time) Claim, will contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    a. The view presented by the Claimant to the Plan from health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

b. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

c. A disability determination by the Social Security Administration regarding the Claimant, presented by the Claimant to the Plan.

2. The adverse benefit determination, for a Disability (Loss of Time) Claim, will be provided to the Claimant in a culturally and linguistically appropriate manner when the Claimant's address is in a county where ten percent (10%) or more of the population is literate only in the same non-English language.

F. Definitions:

1. Authorized Representative

a. A Claimant may select an Authorized Representative by providing written notice to the Fund Office. The Authorized Representative will act on the Claimant's behalf in the pursuit of a Benefit Claim or appeal of an adverse benefit determination. The Claimant may select an Authorized Representative by completing a form provided by the Trustees, or otherwise providing sufficient notice to the Fund. A copy of the form may be obtained from the Fund Office. A notice sufficient to designate an Authorized Representative shall contain the full name and social security number of the Claimant, the full name and mailing address of the Authorized Representative and a short statement that the Claimant wishes to designate the named individual as his Authorized Representative for purposes of filing a specific Claim and/or appeal with the Fund.

b. An Authorized Representative, once elected, will receive all notices and determinations regarding the Claim that would otherwise be sent to the Claimant. An Authorized Representative will be allowed to make any decision or take any action or inaction that is available to the Claimant regarding the Claim. The Fund will continue to contact the Authorized Representative regarding any references to the Claim or Appeal for which he has been designated for a period of one year, unless the Fund receives written notice from the Claimant terminating the designation as Authorized Representative. The term "Claimant, as used herein, shall include an Authorized Representative selected in accordance with these provisions.

c. A provider is not an Authorized Representative, unless the Claimant specifically designates the provider. However, a Claimant may not assign payment of any Claim to an out-of-network provider.

2. Claimant:
A Claimant is an Employee, Beneficiary, Dependent or duly Authorized Representative of an Employee, Beneficiary or Dependent who applies for or appeals a Claim for Benefits. A provider is not a Claimant but may file an initial claim with the designated Preferred Provider Organization, on behalf of a Claimant.

3. Medical Claim for Benefits:

   a. A Medical Claim is a request for payment for medical services provided to a Claimant. A Claim must be in writing or may be submitted electronically, and must include the Claimant's name, address, social security number, and, if the Claimant is a Dependent, the Dependent's age and the name of the Covered Employee.

   b. A Claim is **not** a telephone inquiry, a written or verbal question about eligibility when a service has not been incurred, or a voluntary pre-authorization of benefits. Any inquiry before a service has been incurred will **not** be considered a Claim for Benefits.

   c. An attempt to purchase or receive a prescription drug at a pharmacy counter is not a Claim. Any denial of such purchase or receipt entitles a Claimant to file a Medical Claim after such denial.

4. Disability (Loss of Time) Claim
   A Disability Claim is a Claim for Benefits under the Loss of Time Benefit described in Section VII, or Accidental Death and Dismemberment Benefit described at Section VIII.

Section 12.03 – Appeal of Denial of All Claims

A. Trustee Authority
The Trustees have sole discretion and authority to interpret the Plan Document. The Trustees may delegate this authority to a Claims Appeal Committee, which will conduct quarterly meetings. The Claims Appeal Committee has the discretion and authority to interpret the terms of the Combination Plan Document & Summary Plan Description and the Trust Agreement and to interpret any facts or law relevant to the determination, eligibility, and entitlement to benefits.

If a Claim is denied in full or in part, a Claimant or his duly Authorized Representative may request a review of the denial of the Claim to the Claims Appeal Committee, which has authority to make the final and binding decision on review. The Committee will conduct a full and fair review.

B. Time For Filing Appeal
Any appeal or request for review of a Claim must be made by written application, within 180 days after receipt by the Claimant of written notification of denial of a Claim.

No requests for review shall be considered by the Committee subsequent to the *180-day* period.

C. Decision on Review

1. The Appeals Committee shall hold quarterly meetings to make benefit appeals decisions. If an appeal is filed more than 30 days before a quarterly meeting, then a decision will be rendered by the next quarterly meeting after the Fund's receipt of the Claim. If the appeal is filed less than or equal to 30 days before the next quarterly meeting, then a decision will be rendered by the second meeting after the Fund's receipt of Claim. If special circumstances beyond the control of the Fund exist, such as the

need for a hearing, an extension of time for benefit determination will be made. In the event of an extension due to the Claimant's request for a hearing, the hearing will be held by the second meeting after the Fund's receipt of notice of appeal, with a final decision rendered no later than the third meeting following the Fund's receipt of notice of appeal.

2. If an extension is required because more information is needed from the Claimant, the Claimant will be notified before the initial decision deadline. The Claimant will be provided 45 days from receipt of notice to provide the requested information. The Fund's timeline for benefit determination on an appeal will be tolled until the earlier of:

    i. the Fund's receipt of the requested information; or

    ii. the end of the period afforded the Claimant to provide the requested information.

    Once a final determination on review has been made, the Appeals Committee must notify the Claimant of the determination within 5 days after the decision is made.

3. The Plan shall provide an adverse benefit determination, for Disability (Loss of Time) Claims, that does not afford deference to the initial adverse benefit determination and that is conducted by a Trustee of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, not the subordinate of such individual.

4. In reviewing any adverse benefit determination, for a Disability (Loss of Time) Claim, that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigative or Inappropriate or not Medically Necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

5. A health care professional engaged for purposes of a consultation under paragraph (e) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

D. Notification of Decision on Review
The notice of any decision on review will include:

1. The specific reason(s) for the adverse determination;

    a. Reference to the specific Plan provisions on which the determination is based;

    b. A statement that the Claimant is entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for Benefits.

    c. A statement of the Claimant's right to bring an action under Section 502(a) of ERISA.

d. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, a statement that such a rule, guideline, protocol, or similar criterion was relied on in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge and on request;

e. If the adverse benefit determination is based on a Medical Necessity or Experimental, Investigative or Inappropriate treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge and upon request.

f. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

g. The adverse benefit determination on review, concerning a Disability (Loss of Time) Claim, will contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   i. The views presented by the Claimant to the Plan from health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

   ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

   iii. A disability determination by the Social Security Administration regarding the Claimant, presented by the Claimant to the Plan.

