Carpenters' District Council Of Kansas City And Vicinity Health Plan

Summary Plan Description
And
Plan Document

2003 Edition

CARPENTERS DISTRICT COUNCIL
UNITED BROTHERHOOD OF CARPENTERS AND JOINERS OF AMERICA
LABOR OMNIA VINCIT
Kansas City
& Vicinity

CARPENTERS' DISTRICT COUNCIL OF KANSAS CITY AND VICINITY HEALTH PLAN

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This booklet has been prepared for active participants of the Carpenters' District Council of Kansas City and Vicinity Active Health Plan and retired participants of the Carpenters' District Council of Kansas City and Vicinity Retiree Self-Pay Plan and serves as the Plan's legal document that establishes the Plan. The Trustees reserve the right to interpret, amend or terminate the Plan at any time.

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INTRODUCTION

The Board of Trustees of the Carpenters' District Council of Kansas City and Vicinity Health Plan is pleased to provide you with this updated Summary Plan Description (SPD), which contains current health and welfare benefits information. This also serves as the Plan's official Plan Document. The benefits described in this booklet are effective September 1, 2003.

It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to our members and their families. This is becoming more challenging as health care costs continue to rise at double-digit rates. The Fund has implemented some cost-saving methods such as medical deductibles, out-of-pocket maximums and a mail order prescription drug program to ensure that we can meet your current and future health care needs. You can do your part in helping the Fund manage health care costs by:

- **Visiting PPO providers** — PPO providers, including Hospitals, Physicians and other health care providers, charge negotiated reduced rates. Also, the Plan pays a higher percentage when you use a PPO provider.
- **Using the mail order prescription drug program** — The Fund offers the mail order program for your maintenance medications because the mail order program provides medications at lower rates than retail pharmacies.
- **Examining Emergency treatment alternatives** — In the event of an Emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or an urgent care facility as in an Emergency room. Keep your Physician's telephone number easily accessible and locate the urgent care facility nearest to you beforehand so you'll be prepared in case of an Emergency.

If you have questions about how the Plan works, please call or write the Fund Office at:

Carpenters' District Council of
Kansas City and Vicinity
Health Plan Fund Office
3100 Broadway, Suite 805
Kansas City, Missouri 64111
Telephone: (816) 756-3313
Toll-free: (866) 756-3313

For this edition we've organized the information in an easy-to-understand format and added the following sections:

- **Contact Information** — This tells you whom to call when you need certain information.
- **Life Events** — Details how your benefits are affected by the different events that can occur in your life.
- **How To File A Claim** — Gives you a step-by-step process for filing claims, including what you need to do if a claim is denied.
- **Definitions** — Defines important terms used throughout this SPD. Defined terms are identified by using initial capitalization throughout the SPD.

We urge you to read this information and, if you're married, share it with your spouse. Also, please keep this SPD with your important papers so you can refer to it when needed.

Sincerely,
Board of Trustees

Schedule of Benefits

COMPREHENSIVE MEDICAL BENEFITS FOR ACTIVE EMPLOYEES, RETIREES AND DEPENDENTS	COVERAGE
Calendar Year Deductible	
PPO Providers	$300 per person up to $600 family maximum per calendar year
Non-PPO Providers	$400 per person up to $1,000 family maximum per calendar year
Out-Of-Pocket Maximum (Excluding The Deductible)	
PPO Providers	$1,500 per person per calendar year
Non-PPO Providers	$2,500 per person per calendar year
Annual Maximum For All Covered Expenses	Plan pays up to $300,000 per calendar year per person
Copayment	Plan pays:
Self-Injectable Drugs (Subject To The Deductible, Not Subject To Out-Of-Pocket Maximum)	50% of Reasonable and Customary Charges
All other Covered Expenses	
PPO Providers	90% of Reasonable and Customary Charges
Non-PPO Providers	80% of Reasonable and Customary Charges
Chiropractic Care (Not Subject To The Deductible Or Out-Of-Pocket Maximum)	Plan pays 100% up to $35 per visit
Annual Maximum	$1,000 per person
X-Ray Annual Maximum	$100
Adult Restorative Speech Therapy	Plan pays 80% of Reasonable and Customary Charges
Annual Maximum	$1,500 per person
Dependent Child Speech Therapy	Plan pays 50% of Reasonable and Customary Charges
Annual Maximum	$500 per child
Mental And Nervous Disorders	
Inpatient Treatment	
Annual Maximum (Outpatient Treatment is covered the same as all other Covered Expenses)	30 days per person
Alcohol And Chemical Dependency	
Inpatient Treatment	
(Outpatient treatment is not covered)	
Annual Maximum	$6,000
Hearing Aid (For Hearing Loss Due To Accident Only)	Plan pays 100% up to:
Hearing Exam (For Placement And Fitting)	$50
Hearing Aid	$600 per aid
Maximum Hearing Aid Benefit	$1,200 during a consecutive three-year period
Hospice Care	
Lifetime Maximum	Plan pays 100% of Reasonable and Customary Charges $10,000 per person
Bereavement Counseling For The Immediate Family Following The Death Of A Terminally Ill Person	Plan pays 100% up to $50 per visit, up to six visits per hospice death
Durable Medical Equipment/ Corrective Appliances *	Plan pays up to $10,000 per person (per limb or device) during a consecutive three calendar year period
Organ Transplant Benefit**	Plan pays:
Center-Of-Excellence Network Facility	100% of Reasonable and Customary Charges
Non-Center-Of-Excellence Facility	80% of Reasonable and Customary Charges
Annual Maximum	Subject to Comprehensive Medical annual maximum
Lifetime Maximum	$500,000 for all transplants combined
Organ Procurement	$15,000 per transplant, included in organ transplant lifetime maximum
Anti-Rejection Medications	
Retail Prescription	Not covered after initial prescription
Mail Order Prescription (90-Day Supply)	You pay:
Brand Name Medication Copayment	20% from a minimum of $20 up to a maximum of $100 per prescription
Generic Medication Copayment	15% from a minimum of $10 up to a maximum of $100 per prescription

PRESCRIPTION DRUG BENEFITS FOR ACTIVE EMPLOYEES, RETIREES AND DEPENDENTS	COVERAGE
Retail Pharmacy (34-Day Supply)	You pay:
Brand Name Medication Copayment	20% from a minimum of $20 up to a maximum of $100 per prescription
Generic Medication Copayment	15% from a minimum of $10 up to a maximum of $100 per prescription
Mail Order Program (90-Day Supply)	You pay:
Brand Name Medication Copayment	20% from a minimum of $20 up to a maximum of $100 per prescription
Generic Medication Copayment	15% from a minimum of $10 up to a maximum of $100 per prescription

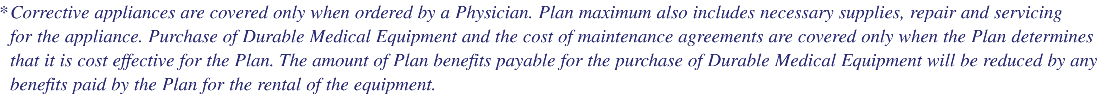
DENTAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS	COVERAGE
Calendar Year I Deductible	
Individual	$25 per calendar year
Family	$75 per calendar year
Calendar Year Maximum	$1,250 per person per calendar year
Dental Services Copayment	Plan pays:
Preventive Services (Not Subject To Deductible)	100%
Basic Services	80%
Major Services	50%
Orthodontic Services (Only For Dependent Children Under Age 19)	50% (not subject to annual maximum)
Orthodontic Services Lifetime Maximum	$1,500

VISION BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS	COVERAGE
Vision Care Services	Plan pays up to $200 per person per consecutive two calendar year period
Vision Surgical Correction Services (RK Or LASIK Only)	
Deductible	$25 per eye
Plan Copayment	Plan pays 100% of Reasonable and Customary Charges
Lifetime Maximum	$1,600 per eye

WEEKLY ACCIDENT AND SICKNESS BENEFITS FOR ACTIVE EMPLOYEES ONLY	COVERAGE
Weekly Benefit Amount Beginning 1st Day Of An Accident Or 8th Day Of Sickness	$300 per week for up to 26 weeks per non-occupational disability

DEATH BENEFITS FOR ACTIVE AND RETIREES ONLY	AMOUNT
Active Employee Benefit	$9,000
Retiree Benefit	$1,500

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT FOR ACTIVE EMPLOYEES ONLY	PRINCIPAL SUM
Benefit	$9,000



Corrective appliances are covered only when ordered by a Physician. Plan maximum also includes necessary supplies, repair and servicing for the appliance. Purchase of Durable Medical Equipment and the cost of maintenance agreements are covered only when the Plan determines that it is cost effective for the Plan. The amount of Plan benefits payable for the purchase of Durable Medical Equipment will be reduced by any benefits paid by the Plan for the rental of the equipment.