h. The adverse benefit determination on review, for a Disability (Loss of Time) Claim, will be provided to the Claimant in a culturally and linguistically appropriate manner when the Claimant's address is in a county where ten percent (10%) or more of the population is literate only in the same non-English language.

i. For Disability (Loss of Time) Claims on review, the statement regarding the Claimant's right to bring an action under Section 502(a) of ERISA will describe the two-year limitations period following a denial on review and provide the Claimant with the calendar date said period expires for the claim.

j. The identities must be provided of those medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

E. Claimant's Rights Regarding Information on Appeal:

1. A Claimant or his duly Authorized Representative may, in writing:

   a. Request a review of the denial of such a Claim upon written application to the Fund;

   b. Request the Fund to provide, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim for Benefits; and

   c. Submit written comments, documents, records, and other information relating to the Claim for Benefits.

   d. Upon receiving a request for review, the Claimant will be provided with a copy of the Plan's Appeals and Hearing Rules.

2. Claimant's Rights Regarding Disability (Loss of Time) Benefit Claims on Review

   a. Before an adverse benefit determination on review is issued, the Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided in order to give the Claimant a reasonable opportunity to respond prior to that date.

   b. Before an adverse benefit determination on review is issued, based on new or additional rationale, the Claimant will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided in order to give the Claimant a reasonable opportunity to respond prior to that date.

   c. If the Plan fails to strictly adhere to all the requirements of this Section, then the Claimant will be deemed to have exhausted the administrative remedies available under the Plan, except as provided in this paragraph below. Accordingly, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If the Claimant chooses to pursue remedies under Section 502(a) of ERISA, the claim or appeal is deemed denied on appeal without the exercise of discretion by the Trustees. Notwithstanding this paragraph, the administrative remedies available under a Plan with respect to claims for Disability (Loss of Time) Benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of

information between the Claimant and the Plan. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the Claimant's request for immediate review under this paragraph, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan will provide the Claimant with notice of the resubmission.

The written decision of the Committee shall be final, binding, and conclusive on the Claimant. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action, including an action or proceedings before any court, administrative agency, or arbitrator.

A copy of the Plan's hearing procedures will be provided to you if you file an appeal of a denied claim.

F. Limitation On When A Lawsuit May Be Filed To Obtain Benefits
A Claimant may not start a lawsuit to obtain Benefits until after:

1. The Claimant has requested an appeal and a final decision has been reached on appeal; or

2. Until the appropriate amount of time described in Section XII (Claims and Appeals Procedures), of the Plan has elapsed since you filed a request for appeal and you have not received a final decision or notice from the Board of Trustees that an extension will be necessary to reach a final decision.

For claims incurred on or after July 16, 2015, any lawsuit brought against the Plan must be initiated no more than two years after the date of:

1. A determination denying the claim for Benefits; or

2. The time for a decision on an appeal has expired.

G. Mandatory Litigation Venue
A participant or Beneficiary shall only bring an action in connection with the Plan in the U.S. District Court for the Western District of Missouri.

Under Federal law, a Covered Person or Beneficiary has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, if dissatisfied with a benefit determination. Before bringing such an action, the Covered Person or Beneficiary must exhaust the Plan's Claims and Appeals Procedures. Any such legal action against the Plan under ERISA must be filed within two (2) years of the date of the decision of the Trustees on appeal.

Article XIII - Administrative Information

The following topics are discussed under this Article on Administrative Information:

Section 13.01 – Coordination of Benefits with Other Plans

The Plan coordinates its Benefit payments with payments to which a Covered Person is entitled from other sources, such as other health insurance plans. The purpose is to ensure that a Covered Person does not have the same claims paid twice by two different plans. The following rules govern the Coordination of Benefits ("COB").

Plan Conflict

When these rules do not resolve a conflict between plans such as when This Plan's rules say the Other Plan should pay first, and the Other Plan's coordination rules say This Plan should pay first, then this Plan will pay the covered claims up to 50% of the Usual, Customary and Reasonable Charge (UCR Charge) subject to the annual deductible and Calendar Year Maximum.

COB Definitions

There are a number of key terms that apply in the context of these rules. For example:

1. "Allowable Expenses" means any necessary, reasonable, and customary medical expense covered by this Plan, and at least a portion of which is covered under at least one of the Other Plans covering the Person for whom claim is made.

   The difference between the cost of a private and semi-private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in this Plan.

   When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

   When benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services and preferred provider arrangements.

2. "Birthday Rule" means the protocol used to determine the primary/secondary payer Plan for Child Dependents of married Covered Persons. The Plan of the spouse with the earliest birthday in a calendar year shall be primary payer for Dependent Children.

3. "Other Plan" means the following types of plans providing benefits or services for or by reason of medical or dental care or treatment:

    a. group insurance coverage,

    b. employer Sponsored Blue Cross, Blue Shield, and other pre-payment coverage,

    c. any coverage under labor-management trusteed plans, or employee benefit organization plans, and

    d. coverage under governmental programs, and any coverage required or provided by any statute, including Medicare.

4. "Person" means a Covered Person eligible for Benefits under Construction Industry Laborers Welfare Fund.

5. "Primary Plan" means the Plan determined to be the first payer of benefits in a particular instance.

6. "Secondary Plan" means the Plan determined to be the second payer of benefits in a particular instance.

7. "This Plan" means the Construction Industry Laborers Welfare Fund.

Coordinating Benefits

Generally, the Plan coordinates Benefits in such a way that two or more plans do not pay more than the UCR amount of a given claim. If any Person, while covered under this Plan is also covered under one, or more Other Plans, and the sum of the Benefits payable under this Plan together with the benefits payable under all Other Plans exceeds the Person's Allowable Expenses, then the Benefits otherwise payable with respect to such Person shall be reduced so that the benefits payable under all of the plans involved shall not exceed the Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had the claim been duly made therefore.

Order of Benefit Determination

If a Person is covered under two of more plans, the order in which benefits shall be paid is as follow:

A. Employee and Spouse

    1. Any Other Plan that has no coordination of benefits provision will be deemed to pay to have primary payment responsibility.

    2. The plan that covers the eligible person as an employee shall be the "primary plan" and shall pay its benefits first.

    3. The plan that covers the eligible person as a dependent shall be the "secondary plan" and shall pay its benefits after the "primary plan".

4. When both husband and wife are eligible under This Plan as Covered Employees, each one shall be covered as Covered Employees under their Plan and as an eligible dependent under their Spouse. In addition, the annual deductible amount will be waived for both Covered Employees. However, regardless of the circumstance, no more than 100% of the Covered Expense shall be paid.

5. The plan which covers the eligible person as a laid-off or retired employee or dependent of such person shall be secondary to any plan that covers the eligible person as an active employee or dependent of such person.

6. If the above rules do not determine the order of benefits, the benefits of a plan covering an employee, member or subscriber for a longer period of time has primary payment responsibility.

B. Dependent Children

1. Any Other Plan that has no coordination of benefits provision will be deemed to pay to have primary payment responsibility.

2. The plan of the dependent child through their employment, if any.

3. The plan of the spouse of the dependent child, if any.

4. The plan of the parent whose birthday (excluding the year of birth) occurs first in a calendar year; provided that, if both parents have the same birthday (excluding the year of birth), the plan that has covered the parent for the longer period of time.

5. The plan of the parent whose birthday (excluding the year of birth) occurs last in a calendar year; provided that, if both parents have the same birthday (excluding the year of birth), the plan that has covered the parent for the shorter period of time.

6. When the parents are separated or divorced, if there is a court order establishing the responsibility for medical, dental or other health care expenses with respect to said children, benefits shall be determined in accordance with the court order. In the absence of a court order, if the parent with custody has NOT remarried, after the plan of the dependent child through their employment and the spouse of the dependent child, the order of payment will be:

   a. The plan of the parent with custody.

   b. The plan of the spouse of the parent (the stepparent) with custody.

   c. The plan of the parent without custody.

7. For Eligible Dependent children when both parents are eligible in the Plan, benefits will be paid under the father as the “primary plan” and under the mother as the “secondary plan”.

C. If none of the above rules determine the order of benefit determination or if the other plan has a rule that is in conflict with these provisions, the plan that has covered the person for the longer period of time shall be the “primary plan”.

The coordination of benefits provisions shall apply to all benefits provided under the Plan with the exception of the Death Benefit and Accidental Death and Dismemberment Benefit.

Section 13.02 – Subrogation

In the event the Plan provides benefits for injury, sickness or other loss (hereinafter the "injury") to any Covered Person, the Plan shall be automatically subrogated to all rights of recovery to any funds or monies that person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Covered Person," for this Section only) may have arising out of said injury, sickness or other loss. Said recovery shall not be limited by characterization of loss and shall 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 Plan is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Plan shall automatically have a first priority lien and shall be entitled to first dollar reimbursement from any recovery regardless of whether the Covered Person is made whole by said recovery. These rights of reimbursement and subrogation are reserved whether the admitted, determined, and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any lawsuit, full or partial judgment, settlement or other recovery. The Plan shall be entitled to assert a lien against third parties, insurers, attorneys, and any other appropriate person or entities admitted, determined, and/or alleged to be liable to the Covered Person in order to protect its right of subrogation.

This right of subrogation is specifically and unequivocally pro tanto subrogation; that is, subrogation from the first dollar received by the Covered Person, and this pro tanto is specifically and unequivocally to take effect before the whole debt is paid to the Covered Person. The Plan's subrogation rights include without limitation, an automatic first priority lien upon the first dollar recovery from any judgment, settlement, or payment of any kind to the Covered Person by any party admitted, determined, and/or alleged to be liable to the Covered Person as well as all rights of recovery of a Covered Person to any payments made by or on behalf of an admitted, determined, and/or alleged to be liable party including, but not limited to, a recovery:

- Against any person, insurer, third party, or other entity that is alleged to be 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" coverages or insurance.

These rights of reimbursement and subrogation are reserved whether the admitted, determined, and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement or other recovery.

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend shall 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 Office as the Plan may require to protect its rights of reimbursement and subrogation. The Covered Person shall do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan or the joinder of the Trustees or Plan in any claim or action against the admitted, determined, and/or alleged to be liable party or parties.

The 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 Plan's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, shall be binding on the Plan without the Plan's written approval thereof, and the Plan expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Plan's subrogation interest shall 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 Plan, pursuant to the subrogation right, shall 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 Plan's recovery.

The Plan reserves the right to initiate an action in the name of the Covered Person or his guardian, conservator or next friend to recover its subrogation interest, and the Covered Person or his guardian, conservator or next friend will cooperate fully with the Plan 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 Office, or (2) to take any other action requested by the Fund Office to protect the interest of the Plan, the Plan may withhold payment of benefits or deduct the amount of any payments made from future claims of the Covered Person.

The Covered Person shall not do any act or engage in any negotiations that would reduce, compromise, or prejudice the Plan'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, party, corporation, insurance carrier, governmental agency or other party which is admitted, determined, and/or alleged to be liable to the Covered Person, (1) the Plan shall be repaid in an amount equal to the full amount of benefits paid by the Plan; and (2) no further benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Plan. If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Plan's right to subrogation, the amount of the Plan's claim shall be deemed to be held in constructive trust, and

the Plan shall be entitled to seek restitution, impose a constructive trust, or seek any other equitable or legal action against the Covered Person or any other party. In addition, the Plan reserves the right to offset and/or deduct any amounts paid as benefits against future claims submitted by the participant and his eligible Dependents.

The Plan shall 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 Plan reserves the right to first dollar from any recovery to the full amount of benefits paid by the Plan 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 shall provide all of the above referenced parties with notice of the Plan'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 guardian, conservator or next friend, provided any such agreement is established in writing.

The "make whole" rule, any similar state law doctrine or the "common fund" doctrine is specifically and unequivocally rejected. The Plan's right of first dollar subrogation or reimbursement applies regardless of whether the Covered Person is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of a written agreement. Any person who is represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

The Plan has the right to offset any pending or future claims against any recovery by the eligible individual or eligible Dependent to the extent the recovery exceeds the unreimbursed benefits paid by the Plan, even if no benefits have been paid by the Plan. The Plan will also have a lien to the extent of the benefits paid, which may be filed with any party alleged, determined, and/or alleged to be liable to the Covered Person on account of the loss incurred.