***The Plan's annual out-of-pocket maximum does not apply to organ transplant benefits received from a non-Center of Excellence facility. The amounts you pay for non-Center of Excellence facilities do not accumulate toward your annual out-of-pocket maximum.*

Contact Information

IF YOU NEED INFORMATION ABOUT...	CONTACT...
■ Locating a PPO provider	Freedom Network P.O. Box 25938 Shawnee Mission, Kansas 66225-5938 (913) 685-6300 Toll-Free (800) 544-3014 www.phpkc.com HealthLink P.O. Box 419104 St. Louis, MO 63141-9104 (314) 989-6300 Toll-Fee (800) 624-2356 www.healthlink.com
■ Comprehensive Medical Benefits ■ Dental Benefits ■ Vision Benefits ■ Weekly Accident And Sickness Benefits ■ Death Benefits ■ Accidental And Dismemberment (AD&D) Benefits	Fund Office at: Carpenters' District Council Of Kansas City And Vicinity Health Plan Fund Office 3100 Broadway, Suite 805 Kansas City, Missouri 64111 Telephone: (816) 756-3313 Toll-Free: (866) 756-3313
■ Prescription Drug Programs	Retail and Mail Order Prescription Drug Programs: AdvanceRx.com P.O. Box 961066 Fort Worth, Texas 76161-9854 Telephone: (800) 966-5772 Web site: www.advancerx.com

INITIAL ELIGIBILITY

For Active Employees

You become eligible for coverage under the Plan if you:

- Perform work under the jurisdiction of the Carpenters' District Council of Kansas City and Vicinity of the United Brotherhood of Carpenters and Joiners of America; and
- Have at least:
  - 700 hours of work for which contributions were received by the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund on your behalf from one or more Contributing Employers during a six-consecutive month period; or
  - 1,000 hours of work for which contributions were received by the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund on your behalf from one or more Contributing Employers during a nine-consecutive month period; or
  - 1,300 hours of work for which contributions were received by the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund on your behalf from one or more Contributing Employers during a 12-consecutive month period.

When Coverage Begins

Coverage begins on the first day of the second calendar month following the calendar month in which you meet one of the above requirements.

INITIAL ELIGIBILITY CONTRIBUTION REQUIREMENTS

To Become Eligible Beginning The First Day Of...	700 Hours Of Contributions Must Have Been Received On Your Behalf For The Months Of...	OR	1,000 Hours Of Contributions Must Have Been Received On Your Behalf For The Months Of...	OR	1,300 Hours Of Contributions Must Have Been Received On Your Behalf For The Months Of...
January	June through November		March through November		December through November
February	July through December		April through December		January through December
March	August through January		May through January		February through January
April	September through February		June through February		March through February
May	October through March		July through March		April through March
June	November through April		August through April		May through April
July	December through May		September through May		June through May
August	January through June		October through June		July through June
September	February through July		November through July		August through July
October	March through August		December through August		September through August
November	April through September		January through September		October through September
December	May through October		February through October		November through October

EXAMPLE

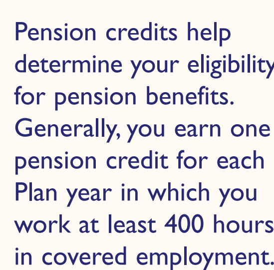
Charles begins work on December 1, 2003 and completes 700 hours of work for which contributions are received in the six consecutive month period ending May 31, 2004. He will be eligible for benefit coverage beginning July 1, 2004.

Active Employees are eligible for:

- Comprehensive Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Weekly Accident and Sickness Benefits;
- Death Benefits; and
- Accidental Death and Dismemberment (AD&D) Benefits.

Retirees may be eligible under the Self-Pay Plan for:

- Comprehensive Medical Benefits;
- Prescription Drug Benefits; and
- Death Benefits.



Pension credits help determine your eligibility for pension benefits. Generally, you earn one pension credit for each Plan year in which you work at least 400 hours in covered employment.

For Retirees

You become eligible for coverage under the Self-Pay Plan if you:

- Are eligible for benefits under the Carpenters' District Council of Kansas City and Vicinity Health Plan on the effective date of your retirement;
- Have 15 pension credits under the Carpenters' District Council of Kansas City Pension Fund (excluding pension credits earned before a permanent break in service); and
- Have been eligible for benefits under the Carpenters' District Council of Kansas City and Vicinity Health Plan for 48 out of the last 60 months before your retirement.

Many benefits under the retiree Self-Pay Plan are the same as those for active Employees, except that there are no Dental, Vision or Accidental Death and Dismemberment Benefits. The Trustees reserve the right to implement other benefit differentials or retiree Plan changes as they deem appropriate in order to maintain the Fund's financial viability.

When you initially apply for benefits from the Carpenters' District Council of Kansas City Pension Fund, you will be given the opportunity to apply for coverage in the Self-Pay Plan. It is important to note that upon your initial retirement, if you are eligible to participate in the retiree Self-Pay Plan, but choose not to, you will not be given the opportunity at a later time to re-apply.

The retiree Self-Pay Plan offers two types of coverage: a) coverage for yourself or b) coverage for yourself and any Dependents. If, at the time of your initial retirement, you choose to purchase coverage for yourself only, you will not be given the opportunity to add coverage for Dependents at a later date. Also, regardless of the coverage purchased when you initially retire, if you should remarry after you retire, you will not be allowed to add your new spouse as a Dependent.

You must apply for retiree coverage by submitting a completed application to the Fund Office at least 30 days before your active eligibility terminates. After your application is received, the Fund Office will notify you of the date your eligibility for active coverage, based on Employer contributions, will end and your first Retiree premium will become due. You will also be provided with the option of having your monthly premium deducted from your monthly pension check. Your eligibility for active coverage will continue until your eligibility based on Employer contributions ends. To continue eligibility under the retiree Self-Pay Plan, you must make the required payment no later than the first of the month following the month after your active eligibility ends. The Trustees establish the self-payment rates, which may be changed at any time. If your self-payment rate changes, you will be notified in writing.

If you are an active Employee, and lose eligibility for active coverage due to retirement and do not meet the eligibility requirements or choose not to elect retiree coverage, you may be eligible for COBRA Continuation Coverage. COBRA Continuation Coverage provides the same benefits as active coverage except that there are no Weekly Accident and Sickness, Death or Accidental Death or Dismemberment Benefits.

Dependent Eligibility

Eligible Dependents include your:

- Legal spouse;
- Unmarried children under the age 19;
- Unmarried children at least age 19 but less than age 23 who are primarily dependent on you for full support and maintenance and who are full-time students. To be eligible for coverage, your Dependent must provide proof of full-time student status to the Fund Office for each term or semester. Under the Plan, your child is considered a full-time student if he or she is enrolled for at least 12 semester hours or the equivalent at an accredited school, college or university and you provide proof of full-time status from the educational institution;
- Your unmarried children who you are required to provide medical coverage for under a Qualified Medical Child Support Order (QMCSO) and meets the eligibility requirements of a dependent child; and
- Unmarried children over age 19 who are incapable of self-sustaining employment because of mental or physical handicap provided:
  - The children depend on you primarily for support and maintenance; and
  - You provide proof of incapability to the Fund Office within 31 days after the Dependent reaches age 19, or within 31 days of the date your eligibility is established, whichever is later. Proof of continuing incapability may also be required from time to time, but not more often than once a year.

In general, your eligible Dependents include your legal spouse and your unmarried Dependent children under age 19.

Children over age 19 may be eligible for coverage if they are full-time students or a re mentally disabled or physically handicapped.

In addition to your natural born child, children covered under the Plan include your stepchildren living in your home, adopted children, children placed for adoption and Foster Children, provided the children are dependent on you for support and maintenance.

The term "placed for adoption" means the assumption and retention of a legal obligation for a child in anticipation of the adoption of the child before the child's 18th birthday. The child's placement with you ends when the legal obligation is terminated.

Eligible Dependents do not include Dependents that are in the Uniformed Services on a full-time basis.

If you and your spouse are both eligible Employees under the Plan:

- Your children may be covered as Dependents of both of you only to the extent that 100% of the Covered Expenses claimed may be reimbursed; and
- Your spouse will be considered an eligible Dependent only to the extent that 100% of the Covered Expenses claimed may be reimbursed.

When Dependent Coverage Begins

Dependent coverage begins on the same date your eligibility begins, or if applicable, a later date such as the date you acquire an eligible Dependent or as specified in a Qualified Medical Child Support Order.

Continuing Eligibility

For Active Employees

Your eligibility will continue on a month-to-month basis as long as you are working, or are available for work, in employment and your Employer (who has contractual obligation to contribute to the Plan) contributes at least:

- 700 hours of contributions during the preceding six-consecutive month period; or
- 1,000 hours during the preceding 12-consecutive month period.

CONTINUING ELIGIBILITY CONTRIBUTION REQUIREMENTS			
To Continue Eligibility For The Month Of...	**700 Hours Of Contributions Must Have Been Received On Your Behalf For The Months Of...**	***OR***	**1,000 Hours Of Contributions Must Have Been Received On Your Behalf For The Months Of...**
January	June through November		December through November
February	July through December		January through December
March	August through January		February through January
April	September through February		March through February
May	October through March		April through March
June	November through April		May through April
July	December through May		June through May
August	January through June		July through June
September	February through July		August through July
October	March through August		September through August
November	April through September		October through September
December	May through October		November through October

If your Employer stops making contributions on your behalf, you may be able to continue coverage by electing COBRA Continuation Coverage and making the self-payments for that coverage, see page 13.

For Retirees

Your eligibility for retiree coverage will continue as long as you make the required payment by the first of each succeeding month. If your monthly payment is not received by the Fund Office, you will lose eligibility for coverage. If you should return to work as an active Employee and you become eligible for active coverage, you will have the same benefits as an active Employee. Once you are no longer eligible as an active Employee, you will be reinstated into the Retiree Self-Pay Plan as long as your monthly premium is paid.

Reciprocal Agreements — When You Work In Another Jurisdiction

The Plan is a signatory to the Master Reciprocal Agreement for Carpenter Health and Welfare Funds. When you work in another jurisdiction and your Employer contributes to another health and welfare fund, the Reciprocal Agreement allows for the return of contributions made on your behalf back to this Fund.

In order to get your contributions returned to this Fund, you must complete a form that is available from the Fund Office and submit it to the health and welfare fund where your contributions were paid. If you decide not to have the contributions made on your behalf reciprocated back to this Fund, the hours reported will not be considered when determining your eligibility for benefit coverage.

Contact the Fund Office for a list of funds participating in reciprocity agreements with the Carpenters' District Council of Kansas City and Vicinity Health Fund.

When Eligibility Ends

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

For Active Employees

When your or your eligible Dependent's coverage ends, you or he or she may be eligible to continue coverage by making monthly self-payments for COBRA Continuation Coverage (see page 13).

Your eligibility for coverage under the Plan will end on the earliest of the following:

- The last day of the month following the month in which your contribution hours are less than the minimum required for continuing eligibility (see page 7);
- The first day you work for an employer who is no longer required to contribute to the Fund;
- The day you work in employment in the jurisdiction of the Fund for an employer that is not required to contribute to the Fund;
- The last day of the month following the month in which the local union or other collective bargaining unit representing you terminates its participation in the Fund (for this purpose, a local union or other bargaining unit is considered terminated as of the last day its Collective Bargaining Agreement requires Employer contributions to the Fund);
- The date the Plan terminates;
- The date you die; or
- The first day of the month following the date you enter the Uniformed Services of the United States and elect to not continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

At the end of each month the contribution hours, which establish continuing eligibility, are reviewed. If you have not met one of the hour requirements shown during the period below, which ends on the date the test is run, eligibility will end on the date shown in the right-hand column.

If You Have Less Than 700 Hours of Contributions Received On Your Behalf...	And	If You Have Less Than 1,000 Hours of Contributions Received On Your Behalf...		Your Eligibility Will Terminate On...
From	To	From	To	
July 1	December 31	January 1	December 31	January 31
August 1	January 31	February 1	January 31	February 28 (29)
September 1	February 28 (29)	March 1	February 28 (29)	March 31
October 1	March 31	April 1	March 31	April 30
November 1	April 30	May 1	April 30	May 31
December 1	May 31	June 1	May 31	June 30
January 1	June 30	July 1	June 30	July 31
February 1	July 31	August 1	July 31	August 31
March 1	August 31	September 1	August 31	September 30
April 1	September 30	October 1	September 30	October 31
May 1	October 31	November 1	October 31	November 30
June 1	November 30	December 1	November 30	December 31

For Retirees

Your eligibility for retiree coverage under the Self-Pay Plan will end on the earliest of the following:

- The date you return to work as an active Employee and you become eligible for active coverage;
- The date you die;
- The date the Plan terminates; or
- The last day of the month for which your required payment is received by the Fund Office.

For Your Dependents

Your eligible Dependent's eligibility will end on the earliest of:

- The date your eligibility under the Plan ends;
- The date you or your Dependent dies;
- The date the Dependent no longer meets the definition of Dependent under the Plan (see page 7 for definition of a Dependent);
- The date the Plan is modified to terminate or limit Dependent benefits;
- The date the Plan terminates; or
- The date specified in a Qualified Medical Child Support Order.

If your eligible Dependent's coverage ends, your eligible Dependents may be eligible for COBRA Continuation Coverage as described on page 13.

Reinstatement Of Eligibility

If your eligibility ends under the active Plan, you can become eligible again by meeting the initial eligibility requirements as described on page 5.

If you are retired and in the retiree Plan, and you return to work as an active Employee, you can become eligible again for active coverage by meeting the initial eligibility requirements as described on page 5. Subsequently, once you are no longer eligible as an active Employee, you will be reinstated into the Retiree Self-Pay Plan as long as your monthly premium is paid.

Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different lifestyle changes occur after you become a participant.

GETTING MARRIED (FOR ACTIVE EMPLOYEES)

When you get married, your spouse is eligible for medical, prescription drug, dental and vision coverage. Once you provide any required information, coverage for your spouse begins on the date of your marriage. At this time, you also may want to update your beneficiary information for your Death and AD&D Benefits.

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

ADDING A CHILD

Your natural born child will be eligible for coverage on their date of birth. If you have a Foster Child, adopt a child or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent. Stepchildren are eligible for coverage on the date of your marriage, provided that they are living in your home, and dependent on you for support. You may also cover a grandchild if you are that individual's legal guardian and he or she lives with you. Once you provide any required information, coverage for your child will begin. The child must meet the Dependent eligibility requirements described on page 7.

GETTING LEGALLY SEPARATED OR DIVORCED

If you and your spouse get a legal separation or divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must** notify the Fund Office **within 60 days** of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your Death and AD&D Benefits, if eligible.

When you get married, provide the Fund Office with:

- A copy of your marriage certificate.
- Your spouse's date of birth.
- A copy of your spouse's medical insurance information, if he or she is covered under another plan.

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

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

If you get legally separated or divorced, provide the Fund Office with:

- A copy of your separation or divorce decree.
- A copy of any QDRO.
- If you have children for whom you do not have custody, a copy of any QMCSO.

If your spouse wants to continue coverage, he or she must:

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage.

This Plan recognizes Qualified Domestic Relations Orders (QDROs) and Qualified Medical Child Support Orders (QMCSOs) and provides benefits for eligible Dependents, as determined by the order. A Qualified Medical Child Support Order (QMCSO) is a court order or administrative order, which has the force of law pursuant to the state's administrative procedure, relating to child support that provides for a child's coverage under the Plan. The Fund Office has the authority to determine if a National Medical Support Notice, issued by a state agency is a QMCSO. QMCSOs other than National Medical Support Notices must contain specific information, be submitted to the Plan Administrator and be approved by the Trustees to be qualified. A copy of the Plan's QMCSO qualification procedures is available free of charge at the Fund Office.

Losing Your Eligibility Due To Lack Of Contribution Hours

A detailed description of the requirements needed to continue eligibility is shown on page 7. If you are an active employee and your eligibility ends under the active Plan, you can become eligible again by meeting the initial eligibility requirements as described on page 5. When your coverage ends, you may be eligible to continue coverage by making monthly self-payments for COBRA Continuation Coverage (see page 13).

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

- Contact the Fund Office.
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.
- If your child is under 23, a full-time student and wants to continue coverage under the Plan, he or she must provide evidence of full-time student status to the Fund Office.

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

- Notify your Employer and the Fund Office.
- Provide the Fund Office with proof of your disability.
- Apply for Weekly Accident and Sickness Benefits.

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

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

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he or she marries, is not dependent on you for support or reaches age 19 (or 23 if a full-time student). You must notify the Fund Office within 60 days of when your child is no longer eligible for coverage. Your child may elect to continue coverage by making COBRA self-payments for up to 36 months.

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

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

If you are receiving Weekly Accident and Sickness Benefits under the Plan or Workers' Compensation benefits, you will receive 20 hours of work credit for each week, or four hours for each day, you are entitled to receive these benefits. No further hours will be credited after your benefits end. No more than 520 hours can be credited for one period of disability. These hours may be used to continue your eligibility under the Plan.

The Fund requires proof of disability that is satisfactory to the Trustees. The Fund also has the right to require you to submit to a medical examination.

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

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

Extending Your Eligibility When You Become Totally Disabled (For Active Employees)

If you are out of work due to a Total Disability, you should notify your Employer and the Fund Office. If you are unable to work due to a non-work related Total Disability, you may be eligible for Weekly Accident and Sickness Benefits and your medical benefits may continue, see page 33. Totally Disabled means wholly and continuously disabled by a Sickness or accidental bodily Injury that prevents you from being gainfully employed in your own occupation. For Dependents, Totally Disabled means prevented by Illness or Injury from engaging in all normal activities of a person of similar age, gender and in good health.

If your eligibility for coverage ends while you or your Dependent is Totally Disabled, your Comprehensive Medical Benefits may continue for up to 13 weeks, provided:

- The expenses incurred are related to the same disability; and
- You or your Dependent remains Totally Disabled.

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

In the Event Of Your Death

If you are eligible for coverage on the date of your death, your beneficiary will receive a Death Benefit (and an AD&D Benefit, for active Employees only, if your death is caused by an accident). See page 34 for more information about Death and AD&D Benefits.

In the event of your death, your spouse or beneficiary should:

- Notify the Fund Office.
- Provide the Fund Office with a copy of your death certificate.
- Apply for your Death Benefit (and AD&D Benefit, if applicable).
- If your Dependents want to continue coverage under the Plan, enroll for COBRA Continuation Coverage.