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

In an action brought by the Plan, the reasonable cost of recovery, including the Plan's attorneys' fees, shall first be deducted from any recovery by judgment or settlement against the party or parties deemed liable by admission, judicial and/or administrative determination, or allegedly liable to the Covered Person. The Plan's subrogation interest, to the full extent of benefits paid or due as a result of the occurrence causing the injury or sickness, shall next be deducted with the balance paid to the Covered Person.

Exchange of Information

Any individual who claims Benefits under this Plan must, upon request, provide all information the Plan believes is needed to coordinate benefits as described in this Section. In addition, all information the Plan believes is needed to coordinate benefits may be exchanged with other companies, organizations or persons.

Facility of Payment
The Fund may reimburse any other plan if:

(a) Benefits were paid by that other plan; but

(b) Should have been paid under this Plan in accordance with this Section.

In such instances, the reimbursement amounts will be considered Benefits paid under this Plan and to the extent of those amounts will discharge the Fund from liability.

Section 13.03 – Right of Recovery
If it is determined that Benefits paid under this Plan should have been paid by any other plan, the Fund will have the right to recover those payments from:

(a) The individual to or for whom the Benefits were paid; and/or

(b) The other companies or organizations liable for the Benefit payments.

In addition, if the Fund Office makes an erroneous payment, the Plan has the right to recover from you, your Dependent or your provider, the amount paid or to withhold future Benefit payments that would otherwise be payable.

Section 13.04 – Change or Discontinuance of the Plan
The Welfare Plan and any or all Benefits may be amended, changed or terminated at any time by a vote of the Board of Trustees. Any amendments or changes by the Board of Trustees and on file at the Fund Office will supersede any statements contained in this document and will govern the payment of all claims.

In the event of the termination of this Plan, the Trustees will apply the Fund to provide payment of any and all obligations of the Fund. The Trustees will distribute and apply any remaining surplus to purposes determined by the Trustees according to the Trust Agreement.

However, no part of the Fund's assets will be used for, or diverted to, purposes other than for the exclusive benefit of the Covered Persons, their families, Beneficiaries or Dependents, or the administrative expenses of the Plan or for any other payments in accordance with the provisions of the Plan. Under no circumstance will any portion of these funds, directly or indirectly, revert or accrue to the benefit of the Employers, the Association or the Union.

Article XIV - Plan Information

The following topics are discussed under this Article on Plan Information:

Section 14.01 – Type of Plan

The Construction Industry Laborers Welfare Fund is a welfare plan that provides Comprehensive Medical, Dental, Vision, Loss of Time, Death, and Accidental Death and Dismemberment Benefits. Details regarding each of the Benefits that the Plan provides are presented in this Combination Plan Document & Summary Plan Description.

Section 14.02 – Establishment and Administration of the Fund

The Construction Industry Laborers Welfare Fund was established and is maintained pursuant to Collective Bargaining Agreements between:

- The Western Missouri and Kansas Laborers District Council of the Laborers International Union of North America, AFL-CIO;
- The Eastern Missouri Laborers District Council of the Laborers International Union of North America, AFL-CIO;
- The Associated General Contractors of Missouri;
- The Heavy Constructors Association;
- The Site Improvement Association of Eastern Missouri;
- Other signatory Employer associations.

Pursuant to contract stipulations, other Employers who are non-members of the Associated General Contractors of Missouri and other Employer associations also make contributions to the Fund on behalf of Covered Employees represented by various Local Unions. You may review the Agreements at your local Union office or you may request a copy by writing to the Fund Office.

Section 14.03 – Source of Contributions

Contributions are made on behalf of Covered Employees working under Collective Bargaining Agreements that require contributions to be made to the Plan. Contributions are due from each Employer as set out in the Collective Bargaining Agreement. Members are entitled to participate in this Plan if they work under one of the bargaining agreements and if their Employer makes the required contribution to the Fund. The Plan also receives contributions from Covered Employees, Retirees and Dependents for the purpose of continuing coverage under the Plan.

Section 14.04 – Contributing Employers
Participants and Beneficiaries may receive from the Board of Trustees, upon written request, information as to whether a particular Employer or employee organization (Union) is a Plan sponsor and if so, the address of the Employer or Union. For a copying charge, a copy of any Collective Bargaining Agreement between any Union and Employer Association or Employer who is required to make contributions to the Fund may be obtained by participants and Beneficiaries upon written request to the Board of Trustees and such agreements are also available for examination by participants and Beneficiaries at the Fund Office.

Section 14.05 – Fund Office
Although the Trustees are legally designated as the Plan Administrator, they have delegated many of the day-to-day administrative functions to a third-party administrator, currently Wilson-McShane Corporation.

Section 14.06 – Interpretation of the Plan
The Board of Trustees of the Welfare Plan will have the sole authority to revise, amend, change, interpret, construe and apply the provisions of the Plan. This authority includes, but is not limited to, provisions relating to:

- eligibility for Benefits;
- entitlement to Benefits; and/or
- nature of, amount and duration of Benefits; subject to the applicable provisions of the Trust Agreement and the applicable Collective Bargaining Agreements.

No Employer or Union or any representative of any Employer or Union is authorized to interpret this Plan on behalf of the Board of Trustees nor can any Employer or Union act as an agent of the Board of Trustees.

Section 14.07 – Identification of Provider of Benefits
All Benefits are self-funded by the Construction Industry Laborers Welfare Fund.

Section 14.08 – Fund Assets
Commerce Bank & Trust is the depository for contributions into the Fund. Benefits and administrative expenses are paid from accounts in this bank. Contributions not needed for Benefits and immediate administrative expenses are invested as the Trustees receive them. All expenses incurred in administering the Fund are paid out of amounts derived from these investments and from Employer contributions.

Section 14.09 – Audit of Financial Records
An independent auditor examines the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees submit annual financial statements and other reports to the United States Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office.

Section 14.10 – Service of Legal Process
The name and address of the agent who the Trustees have appointed for service of legal process is:

Wilson-McShane Corporation
Construction Industry Laborers
Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500

or

Mr. Bradley J. Sollars
Arnold, Newbold, Sollars & Hollins, P.C.
1100 Main Street, Suite 2001
Kansas City, MO 64105-5178

12200 N Ambassador Dr Suite 400
Kansas City, MO 64163

Service of legal process may also be made on any Trustee.