For Active Employees

If you die while an active Employee, coverage for your eligible Dependents will be continued for the period of time that eligibility would be maintained based on your accumulated hours, but not less than 90 days.

If you die while an active Employee and are making self-payments to maintain eligibility, coverage for eligible Dependents will be continued for the month in which you die and for 90-days following the month of your death. No self-payments will be required during the 90-day period.

Your spouse and/or eligible Dependents may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments (see page 13).

For Retirees

If you are a retiree and you elected coverage for your spouse and/or eligible dependents, your surviving spouse and eligible Dependents can continue coverage by making self-payments. Your surviving spouse can continue coverage through self-payments until he or she remarries. If the self-payments are discontinued for any month, or if your surviving spouse does not elect to make self-payments when first eligible, your spouse will not be eligible to continue coverage by making self-payments.

Your spouse and/or eligible Dependents may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments (see page 13).

When You Leave Covered Employment

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of plan benefits to Employees and eligible Dependents ("Qualified Beneficiaries") who would otherwise lose coverage under a plan. Qualified beneficiaries include you and each Dependent who was covered under the Plan on the day before a qualifying event occurs and who would lose coverage as a result of a "Qualifying Event" (see below). Children born, adopted or placed for adoption during the period of COBRA coverage have the same COBRA rights as a spouse or Dependents who were covered by the Plan on the day the event that triggered COBRA Continuation Coverage.

Under certain circumstances, you can continue coverage by making self-payments to the Plan. You will *not* be eligible to continue coverage for Weekly Accident and Sickness, Death or Accidental Death and Dismemberment Benefits. By making self-payments, you may continue medical and prescription drug benefits and if you were eligible, vision and dental benefits.

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan on the day before the qualifying event. If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA

Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office within 60 days, in writing, of the birth or placement to have this child added to your coverage. Like all qualified beneficiaries with COBRA Continuation Coverage, the continued coverage of children born or placed with you for adoption during the period of COBRA Continuation Coverage depends on timely and uninterrupted premium payments on their behalf.

Qualifying Events

If you or your Dependents lose coverage as a result of a qualifying event, you are entitled to elect COBRA Continuation Coverage. Qualifying events include your:

- Reduction in hours or termination of employment;
- Death;
- Legal separation or divorce;
- Entitlement to Medicare; and
- Dependent no longer meets the definition of a Dependent under the Plan.

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

Notifying The Fund Office

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

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

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

When the Fund Office is notified that a qualifying event has occurred, you and your Dependents will be notified of your right to elect COBRA Continuation Coverage. Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your Dependents have the option to elect coverage independently from you if you choose not to elect COBRA Continuation Coverage. If you or your qualified beneficiary choose not to elect COBRA Continuation Coverage and then change your mind, you may revoke your initial election only if your initial election coverage period has not run out. However, COBRA Continuation Coverage will only begin on the date of your revocation of election.

Period Of Coverage

Coverage continues for a maximum of:

- 18 months if your coverage ends due to your termination of employment or your reduction in hours.
- 29 months if you or one of your Dependents is disabled when your coverage ends or if you become disabled within the first 60 days of COBRA coverage. To continue coverage for up to 29 months, you must notify the Fund Office of your determination of disability by the Social Security Administration within 60 days of the determination and before the initial 18 months of COBRA coverage ends.

- 36 months if your spouse or other Dependent's coverage ends because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Eligible Dependent child no longer qualifying for Dependent coverage under the Plan.

Loss Of Continued Coverage

COBRA Continuation Coverage for each person will also be terminated if:

- You fail to make the self-payment for COBRA Continuation Coverage on time;
- After you have elected COBRA Continuation Coverage, you become covered under another group health plan that has no exclusion or limitation on pre-existing conditions;
- After you have elected COBRA Continuation Coverage, you become entitled to Medicare; or
- The Fund no longer maintains any group health plans.

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

Paying for COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage. For disability coverage extensions, the cost of COBRA Continuation Coverage will not exceed 150% of the cost to provide this coverage.

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

Serving In The Uniformed Services (For Active Employees)

If you are called into the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage means Hospital, surgical, medical, dental, vision or prescription drug coverage provided under the Plan.

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

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

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you must pay your share, if any, of the cost of coverage. If your service continues for more than 31 days, you may elect to continue coverage

If you are called to military service:

- Notify your Employer and the Fund Office; and
- Make self-payments if you wish to continue your coverage.

Uniformed services means the:

- United States Armed Forces;
- Army National Guard;
- Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- Commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

under the Plan by making monthly self-payments. To continue coverage, you or your Dependent must pay the required self-payment.

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

Your coverage will continue until the earlier of:

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

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

- Your coverage would otherwise end as described above;
- Your former Employer ceases to provide any health plan coverage to any Employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

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

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

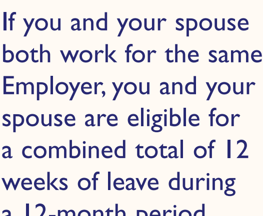
Reinstating Your Coverage

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

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

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

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



If you and your spouse both work for the same Employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

Family And Medical Leave Act (For Active Employees)

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks of unpaid leave for your serious Illness, to care for a child after the birth, adoption or placement for adoption of a child or to care for your seriously ill spouse, parent or child. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for a length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave.

Eligibility

To be eligible for FMLA benefits, you must:

- Work for a covered Employer;
- Have worked for the Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

If you and your Employer have a dispute over your eligibility and coverage under the Family and Medical Leave Act, your benefits will be suspended pending resolution of the dispute. The Trustees have no direct role in resolving such disputes.

Leave Entitlement

Leave for birth or adoption (including foster care placement) must conclude within 12 months of the birth or placement.

An Employer covered under FMLA may grant you up to a total of 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- To take medical leave when you are unable to work because of a serious health condition.

Spouses employed by the same Employer are jointly entitled to a combined total of 12 weeks of family leave for the birth or placement of a child for adoption or foster care and to care for a child or parent (but not parent-in-law) who has a serious health condition.

Under some circumstances, you may take FMLA leave intermittently — which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule. Intermittent FMLA leave for birth or adoption or foster care placement requires your Employer's approval. FMLA leave may be taken intermittently whenever it is Medically Necessary to care for a family member's serious health condition, or because you have a serious health condition and are unable to work.

Maintenance Of Health Benefits

A covered Employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an Employer covered under FMLA must continue to make contributions on your behalf while you are on FMLA leave as though you had been continuously employed.

Returning To Work

Upon return from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits and other employment terms and conditions. In addition, your use of FMLA leave cannot result in the loss of benefits that you earned or were entitled to before using FMLA leave.

Termination Of FMLA Health Care Coverage

Health care coverage during an FMLA leave ends on the earliest of the following dates:

- When you return to work; or
- When 12 weeks of leave ends.

FMLA And Other Benefits

You will not accrue additional benefits or seniority during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Welfare benefits other than health care must be reinstated when you return to work without any new conditions or need to meet eligibility requirements.

How FMLA Works With COBRA

Taking a family or medical leave is not itself considered a COBRA qualifying event. If you return from leave within 12 weeks, there will not be a loss of coverage.

If you do not return from leave, that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

Taking An FMLA Leave

If you need to take an FMLA leave, your Employer may require you to provide:

- 30-day advance notice of the need to take the FMLA, if the need is foreseeable;
- Medical certifications supporting the need for leave due to a serious health condition affecting you or an immediate family member;
- Second or third medical opinions and periodic recertifications (at your Employer's expense); and
- Periodic reports during FMLA leave regarding your status and intent to return to work.

When leave is needed to care for an immediate family member or your own Illness, and is for planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your Employer's operation. You and your Employer must certify to the Trustees, in writing, that you have been granted leave under the Family and Medical Leave Act.

When you retire:

- Notify the Fund Office in advance of your retirement.
- Apply for retiree benefits if you are eligible.
- If you want to continue coverage under the Plan, enroll for COBRA Continuation Coverage, unless you qualify for retiree coverage.

When You Retire

Coverage for you and your Dependents will end under the active Plan when you retire. When you retire, you may be eligible for coverage under the Kansas City and Vicinity Carpenters' Retiree Self-Pay Plan if you meet the eligibility requirements described on page 6. Benefits under the retiree Self-Pay Plan are the same as those for active Employees, except that there are no Dental, Vision, Weekly Accident and Sickness or Accidental Death and Dismemberment Benefits.

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

Returning To Work

For Active Employees

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

If you return to work following a military leave of absence, your coverage will be reinstated as described on page 15.

For Retirees

Your retiree coverage under the Plan will end when you return to employment and you become eligible for active coverage as the result of hours contributed on your behalf (see page 5 for the Plan's initial eligibility requirements).

(For Active Employees, Retirees And Eligible Dependents)

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

HOW THE PLAN WORKS

Preferred Provider Organization (PPO)

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

It's your decision whether or not to use a PPO provider. You always have the final say about the Physicians and Hospitals you and your family use. To encourage you to use PPO providers whenever possible, the Plan pays a higher percentage of Covered Expenses when you use a PPO provider. Also, there are lower deductibles and out-of-pocket maximums if you use PPO providers. If you have questions about, or need a listing of Physicians and Hospitals that participate in the PPO network (provided free of charge), contact the Fund Office (see page 4 for PPO contact information).

The Plan pays different levels based on whether you use a PPO or non-PPO provider as listed in the "Schedule Of Benefits" on page 2. Once your copayment amounts for Covered Expenses (excluding the deductible) reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of remaining Reasonable and Customary Charges for the rest of that year up to the annual maximum.

Note some expenses may be covered differently or subject to different benefit maximums. See the "Schedule Of Benefits" on page 2 for more information.

Annual Deductible

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

The annual deductible is the amount of Covered Expenses that you pay each calendar year before the Plan begins to pay benefits for PPO and non-PPO provider services.

The deductible applies to each Covered Person each calendar year. The family deductible is met once two or more covered members of a family meet the amount as shown in the "Schedule Of Benefits" for family maximum. Once the individual and/or family deductible is met, no further deductibles are required for that year. Deductibles cannot be carried over from one calendar year to the next.

Common Accident Deductible

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

Preferred Provider Organization (PPO)

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

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

When you need to see a Doctor…

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

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

If you need to be Hospitalized:

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

Copayment

Once you or your family has met the annual deductible, the Plan pays a percentage of Covered Expenses, called a "copayment." The amount the Plan pays depends on the type of Covered Expense as listed in the "Schedule Of Benefits" on page 2. Your payment is the remaining percentage of Covered Expenses.

Out-Of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay out-of-pocket in a calendar year for Covered Expenses. If your copayments toward Covered Expenses reach the out-of-pocket maximum (excluding the deductible), the Plan pays 100% for most additional Covered Expenses for the rest of the calendar year, up to the annual maximum shown in the "Schedule Of Benefits." There are separate out-of-pocket maximums for PPO and non-PPO provider Covered Expenses. Your copayment amounts toward the out-of-pocket maximum do not include amounts you pay toward meeting your annual deductible.

Annual And Lifetime Maximums

You and each eligible Dependent can receive medical benefits up to the annual and lifetime maximums specified in the "Schedule Of Benefits" on page 2. Certain services have separate annual and/or lifetime maximums.

Reasonable And Customary Charges

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

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

Medically Necessary

The Plan pays benefits only for services and supplies that are Medically Necessary. In general, "Medically Necessary" means a service or supply ordered by a Physician that the Fund, or a party or entity selected by the Fund, determines is:

- Provided for the diagnosis or direct treatment of an Injury or Illness;
- Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the person's Injury or Illness;
- Provided according to generally accepted medical practices on a national basis; and
- The appropriate supply or level of service that can be provided on a cost-efficient basis (including, but not limited to, inpatient versus outpatient care, electric vs. manual wheelchair, surgical vs. medical and other types of care).

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

Your Responsibility

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

HERE'S AN EXAMPLE OF HOW USING A PPO PROVIDER CAN SAVE YOU MONEY.

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

	PPO Hospital*	Non-PPO Hospital
Covered Expenses	$1,700	$2,000
Deductible	- $300	- $400
Expenses For Reimbursement	$1,400	$1,600
Plan Pays	x 90% = $1,260	x 80% = $1,280
Charles Pays	$440 (10% plus $300 deductible)	$720 (20% plus $400 deductible)

In the above example, using a PPO Hospital saves Charles $280.

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

CHOOSING A PHYSICIAN

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

One way to find a Physician is to ask around. Ask a family member, friend or co-worker if they have the name of a Physician they would recommend. Before visiting a Physician, you should contact the PPO (see page 4 for PPO contact information) to ensure your Physician is in the PPO.

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

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

Extension Of Benefits

If your eligibility for coverage ends while you or your Dependent is Totally Disabled, your Comprehensive Medical Benefits may continue for up to 13 weeks, provided:

- The Expenses Incurred are related to that Total Disability; and
- You or your Dependent remains Totally Disabled.

You or your Dependent will be eligible for benefits through the end of the period for which you were already eligible. Then, if you or your Dependent qualify for an extension, the extension will begin when you or your Dependents' eligibility otherwise would end.

An extension of benefits will end for you or your Dependent when the first of the following dates occur:

- The date you or your Dependent are no longer Totally Disabled;
- The end of the 13-week extension of benefits period;

- The date you or your Dependent has received benefits totaling the medical benefit maximum; or
- The date you or your Dependent become covered under another welfare fund, group plan or any plan sponsored by an employer.

Payments made under the extension of benefits provision after the calendar year in which your eligibility ends will be subject to a new deductible.

Reasonable and Customary Charge

The Reasonable and Customary Charge is determined by comparing the charge with charges made by other Physicians and providers of medical services and supplies for similar services and supplies in your geographic area.

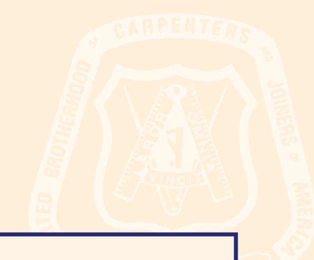
Covered Medical Expenses

The Reasonable and Customary Charge is determined by comparing the charge with charges made by other Physicians and providers of medical services and supplies for similar services and supplies in your geographic area.

Covered medical expenses are the Reasonable and Customary Charges actually incurred by a Covered Person in connection with the treatment of a Non-Occupational Injury or Disease. If a charge is more than the Reasonable and Customary Charge, only the Reasonable and Customary Charge will be considered a Covered Expense. **Please keep in mind that charges relating to Covered Expenses will be paid according to the Plan's benefit maximums and limitations as shown in the "Schedule Of Benefits" on page 2.**

The following services and supplies are considered Covered Expenses under the Plan.

1. Hospital expenses for semi-private room and board charges while Hospital confined. If a Hospital has only private rooms, the Plan will cover 90% of the most common private room rate charged by the Hospital, unless a Physician determines that a private room is required for isolation due to a diagnosis or is required by the Hospital's public health regulations.
2. Hospital miscellaneous charges for necessary services and supplies furnished by the Hospital, and not included in the room and board charges, while Hospital confined. These charges include:
   a. Meals and special diet;
   b. General nursing services;
   c. Use of operating room, including cystoscopic room and cast room;
   d. Complete anesthetic charges, whether administered by an authorized outside anesthetist or an employee of the Hospital;
   e. Blood transfusions, including administration and blood typing;
   f. Oxygen;
   g. Medicines;
   h. Laboratory services;
   i. X-rays and the use of radium and radioactive substances;
   j. Basal metabolism test;
   k. Electrocardiograms and electroencephalograms;
   l. Physical therapy;
   m. Dressings and casts, including preparations or use of gauze, cotton fabrics, solutions, plasters and other material in dressings or casts;
   n. X-rays and radiation treatment; and
   o. Ambulance service to and from the Hospital.
3. When Hospital confinement is not required, benefits are payable for Hospital Expenses Incurred in connection with:
   a. A surgical procedure resulting from accidental bodily Injury or Sickness; or
   b. Emergency first-aid treatment resulting from Injury.



4. Charges for the diagnosis, treatment and inpatient or outpatient surgical procedure performed as a result of an accidental bodily Injury or Sickness. The operation must be recommended and performed by a legally qualified Physician, Surgeon or assistant Surgeon.
5. Charges for organ transplant surgery. Organ transplants are subject to the annual and lifetime maximum shown in the "Schedule Of Benefits," as well as the copayments and other maximums shown in the "Schedule Of Benefits." The Plan pays a higher percentage of charges if the procedure takes place at a Center of Excellence network facility.
6. Charges for x-ray or laboratory examinations, including basal metabolism determination or an electrocardiogram performed by, or under the supervision of, a legally qualified Physician.
7. Charges for chiropractic care for Non-Occupational Injuries or Diseases. These charges are not subject to the deductible and out-of-pocket maximum. Covered Expenses include office visits and chiropractic x-rays.
8. Charges for private duty nursing services of a registered graduate nurse, other than one who ordinarily resides with you or is a member of your immediate family (including your spouse, your or your spouse's children, brothers, sisters or parents or any other person related to the person).
9. Charges for treatment by a physical therapist, other than one who ordinarily resides with you or who is a member of your immediate family (including your spouse, your or your spouse's children, brothers, sisters or parents or any other person related to the person).
10. Charges for dental work or treatment or dental x-rays, as required as the direct result of the extraction of impacted third molars or of an Injury to the jaw or sound natural teeth incurred within one year of such accident, except as provided for active Employees and their Dependents under the Dental Benefit described on page 29.
11. Charges for self-injectable drugs (other than insulin) requiring a Physician's prescription and charges for syringes do not apply toward the out-of-pocket maximum.
12. Charges for durable medical equipment including: surgical dressings, casts, splints, trusses, braces, crutches, artificial limbs, artificial eyes, rental of a wheelchair or Hospital-type bed and oxygen (including rental of equipment for its administration) or artificial respirator.
13. Charges for anesthesia (including administration) in a Hospital by a Physician.
14. Charges for blood and plasma.
15. Charges for radiation therapy treatments including treatment with x-ray, radium, cobalt or other radioactive material.
16. Charges for local ambulance service.
17. Charges for Hospital confinement for treatment of alcoholism and chemical dependency, subject to the limitations stated in the "Schedule Of Benefits."
18. Charges incurred for pregnancy and pregnancy-related conditions by you or a Dependent spouse. Under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Plan may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother of a newborn or a newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

A Center of Excellence network consists of state-of-the-art facilities recognized for organ and bone marrow transplants. The network provides you with access to experienced medical institutions and Surgeons throughout the country.