Section 14.11 – Identification Numbers
The Employer Identification Number assigned to the Fund by the Internal Revenue Service is: 44-0568755. The number assigned to the Plan by the Board of Trustees is: 501.

Section 14.12 – General Information
Welfare records are available, subject to federal confidentiality rules, in the Fund Office for participants during regular office hours.

Section 14.13 – Required Documents
Certain documents are required to be submitted to the Fund Office before Benefits will be paid. No Benefits will be payable until the following applicable documents are received and approved by the Fund Office:

1. Enrollment card completed by the Covered Employee;
2. Marriage license;
3. Birth certificate issued by the State that lists the name of the mother and father for all children;
4. Complete copy of a Divorce Decree, Property Settlement and Qualified Medical Child Support Order (QMCSO), if applicable;
5. Any other documents as defined in Section 2.09.

Section 14.14 – Responsibility to Notify
It is your responsibility to notify the Construction Industry Laborers Welfare Fund, PO Box 909500, Kansas City, MO 64190-9500 of any change in your status whenever you:

1. Change your home address;
2. Change your marital status;
3. Change your Dependents;
4. Change your Beneficiary; or
5. Change your Local Union affiliation.

Failure to notify the Fund Office of a change could delay the processing of your claim; or your claim could be denied or processed incorrectly. Notification must be made in writing to the Fund on forms supplied by the Fund.

Section 14.15 – Plan and Fiscal Year

The fiscal records of the Plan are kept on a calendar year basis, from January 1 - December 31 each year.

Section 14.16 – Board of Trustees

Union Trustees	Employer Trustees
Mr. Jason P. Mendenhall, Chairperson Laborers Local 663 7820 Prospect Kansas City, MO 64132	Mr. James Fitzgerald, Secretary N.B. West Contracting 2780 Mary Avenue Brentwood, MO 63144
Mr. Trent Ely Laborers Local 830 899 Ste. Genevieve Drive Ste. Genevieve, MO 63670	Mr. Paul Ideker Ideker, Inc. 4614 S. 40th Street St. Joseph, MO 64507
Mr. Gabriel Jones Laborers Local 663 7820 Prospect Kansas City, MO 64132	Mr. Joe Garrison Irvinbilt Construction Company 10 Hickory Street PO Box 80 Chillicothe, MO 64601
Mr. Patrick Pryor Missouri & Kansas Laborers District Council 3450 Hollenberg Drive Bridgeton, MO 63044	Mr. Byron Hornung Comanche Construction P.O. Box 14158 Shawnee Mission, KS 66285
Mr. Nate Rose Laborers Local 660 2633 West Clay Street St. Charles, MO 63301	Mr. David Kaestner Millstone Weber, LLC 601 Fountain Lakes Boulevard St. Charles, MO 63301
Mr. Mitchell Rowley Laborers Local 1290 2600 Merriam Lane Kansas City, KS 66106	Mr. Dexter Phillips Musselman and Hall Contractors, LLC 4922 East Blue Banks Avenue PO Box 300858 Kansas City, MO 64130
Mr. Bill Tillman Laborers Local 1290 2600 Merriam Lane Kansas City, KS 66106	Mr. Wyatt Phillips Phillips Hardy Incorporated 15290 HWY 135 Boonville, MO 65233
Mr. Brad Turner Laborers Local 840 PO Box 461 Rolla, MO 65402	

The above are the Trustees at the time of publication. A current listing can be obtained by writing the Fund Office.

Article XV - Use and Disclosure of Protected Health Information

A. It is the intent of this Plan to be in compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued by the Secretary of Health & Human Services (together referred to herein as The Privacy Rule). The Privacy Rule is incorporated herein by reference.

B. All capitalized terms have the meaning as stated in this Plan Document or The Privacy Rule.

C. This Article establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees. The Board of Trustees is the Plan Administrator under the Employee Retirement Income Security Act of 1974 (ERISA).

D. PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows:

1. Underwriting and budgeting;

2. Claims review and processing;

3. Amending or modifying the Plan of Benefits (plan design);

4. Claims assistance;

5. Eligibility review;

6. Any and all general administration of the Plan.

E. PHI may be disclosed to the Board of Trustees, or individual Trustees as authorized by an individual.

F. The Construction Industry Laborers Welfare Fund shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.

G. The Board of Trustees:

1. Shall not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law.

2. Shall comply with verification procedures of the group health plan.

3. Shall ensure adequate separation between the group health plan and the Plan Sponsor as follows:

    a. Describe those employees or classes of employees or other persons under the control of the Plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

    b. Restrict the access to and use by such employees and other persons described in subsection G.3.a. of this Article XV to the Plan administration functions that the Plan Sponsor performs for the group health plan; and

    c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in subsection G.3.a. of this Article XV with the Plan Document provisions required by this paragraph.

4. Shall not use or disclose PHI for employment related decisions.

5. 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.

6. 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.

7. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

8. Make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.

9. Make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporate any amendments to PHI in accordance with HIPAA.

10. Make available to the Plan the information required to provide an accounting of disclosures.

11. 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

12. Return or destroy all PHI received from the Plan that the Plan Sponsor 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

H. Each Trustee shall certify compliance with The Privacy Rule and the Privacy Policy of the Construction Industry Laborers Welfare Fund.

I. This provision of Article XV concerning security of electronic PHI is effective April 20, 2005 and is adopted to further comply with The Security Rule, which is incorporated herein by reference. The Board of Trustees shall:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

2. Ensure that the adequate separation discussed above in Paragraph G, subparagraph 3, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The terms electronic protected health information, electronic PHI and e-PHI, as used in the Plan, mean protected health information that is transmitted by or that is maintained in an electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CDs, CD-ROM, flash memory devices, backup tapes or disks, etc.

Article XVI - Statement of ERISA Rights

Federal law and regulation require the following statement of ERISA rights:

As a participant in Construction Industry Laborers Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your Spouse or your 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 Combination Plan Document & Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $200 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees, reserve the right to amend, modify or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes.