19. Charges for the following will be Covered Expenses for a person to whom the Plan is providing benefits in connection with a mastectomy:
    a. Reconstruction of the breast on which the mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
20. Charges due to an elective abortion only if the life or physical condition of the mother would be endangered if the child were carried to term.
21. Charges for the treatment of mental and nervous disorders, subject to the limitations stated in the "Schedule Of Benefits."
22. Charges for second and/or third surgical opinions. These charges will be considered Covered Expenses when:
    a. The second and/or third opinion is rendered by a board certified specialist;
    b. The specialist makes a personal examination of you or your eligible Dependent; and
    c. A written report is sent to the Fund Office by the specialist on a form designed for this purpose.

The Plan covers charges for second and/or third surgical opinions. These charges will be considered Covered Expenses when:

- The second and/or third opinion is rendered by a board certified specialist; and
- The specialist makes a personal examination of you or your eligible Dependent.

23. Charges for hospice care are payable up to the amount listed in the "Schedule Of Benefits" on page 2 for the following services and supplies (after the annual deductible) when provided to a Terminally Ill Person under a Hospice Care Program through a Hospice Care Agency:
    a. Care in the Terminally Ill Person's or family member's home including the following services and equipment:
        (1) Physician services;
        (2) Physical, respiratory and occupational therapies;
        (3) Drugs, medications and medical supplies;
        (4) Private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) when certified by a Physician;
        (5) Rental of Durable Medical Equipment (DME); and
        (6) Oxygen and rental of related equipment.
    b. Outpatient care in a licensed medical facility for:
        (1) Physician services;
        (2) Laboratory, X-ray and diagnostic testing; and
        (3) Ambulance service or alternative types of transportation.
    c. Inpatient care in a Hospital or hospice facility for:
        (1) Room and board, which may include overnight visits by family;
        (2) Nursing services;
        (3) All other related Hospital expenses;
        (4) Physician services; and
        (5) Ambulance service or alternative types of transportation.
    d. The following additional services provided to the Terminally Ill Person and family members:
        (1) Visits by a licensed social worker to evaluate the social, psychological and family problems related to the terminal Illness and the development of a plan to assist in resolving these problems;
        (2) Emotional support services to assist in relieving stress, coping with the anticipated loss, helping families to complete unfinished business and maintaining the Terminally Ill Person in the most appropriate environment;

(3) Special incidental services for the Terminally Ill Person, such as special dietary requirements, transportation between home and other sites of care; and

(4) Bereavement counseling for the immediate family following the death of the Terminally Ill Person. (Coverage is limited to the maximum listed in the "Schedule Of Benefits.")

24. General administration of anesthesia and Hospital charges for dental care for eligible Dependent children under age five.
25. Charges for a colonoscopy.
26. Charges for PSA testing.
27. Charges for vasectomies.
28. Charges for birth control devices (except oral contraceptives).
29. Charges related to Work Hardening.
30. Charges for adult restorative speech therapy, up to the maximum shown in the "Schedule Of Benefits" to restore speech that was lost or impaired due to an Illness or Injury. Covered Expenses will include treatment prescribed by a legally qualified Physician or speech therapist and rendered on an inpatient or outpatient basis.

31. Charges for your Dependent child's speech therapy while not Hospital confined, up to the maximum shown in the "Schedule Of Benefits." Covered Expenses will include treatment prescribed by a legally qualified Physician or speech therapist and rendered on an outpatient basis by a:
    a. Duly constituted and lawfully operated Hospital;
    b. Licensed speech therapy institute or center; or
    c. Licensed Physician or speech therapist, other than one who ordinarily resides with the person or is a member of the person's immediate family.
32. Charges for a hearing exam or hearing aid needed because of hearing loss due to an accident, up to the maximums shown in the "Schedule Of Benefits."
33. Expenses for corrective appliances (prosthetic and orthotic devices, other than dental) for:
    a. Rental up to the allowed purchase price of the device;
    b. Purchase of standard models at the option of the Plan;
    c. Medically Necessary repair, adjustment or servicing of the device; and
    d. Medically Necessary replacement of the device due to change in the Covered Person's physical condition or if the device cannot be satisfactorily repaired.

Corrective appliances are covered only when ordered by a Physician. The overall Plan maximum listed in the "Schedule Of Benefits" on page 2 is per person per limb or device for the appliance including necessary supplies, repair and servicing over any three consecutive calendar years. The definition of Durable Medical Equipment is on page 63.

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

Medical Expenses Not Covered

You should be aware that not every medical expense is covered by the Plan. For a list of expenses not covered by the Plan, see "General Plan Exclusions" on page 36.

Prescription Drug Benefits

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

(For Active Employees, Retirees And Eligible Dependents)

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with a network of preferred pharmacies through the prescription drug provider listed in "Contact Information" on page 4. When you have your prescriptions filled at a preferred pharmacy, you save money for yourself and the Plan.

The Plan offers coverage for your short-term prescription needs as well as your long-term prescription needs. When you have prescriptions filled at a preferred retail pharmacy, benefits are payable for up to a 34-day supply. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail order program (see page 27). When you use the mail order program, you can have prescriptions filled for up to a 90-day supply. You do not need to meet a deductible before your prescription drugs are covered.

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

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

You can obtain a prescription drug claim form from the Fund Office or by contacting the prescription drug provider listed on page 4.

Most prescription medications have two names: the generic name and the brand name. By law, both Generic and Brand Name Medications must meet the same standards for safety, purity and effectiveness – and the Generic Medication generally costs less.

You should ask your Physician if a generic equivalent is available for any prescriptions you need filled.

Prescriptions Filled At Preferred Pharmacies

You should present your ID card when you have prescriptions filled at a preferred pharmacy. When you present your ID card at a preferred pharmacy, all you need to do is pay the applicable copayment. The amount of the copayment varies depending on whether your prescription is for a Generic or Brand Name Medication, as shown in the "Schedule Of Benefits" on page 3. You do not have to complete any claim forms.

Prescriptions Filled At Non-Preferred Pharmacies

If you have a prescription filled at a non-preferred pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You will then need to submit a claim form to the prescription drug provider listed in "Contact Information" on page 4. You will be reimbursed only the amount the Plan would pay for the drug at a preferred pharmacy, minus the applicable copayment.

Generic Equivalents And Brand Name Medications

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

When you receive a Brand Name Medication, you pay a higher copayment. When you or your Dependent need a prescription, you may want to ask your Doctor whether a Generic Medication can be substituted for a Brand Name Medication.

In general, using Generic Medications will help control the cost of health care while providing quality medications — and can be a significant source of savings for you and the Plan. Your Doctor or pharmacist can assist you in substituting Generic Medications when appropriate.

Prescriptions Filled Through The Mail Order Program

You should use the mail order program when you need to have prescriptions filled for maintenance medications. When you order by mail, you can get up to a 90-day supply at one time. The mail order program copayments are listed in the "Schedule Of Benefits" on page 3. You can call for a price and send in a check or you can use your credit card (see page 4 for contact information). Because the price of prescription drugs changes frequently, the price of your prescription may change from the time you mail in your copayment until the time your prescription is dispensed. If the price of your prescription changes, the mail order program provider will send you a bill for any balance due.

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

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

When you need to order medication through the mail order program, you should…

Step 1: Ask your Physician to prescribe a 90-day supply of medication with refills.

Step 2: Mail the original prescription along with a completed order form, envelope, patient profile and copayment to the mail order program. You can obtain forms and envelopes from the Fund Office or by contacting the provider as listed on page 4.

Step 3: Allow about 14 days from the time you mail in your order to receive your prescription(s).

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

After you have had your first prescription filled you can obtain refills via:

- **Internet** — Have your prescription number, zip code and credit card information ready.
- **Mail** — Mail your refill slip and copayment.
- **Telephone** — Have your prescription number, zip code and credit card information ready.

The internet and mailing address and telephone number are listed in "Contact Information" on page 4.

Covered Prescription Drug Expenses

The Plan covers certain medications that require a written prescription from a Physician or dentist. A licensed pharmacist must dispense these prescriptions.

The following are considered covered prescription drug expenses under the Plan.

1. Federal legend drugs. Legend drugs are drugs with the following wording on the container "Federal Law Prohibits Dispensing without a Prescription."
2. Up to six Viagra pills per month for you or a covered spouse with medical diagnosis of impotence.
3. Drugs that require a prescription under state law but not under federal law.
4. Compound drugs.
5. Injectable insulin.

Prescription Drug Expenses Not Covered

In addition to the "General Plan Exclusions" on page 36, the following expenses are not covered under the Plan's prescription drug benefits.

1. Drugs or medicines lawfully obtainable without a prescription order of a Doctor or dentist, except insulin.
2. Any charge for the administration of prescription legend drugs or injectable insulin.
3. Medication that is taken by or administered to you or your eligible Dependents, in whole or in part, while a patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, convalescent Hospital, nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
4. Refilling of a prescription in excess of the number specified by the Physician or dentist, or any refill dispensed after one year from the order of a Physician or dentist.
5. Prescription drugs that may be properly received without charge under a local, state or federal program, including Workers' Compensation.
6. Anti-rejection drugs required as the result of a covered organ transplant that are provided at a retail pharmacy.

7. Drugs, medicines or devices for:
   a. Antiviral drugs used for influenza (flu) prevention;
   b. Anabolic steroids;
   c. Therapeutic devices or appliances, support garments and other non-medical substances, regardless of their intended use;
   d. Fertility and/or infertility (Fertility drugs are covered under the Comprehensive Medical Benefit as listed in the "Schedule Of Benefits" on page 2);
   e. Diabetic supplies, including lancets, test strips, test tape and alcohol swabs, except as covered under the Comprehensive Medical Benefit;
   f. Dental products such as fluoride preparations and products for periodontal disease, except as provided for active Employees and their Dependents under the Dental Benefit;
   g. Injectable drugs, except insulin;
   h. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, vitamins, weight reduction/control special foods, food supplements, liquid diets, diet plans or any related products, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during Hospitalization and except for prenatal vitamins or minerals requiring a prescription;
   i. Medical Foods (as defined in "Definitions" on page 66);
   j. Hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa);
   k. Sexual dysfunction medications (i.e., Muse, Caverject), except Viagra is covered up to six pills per month;
   l. Tobacco/smoking cessation;
   m. Vitamin A derivatives (retinoids) for dermatologic use (for example, Retin A);
   n. Weight control or anorexiants (i.e., Meridia, Xenical), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD);
   o. Compounded prescription drugs in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law;
   p. Take-home drugs or medicines provided by a Hospital, Emergency Room, Ambulatory Medical-Surgical Facility or other health care facility; and
   q. Vaccinations, immunizations, inoculations or preventative injections.

(For Active Employees And Their Eligible Dependents)

Preventive dental care can be important. To help you meet the cost of routine and unexpected dental care, the Fund provides dental benefits.

When you or your family need dental care, you can choose any dentist. The Plan will pay Covered Expenses for the services of a dentist licensed to practice dentistry as shown in the "Schedule Of Benefits."

ANNUAL DENTAL DEDUCTIBLE

The annual deductible is the amount of covered dental expenses that you pay each calendar year before the Plan begins to pay benefits. The amount of the deductible is shown in the "Schedule Of Benefits" on page 3. The dental deductible is separate from the medical deductible.

The deductible applies to each Covered Person each calendar year. The family deductible is met once three covered members of a family meet the individual deductible. Once the individual and/or family deductible is met, no further deductibles are required for that year.

COPAYMENT

Once you or your family has met the annual dental deductible, the Plan pays a percentage of Covered Expenses, called a copayment. The amount the Plan pays depends on the type of dental service you receive. Your payment is the remaining percentage of Covered Expenses.

PREDETERMINATION REVIEW

Predetermination review lets you and your dentist know how much the Plan will pay before treatment begins. The Plan does not require advance approval of dental treatment plans. It is, however, recommended for major or extensive dental work so you will know, in advance, the amount that will be paid by the Plan.

COVERED DENTAL EXPENSES

The Plan covers the following dental services and supplies, up to Reasonable and Customary Charges when provided by a dentist.

Preventive Services

1. Routine periodic examinations, up to twice in any calendar year,
2. Bitewing and periapical x-rays as required.
3. Full-mouth x-rays, once in any 36 consecutive months.
4. Dental prophylaxis (cleaning, scaling and polishing including periodontal maintenance visits), up to twice in any calendar year.
5. Topical fluoride application for Covered Persons under age 19 once in any calendar year.
6. Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain).
7. Space maintainers that replace prematurely lost teeth of eligible Dependent children under age 16 once in a five-year period.

8. Dental sealants for eligible Dependent children up to age 16, subject to the following limitations:
   a. Sealants are limited to the occlusal surface (the fit of the teeth when brought together) of non-carious, non-restored permanent molars;
   b. Sealants are not payable for premolars (premolars are one of the two teeth between the molars and the canines of the upper and lower jaw) and primary molars;
   c. Sealants are only to be applied to teeth that do not have decay or previous restorations; and
   d. Sealants are payable once per lifetime.

Basic Services

1. Restorative services using amalgam, synthetic porcelain and plastic filling material.
2. Endodontics, which include root canal filling and pulpal therapy (therapy for the soft tissue of a tooth).

Major Services

1. Prosthetics, which include bridges and dentures, once in any five-year period.
2. Periodontics, which include treatment of diseases of the gums and bone supporting the teeth.
3. Crowns, jackets, inlays and onlays required due to gross decay or fracture and when teeth cannot be restored with a filling material under Basic Services.
3. Oral surgery, including extractions.

Orthodontic Services

Orthodontic services are treatments for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. The Plan covers orthodontic services only for eligible Dependent children under age 19, up to the annual and lifetime maximum amounts listed in the “Schedule Of Benefits” on page 3.

Dental Expenses Not Covered

You should be aware that some expenses are not covered by the Plan. In addition to any General Plan Exclusions (see page 36), the Plan does not cover dental services that are not considered necessary by the Plan. The fact that a dentist may prescribe, order, recommend or approve a service does not, of itself, make it necessary or make the charge a Covered Expense, even though the service is not specifically listed as an exclusion. The Plan is the final authority for determining whether services are necessary.

Limitations

Dental expenses covered by the Plan are limited for the following services:

1. The Fund will pay for fixed bridgework and partial or removable dentures only if the replacement or addition of teeth is needed to replace one or more teeth extracted after the existing denture or bridgework was installed and while you or your eligible Dependent is covered under the Plan. Also, the dental work must be done within 12 months after the tooth was extracted.
2. Replacements of dentures or bridgework will be covered for newly eligible participants at 50% of Reasonable and Customary Charges (after the deductible), provided you have already had the dentures or bridgework in place at least five years and they cannot be repaired or made serviceable.

Exclusions

The Plan does not cover the following expenses.

1. Expenses for dental implants.
2. Expenses for the treatment of temporomandibular joint (TMJ) dysfunction or syndrome.
3. Expenses for orthognathic services/surgery for treatment of prognathism, retrognathism and other cosmetic reasons.
4. Mouth guards or night guards.
5. Bleaching, bonding or any other cosmetic procedures (with the exception of orthodontia for Dependent children under age 19 only).
6. Replacement of lost or stolen appliances.
7. Appliances, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion.
8. A service not reasonably necessary or not customarily performed for the dental care of the Covered Person.
9. A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist.
10. Charges made for the cost and administration of a general anesthetic made by a dentist for a procedure performed in his or her office.
11. Nutritional guidance, hygiene instructions, periodontal splinting and implants.
12. Temporary appliances.

Vision Benefits

(For Active Employees And Their Eligible Dependents)

Vision services must be provided by, and supplies received from, an optician, optometrist or ophthalmologist acting within the usual scope of his or her practice to be considered Covered Expenses under this benefit.

When you need vision care…

- Schedule an appointment with the optician, optometrist or ophthalmologist of your choice.
- File a completed claim form with the Fund Office.

The Plan provides two separate coverages for vision expenses for you and your eligible Dependents –Vision Care Services and Vision Surgical Correction Services.

Vision Care Services

Vision Care Services provide you and your eligible Dependent with coverage for routine vision-care related expenses, up to the amount listed in the "Schedule Of Benefits" on page 3 during a two-consecutive calendar-year period.

Covered Vision Care Services Expenses

These vision care services are considered Covered Expenses under the Plan.

1. Eye examinations.
2. Lenses and frames (including tinted lenses).
3. Contact lenses (including colored contact lenses).

Vision Care Services Expenses Not Covered

In addition to the "General Plan Exclusions" on page 36, the following expenses are not covered under the Plan's vision care services.

1. Vision therapy (orthoptics) and supplies.
2. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Vision Surgical Correction Services

Vision Surgical Correction Services cover surgical procedures for you or your eligible spouse to correct nearsightedness or farsightedness, limited to Radial Keratotomy (RK) or LASIK surgery only.

You must pay a Vision Surgical Correction Services deductible before the procedure is covered up to the maximum listed in the "Schedule Of Benefits" on page 3. If, after the procedure, your vision changes in one (or both) eyes and you need further surgery, it will not be covered under the Plan.

Weekly Accident and Sickness, Death and Accidental Death and Dismemberment (AD&D) Benefits help provide financial protection to you and/or your family in the event you become Injured, die, or become terminally Ill. This section describes these benefits. Retirees are eligible for Death Benefits only.

WEEKLY ACCIDENT AND SICKNESS BENEFITS (FOR ACTIVE EMPLOYEES ONLY)

If you become Totally Disabled while you are covered under this Plan and while you are employed by a Contributing Employer, you may be eligible for Weekly Accident and Sickness Benefits.

The amount of Weekly Accident and Sickness Benefit is listed in the "Schedule Of Benefits" on page 3.

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

- Call your Employer and the Fund Office.
- See a Physician as soon as possible.
- File a claim with the Fund Office.

Eligibility

You must be an eligible active Employee under the Plan to receive Weekly Accident and Sickness Benefits and the disability must:

- Be an accidental bodily Injury or a Sickness that prevents you from working at your occupation;
- Require the regular care and attendance of a legally qualified Physician or Surgeon; and
- Be the result of an accidental Non-Occupational Injury or Sickness.