Article XVII – Important Terms

The following topics are discussed under this Article on Important Terms:

Section 17.01 – Accident or Accidental Injury

The terms "Accident" or "Accidental Injury" mean a physical injury, such as a cut, break, sprain or bruise, occurring from an unexpected, undesirable and unavoidable act. This does NOT include overuse of muscles resulting in strains or aching arms and legs. **Intentionally inflicted injuries are excluded.**

Section 17.02 – Ambulatory Surgical Care Center

The term "Ambulatory Surgical Care Center" means a licensed public or private institution approved by the appropriate governmental body of the state with:

A. an organized medical staff of Physicians;

B. permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and

C. continuous Physician and registered professional nursing services whenever a patient is in the facility.

Section 17.03 – Association
The term "Association" means:

- The Western Missouri and Kansas Laborers District Council of the Laborers International Union of North America, AFL-CIO;
- The Eastern Missouri Laborers District Council of the Laborers International Union of North America, AFL-CIO;
- The Associated General Contractors of Missouri;
- The Heavy Constructors Association;
- The Site Improvement Association of Eastern Missouri;
- Other signatory Employer associations.

Section 17.04 – Beneficiary
The term "Beneficiary" means a person designated by a Covered Employee or Retiree or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or may become, entitled to receive any type of Benefit from this Fund.

The Spouse is the automatic Beneficiary if the Covered Employee is married. If the Covered Employee is not married or ceases to be married, the Beneficiary will be the person or persons designated by the Covered Employee. The designation of a Beneficiary by a Covered Employee or the change of a Beneficiary designation by a Covered Employee must be in writing on such form as the Trustees shall prescribe and shall become effective only when filed with the Fund Office. A former Spouse will only be a Beneficiary if so designated by the Covered Employee after the date of divorce.

When a Covered Employee dies without designating a Beneficiary, any Death Benefit shall be paid to the living legal Spouse. If there is no living legal Spouse, the Death Benefit shall be paid in equal shares to the Covered Employee's living children. If there are no living children, the Death Benefit shall be paid in equal shares to the Covered Employee's living parents. If there are no living parents, the Death Benefit shall be paid in equal shares to the Covered Employee's living siblings. If there are no living siblings, the Death Benefit shall be paid to the Covered Employee's estate.

The Covered Employee or Retiree may change Beneficiaries at any time by completing the proper form and forwarding it to the Fund Office.

Section 17.05 – Benefits
The term "Benefits" means the health and welfare benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Trustees.

Section 17.06 – COBRA Continuation Coverage
The term "COBRA Continuation Coverage" means a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requiring all health and welfare funds sponsoring group health plans to offer Covered Employees and their families the opportunity for a temporary extension of health coverage under certain circumstances if they become ineligible for coverage under the Plan.

Section 17.07 – Coinsurance
The term "Coinsurance" means the percentage of Covered Charges paid by the Plan.

Section 17.08 – Collective Bargaining Agreement
The term "Collective Bargaining Agreement" means the labor agreement between the Union and the Association and any other Employer, group of Employers or association of Employers.

Section 17.09 – Co-Payment
The term "Co-Payment" means the flat dollar amount of Covered Charges that you are required to pay after the calendar year deductible has been satisfied.

Section 17.10 – Convalescent Facility
The term "Convalescent Facility" means an institution, or a distinct part of an institution, which meets fully every one of the following requirements:

A. It is primarily engaged in and duly licensed to provide for compensation from its patients on an inpatient basis, Skilled Nursing and Physical Restoration Services for patients convalescing from Injury or Sickness;

B. It is under the full-time supervision of a Physician or registered nurse;

C. It provides Skilled Nursing Services on a 24-hour basis under the direction of a full-time registered nurse, with licensed nursing personnel on duty at all times; and

D. It maintains a complete medical record on each patient.

The term "Convalescent Facility" shall not include:

A. an institution (or part of an institution) which is used principally as a place for rest, Custodial Care or educational care;

B. a place for mental disorders (including, but not limited to, drug addiction, alcoholism, and mental retardation); or

C. a place for the aged.

Section 17.11 – Convalescent Period
The term "Convalescent Period" means a period of consecutive days beginning the first day a Covered Person becomes confined in a Convalescent Facility for the purpose of receiving Skilled Nursing and Physical Restoration Services for treatment of an Accident or Illness. The Covered Person must have previously been confined in a Hospital for at least three consecutive days. The Convalescent Facility confinement must commence within 14 days following termination of Hospital confinement.

Section 17.12 – Cosmetic Surgery
The term "Cosmetic Surgery" means the surgical alteration, including plastic surgery, of tissue to improve appearance or preserve, alter, enhance or restore a pleasing appearance of an individual, which is not intended to affect a substantial improvement or restoration of bodily function.

Section 17.13 – Covered Charge or Covered Expense
The terms "Covered Charge" or "Covered Expense" means the expense incurred, or portion of such expense determined to be allowable after application of the appropriate discount by the PPO, for medical care, services or supplies that are Medically Necessary for the treatment of an Illness or Accidental Injury and not specifically excluded under the limitations of the Plan.

Section 17.14 – Covered Employee
The term "Covered Employee" means:

- Any person who is employed by an Employer and for whom the Employer is required to make contributions into the Trust Fund;

- Any full-time employee of the Union, a Local Union or a participating Union;

- Any full-time employee of the Association;

- Any full-time employee of the Trustees; or

- Any other employee of an Employer who has been accepted as such by the parties hereto and the Trustees.

- Any retiree receiving a monthly benefit under the Construction Industry Laborers Pension Plan and who was eligible for Benefits under the Construction Industry Laborers Welfare Plan at least one calendar quarter in the immediate five-year period before the effective date of retirement, except those who receive a lump sum pension settlement from the Pension Fund.

Section 17.15 – Covered Person
The term "Covered Person" means either the Covered Employee or the Dependent.

Section 17.16 – Custodial Care
The term "Custodial Care" means care which is comprised of services and supplies (including Room and Board and other institutional services) provided to an individual, whether disabled or not, primarily to assist him in the activities of daily living. These services and supplies are considered Custodial Care, regardless of the practitioner or provider by whom or by which they are prescribed, recommended, or performed.

Room and Board and skilled nursing services, when provided to an individual in a Hospital or other institution to which coverage is specifically provided, are not considered Custodial Care when these services must be combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards and establishes a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition.

Section 17.17 – Dependent
The term "Dependent" means:

1. Your legal Spouse.

2. Your natural, adopted or stepchild who is under the age of 26. This also includes a child who has been placed with you for adoption.

3. Your child who is Totally Disabled. A Totally Disabled child is one who is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to last for a continuous period of 12 months or more or result in death, provided the child became so Totally Disabled prior to attainment of age 19 and the child is dependent on you for more than one-half of his or her support during the year and documented proof of such incapacity is submitted to the Trustees within 31 days after the date the child would ordinarily no longer be a Dependent. Documented proof may be requested from time to time by the Fund Office.

4. Any other minor child who is not the natural, adopted or stepchild of the Covered Employee but for whom the Covered Employee has been appointed Legal Guardian, until the child's 18th birthday.

Section 17.18 – Disqualifying Employment
The term "Disqualifying Employment" means employment that is:

- within the geographic jurisdiction of the Fund;

- in any industry in which Covered Employees eligible under the Plan are employed; and

- with an employer that is not a Contributing Employer.

Section 17.19 – Durable Medical Equipment
The term "Durable Medical Equipment" means equipment that meets all the following criteria:

A. Is certified, in writing, by the prescribing Physician as Medically Necessary in the treatment, habilitation or rehabilitation of a patient,

B. Is clearly related to and necessary for the treatment, habilitation, or training of persons with the specified condition,

C. Must improve the function of a malformed body member or retard further deterioration of the patient's condition,

D. Would NOT be necessary in the absence of an Illness or physical or mental disability,

E. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,

F. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),

G. Is appropriate for and intended for use in the home.

Section 17.20 – Employer or Contributing Employer
The terms "Employer" or "Contributing Employer" means:

- Any member of the Association who is a party to, or otherwise bound by, a Collective Bargaining Agreement with the Union requiring contributions to be made to the Trust Fund as provided by a Collective Bargaining Agreement with respect to Covered Employees represented by the Union;

- Any Employer who is a non-member of the Association who has signed a Participation Agreement as approved by the Trustees;

- Any other Employer, association of Employers or group of Employers who have been accepted and approved by the Trustees; or

- The Trustees of the Union, participating Unions and the Association as to Covered Employees of the Association solely for the purpose of making the required contributions to the Trust Fund. The Union, participating Unions or the Trustees shall not participate in the selection of any Association Trustees.

Section 17.21 – Experimental, Investigative or Inappropriate Drug, Device, Treatment or Procedure
The term "Experimental, Investigative or Inappropriate Drugs, Devices, Treatment or Procedure" means drugs, devices, treatments or procedures, and/or supplies that are:

- It is 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 Illness or the likelihood that the service or treatment will measurably improve the Covered Person's Illness or medical condition.

- The drug or device cannot be lawfully marketed without U.S. Food and Drug Administration approval and that no approval for marketing has been given at the time the drug or device is furnished;

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

  - The subject of a Phase I or Phase II clinical trial, the experimental or research arm of a Phase III clinical trial, or in any other manner with the objective of evaluating the maximum tolerated dose, safety, toxicity or efficacy;
  - Provided following a written protocol or other document with the objective of evaluating the safety, toxicity or efficacy; or
  - Experimental, Investigative or Inappropriate based on the patient's informed consent document used with the drug, device or medical treatment;

- The uniform medical policy of the national Blue Cross and Blue Shield Associate (as amended from time to time) has determined that the device or medical treatment/procedure is investigational based on:

  - Not receiving final approval from the appropriate governmental regulatory bodies;
  - Scientific evidence does not permit conclusions about the effect of the device or medical treatment/procedure on health outcomes;
  - The device or medical treatment/procedure does not improve the overall health outcome;
  - The device or medical treatment/procedure is not as beneficial as established alternatives; or
  - The improvement is not attainable outside the investigational settings.

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.

Section 17.22 – Free Standing Residential Alcohol or Drug Treatment Center

The term "Free Standing Residential Alcohol or Drug Treatment Center" means a facility, which meets **all** of the following requirements:

A. It must have a current accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

B. It must be licensed by the State Department of Mental Health or appropriate licensing agency for the treatment of alcohol or drug abuse by the state in which the facility is located;

C. It continuously provides 24-hour a day nursing services by registered nurses on duty or call;

D. It must have a licensed Physician or Physicians on staff or under contract to provide medical services and oversee patient's care and treatment;

E. It must be able to provide acute care services or be under contract with a facility which can provide acute medical care services; and

F. It maintains a complete medical record on each patient.

Free Standing Residential Alcohol or Drug Treatment Center does not include an institution (or part of an institution), which is used principally as a place for rest, Custodial Care or educational care. Nor does it include a place for mental disorders or a place for the aged.

Section 17.23 – Hospital
The term "Hospital" means only those facilities or institutions which meet all of the following criteria:

A. Are licensed as a Hospital by the state or by the county or municipality where the facility or institution is located.

B. Operate primarily for the active care of the sick and injured and not for Custodial Care or educational service.

C. Provide 24 hour-a-day, on the premises, nursing services by registered nurses (R.N.).

D. Have a staff of one or more Physicians available at all times.

E. Provide organized facilities for diagnosis and surgery on its premises.

F. Are not primarily clinics, nursing, rest or convalescent homes or extended care facilities.

G. Maintain permanent and full-time facilities for bed care of 50 or more resident patients.

A "Hospital" is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

Section 17.24 – Illness
The term "Illness" means a bodily disorder, disease or pregnancy that requires Medically Necessary treatment by a legally licensed Physician and is not caused by an Accident as defined in Section 17.01.

Section 17.25 – Medically Necessary or Medical Necessity
The terms "Medically Necessary" or "Medical Necessity" mean:

- A service or supply essential to a Covered Person's health that is:

- Appropriate and necessary for the symptoms, diagnosis and treatment of the Covered Person's medical/surgical condition;

- Consistent with acceptable medical practice according to the medical policy established by the national Blue Cross and Blue Shield Association (the right to review this medical policy is available upon review of a denied claim in accordance with terms of the Plan document).

- Not primarily for the convenience of the Covered Person, his family, Physician, or other provider;

- Consistent with attaining reasonably achievable outcomes; and

- Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

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.

The Plan pays Benefits only for services or supplies that are Medically Necessary.

Section 17.26 – Physician
The term "Physician" means a legally licensed medical doctor, osteopath, surgeon, dentist, podiatrist, chiropractor, nurse practitioner, physician assistant, psychiatrists (with an MD or DO) and psychologists (with a Ph.D., Psy.D., Ed.D.) or Social Workers (LSCSW or LCSW only), when practicing within the scope of their respective licenses. Regarding Behavioral Health Treatment, the Fund recognizes the following licensures for talk therapy:

State of Kansas: LCPC - Licensed Clinical Professional Counselor
State of Missouri: LPC - Licensed Professional Counselor

Other states may use LCPC, LPC or other suffixes to designate a Licensed Professional Counselor. In states other than Nebraska and Georgia, the Fund will recognize that the licensure of Professional Counselor can treat and diagnose independently. Regarding other talk therapists, the Fund will recognize the licensure of:

LCSW - Licensed Clinical Social Worker
LMFT - Marriage and Family Therapist
LMSW - Masters Level Social Worker (Michigan Only)
PHD/PSYD - Psychologist

All talk therapists must have five years Post Master's Degree experience and able to treat and diagnose independently.

Regarding medical doctors and nurses, the Fund will recognize the licensure of:

MD/DO - Psychiatrist
ARNP - Nurse Practitioner (Med Management)

Section 17.27 – Plan
The term "Plan" means the Construction Industry Laborers Welfare Fund.

Section 17.28 – PPO Provider
The term "PPO Provider" means a Hospital, Physician and other clinical facilities who have a written PPO agreement with a network to provide health care services and supplies to Plan participants for a negotiated charge at the time the service or supply is provided. The contact information for the current PPO is listed on page iii of this document. A list of providers is available to Covered Persons upon request.

Section 17.29 – Qualified Beneficiary
The term "Qualified Beneficiary" means:

A. A Covered Employee who suffers a loss of eligibility under the Plan due to either a reduction in hours of employment, termination of employment or entitlement to Medicare; or

B. The Spouse of a Covered Employee who suffers a loss of eligibility under the Plan due to either the Covered Employee's reduction in hours of employment, termination of employment, entitlement to Medicare or the Spouse's divorce or legal separation from the Covered Employee, provided that the Spouse was the Covered Employee's legal Spouse, in accordance with prevailing law, on the day before his loss of eligibility, divorce or legal separation; or

C. The dependent children of a Covered Employee who suffers a loss of eligibility under the Plan due to either the Covered Employee's reduction in hours of employment, termination of employment, entitlement to Medicare, the divorce or legal separation of the Covered Employee and Spouse or the dependent child's failure to satisfy the definition of Dependent contained in this Plan, provided that the dependent was a Dependent on the day before the Covered Employee suffered a loss of eligibility under the Plan due to either a reduction in hours of employment, termination of employment, entitlement to Medicare, divorce or legal separation.

Section 17.30 – Qualified Medical Child Support Order (QMCSO)
The term "Qualified Medical Child Support Order (QMCSO)" means a Court Order signed by a judge as part of your divorce or legal separation or administrative order, which has the force of law pursuant to the state's administrative procedure relating to child support, which requires you to maintain health coverage for your children through the Welfare Fund. The Welfare Fund has adopted simple step-by-step procedures for you to follow to obtain a QMCSO. The procedures explain the contents required to be included in a QMCSO. These procedures are available from the Fund Office free of charge**,** upon request.

The QMCSO procedures require that the Court Order be submitted to the Fund Administrator for review and qualification before it is effective. To prevent a loss of coverage, you should send the Court Order to the Fund Administrator as soon as possible but no later than 90 days after the court has signed the Order. If the Court Order is submitted later than 90 days after it is signed by the Court, your child may not be covered until after the Order is qualified by the Fund Administrator. You should request and review the procedures carefully and discuss them with your attorney if you are involved in divorce or legal separation proceedings.

Section 17.31 – Skilled Nursing Services
The term "Skilled Nursing Services" means one or more of the professional services that may be rendered by a registered nurse or by a licensed practical nurse under the direction of a registered nurse. The term "Skilled Nursing Services" does not include Private Duty Nursing.

Section 17.32 – Spouse
The term "Spouse" means your legal spouse who is not legally separated or divorced. A legal spouse includes a same-sex spouse where the Covered Employee and Spouse were legally married in a state that recognizes same-sex marriages. Domestic partners are excluded.

Section 17.33 – Totally Disabled and Total Disability
The terms "Totally Disabled" and "Total Disability", unless otherwise specifically defined, means a disability, resulting solely from an Illness or Accidental Injury, which prevents the Covered Employee from engaging in any occupation for compensation or profit or prevents the Covered Employee's Dependent(s) from engaging in substantially all the normal activities of a person of like age and sex in good health. The Covered Person must be under the regular care and actual attendance of a Physician.

Section 17.34 – Trust Agreement
The term "Trust Agreement" means the amended Trust Agreement establishing the authority to maintain this Health Care Fund.

Section 17.35 – Trustees or Board of Trustees
The terms "Trustees" and "Board of Trustees" mean 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 shall constitute the "Administrator," the "Plan Sponsor" and the "Named Fiduciaries" of the Trust and of the Health Care Plan established and maintained under the authority of the Trust Agreement.

Section 17.36 – Trust Fund, Fund or Health Care Fund
The terms "Trust Fund," "Fund" or "Health Care Fund" mean the Trust Fund created pursuant to the Trust Agreement and shall mean generally the monies or other things of value that comprise the corpus and additions to the Trust Fund.

Section 17.37 – Union
The term "Union" means Laborers International Union of North America (LIUNA).

Section 17.38 – Usual, Customary and Reasonable Charge (UCR Charge)
The term "Usual, Customary and Reasonable Charge (UCR Charge)" means that the charge, by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90th percentile of prevailing health care charged data. The area reference is the zip code for the general level of charges being made by a Physician of similar training and experience.

For providers within the primary PPO Network, UCR Charge will be the allowed amount as negotiated by the PPO Network.

For providers not in the primary PPO Network, the UCR Charge will be based on the Fair Health Relative Value at the 90th percentile.

Every effort has been made to assure that the information contained in this Combined Plan Document and Summary Plan Description is accurate and up to date as of the time of its printing. You will be notified, in writing, of any changes in the Plan that may affect your Benefits or rights under the Plan.