Benefits

The amount of Weekly Accident and Sickness Benefits is listed in the "Schedule Of Benefits" on page 3. Benefits are payable for up to 26 weeks. If you are disabled for part of a week, you will receive 1/5 of your weekly benefit for each day of disability.

Weekly Accident and Sickness Benefits are subject to Social Security, federal income and unemployment taxes and may be included in your gross income for tax purposes. At year end, you will receive a W-2 Form from the Fund that shows the amounts paid and withheld. If you have questions about including your benefits in your gross income or about exclusions in the law, you should consult your tax advisor or legal counsel.

If you are receiving Weekly Accident and Sickness Benefits under the Plan or Workers' Compensation benefits, you will receive 20 hours of work credit for each week, or four hours for each day, you are entitled to receive these benefits. These credited hours may be used to continue your eligibility for benefits. No further hours will be credited after your benefits end. No more than 520 hours can be credited for one period of disability.

When Benefits Begin

Benefits begin on the first day of an accidental bodily Injury or the eighth day of disability due to a Sickness. A period of disability will not begin until the first day you are actually examined or treated by a Physician.

If you have successive periods of disability they will be considered one period of disability unless they are separated by a return to active full-time employment for at least two full weeks. If the disabilities are due to entirely unrelated causes and begin after a return to active full-time employment, they will be treated as separate periods of disability.

If you are disabled as the result of a maternity or pregnancy-related condition, the disability will be treated the same as a disability caused by a Sickness.

Benefit Exclusions And Limitations

Weekly Accident and Sickness Benefits are not payable for any accidental Injury or Sickness that is work-related.

Death Benefit (For Active Employees And Retirees Only)

The Death Benefit is paid if you die while eligible for benefits as an active or retiree, even if the cause of death is work-related.

Benefit Amount

The amount of the benefit is shown in the "Schedule Of Benefits" on page 3. For your Death Benefit to be paid to your beneficiary, written notice of your death must be received by the Fund Office within 12 months after your date of death.

After the Fund Office receives proof of your death, the Plan may, at its option, pay a portion of the benefit due, but not exceeding $500, to any person that the Plan determines has incurred expenses on your behalf for your fatal Illness or burial. This payment will satisfy, to the extent of the amount paid, all claims under the Plan. The beneficiary is entitled to receive only the remainder, if any, of the proceeds.

Continuation Of Coverage

If you die while an active Employee, coverage for your eligible Dependents will be continued for the period of time that eligibility would be maintained based on your accumulated hours, but not less than 90 days.

If you die while an active Employee and are making self-payments to maintain eligibility, coverage for eligible Dependents will be continued for the month in which you die and for 90 days following the month of your death. No self-payments will be required during the 90-day period.

If you are a retiree and die, coverage ends at the end of the month for which payment was made.

In the event of your death, your beneficiaries should contact the Fund Office.

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

The Accidental Death and Dismemberment (AD&D) benefit is payable for the loss of life, the loss of limb(s) or the entire and irrecoverable loss of sight of one or both eyes. Benefits are payable only if the loss results from an accident while you are eligible. The loss must occur within 90 days of the accident.

Benefit Amount

If you suffer any combination of losses as shown below as the result of one accident, only one amount (the largest) is payable for all losses. The amount payable for all losses resulting from one accident will not exceed the principal amount listed in the "Schedule Of Benefits" on page 3. Benefits are payable for the following losses:

TYPE OF LOSS	BENEFIT
Life	Principal Sum
Both hands, both feet, loss of sight in both eyes, one hand and one foot, one hand and sight in one eye, one foot and loss of sight in one eye	Principal Sum
One hand, one foot or loss of sight in one eye	One half of the Principal Sum

Benefits are paid directly to you for an injury or to your beneficiary in the event of your death. The AD&D Benefit is in addition to the Death Benefit.

Limitations And Exclusions

The following limitations apply to payment of the AD&D Benefit:

1. The loss must occur within 90 days from the day of the accident.
2. The loss of limb means dismemberment by severance at or above the wrist or ankle joint.
3. The loss of sight means the total and irrecoverable loss of sight.
4. If more than one of the losses listed above is suffered as the result of any one accident, only the full principal sum is payable.

No payment will be made for death or any loss resulting from or caused directly by any of the following.

1. Bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or wound), disease or Illness of any kind or medical or surgical treatment.
2. Intentional self-destruction or intentional self-inflicted Injury.
3. Participation in or as the result of the committing of a felony.
4. Insurrection, participation in a riot or police duty as a member of any military, naval or air organization.
5. Travel or flight in any aircraft, except as a fare-paying passenger on a licensed passenger aircraft.

Naming A Beneficiary

You may designate anyone you wish as your beneficiary for Death and AD&D Benefits (if you are eligible for AD&D). To change or designate a beneficiary(ies), you need to file a form with the Fund Office. You can change your beneficiary at any time, without the consent of your previous beneficiary. The designation will take effect, after the Fund Office receives your completed and signed form, as of the date you signed the form whether or not you are living at the time the Fund Office receives your form.

A Beneficiary is the person or persons shown in the Plan's records that you designate to receive your Death Benefits.

If you name more than one beneficiary and you don't identify how much each beneficiary receives, the beneficiaries will share the benefit equally.

It is very important that you designate a beneficiary. If you do not designate a beneficiary, your Death Benefit and AD&D Benefit, if eligible, will be paid as follows:

- To your surviving spouse; or if none,
- To your surviving children in equal shares; or if none,
- To your surviving parent(s) in equal shares; or if none,
- To your estate.

If a beneficiary dies before you, that beneficiary's benefit will automatically terminate. Any amount that the beneficiary would have been eligible to receive will be paid equally to the beneficiary or beneficiaries that survive you, unless you have made a written request otherwise.

If your beneficiary is a minor or in the opinion of the Trustees is legally incapacitated, the Trustees reserve the right to make payment of any benefit pursuant to the to the requirements of state law governing payments to minors and/or incapacitated individuals.

General Plan Exclusions

The following lists excluded items for which charges may be incurred applies to all such charges unless an exception is stated, and applies to all benefits provided under the Plan. In addition to the exclusions listed under each benefit section, no benefits are payable under the Plan for any of the following exclusions.

1. **Autopsy:** Expenses for an autopsy and any related expenses.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for missed appointments, telephone calls and/or photocopying fees.
3. **Educational Services:** Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an Injury, Illness or disability of a Covered Person. However, education/medical training for diabetics is covered once per lifetime.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by a Contributing Employer, or if benefits are otherwise provided under this Plan or any other plan that a Contributing Employer contributes to or otherwise sponsors, such as an HMO.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any specific Plan benefit limitation, annual maximum or overall (lifetime) maximum as described in this Summary Plan Description/Plan Document.
6. **Expenses Exceeding Reasonable and Customary Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator to exceed the Reasonable and Customary Charge as defined on page 67.
7. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party. See “Subrogation” on page 52 for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
8. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before you or your eligible Dependents became covered under the Plan or after the date the Covered Person’s coverage ends, except under those conditions described in “COBRA Continuation Coverage” on page 13.
9. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies or drugs or medicines that are determined by the Plan Administrator to be Experimental and/or Investigative as defined in “Definitions” on page 64.
10. **Government-Provided Services (CHAMPUS, VA, etc.):** Expenses for services when benefits are provided to the Covered Person under any plan or program (including, without limitation, CHAMPUS and VA programs) established under the laws or regulations of any government, including the federal, state or local government, government of any other political subdivision of the United States or of any other country, any political subdivision of any other country or under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
11. **Illegal Act**: Expenses Incurred by any Covered Person for Injuries resulting from or sustained as a result of commission, or attempted commission, by the Covered Person of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Person. The Plan Administrator’s discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination

with respect to prosecution of the Covered Person (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

12. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator not to be Medically Necessary as defined in "Definitions" on page 66.
13. **Treatment for temporomandibular joint syndrome (TMJ).** Expenses for services rendered or supplies provided for the treatment of temporomandibular joint syndrome (TMJ).
14. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability of a Covered Person, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.
15. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Person is not required to pay or that are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
16. **No Physician Prescription:** Expenses for services rendered or supplies provided that are not prescribed by a Physician.
17. **Non-Emergency Travel and Related Expenses:** Expenses for, and related to, non-Emergency travel or transportation (including lodging, meals and related expenses) of a health care provider, Covered Person or family member of a Covered Person.

18. **Occupational Illness or Injury or Conditions Subject to Workers' Compensation:** All Expenses Incurred by a Covered Person arising out of or in the course of employment (including self-employment) if the Injury, Illness or condition is subject to coverage, in whole or in part, under any Workers' Compensation, occupational disease or similar law. This applies even if you or your covered Dependent was not covered by Workers' Compensation insurance, or if your rights under Workers' Compensation, occupational disease or similar law has been waived, denied, disputed or challenged.
19. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Person is confined to a Hospital or other specialized health care facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

20. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports or by any third party.
21. **Private Room in a Hospital or Specialized Health Care Facility:** The use of a private room in a Hospital or other specialized health care facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Physician. If a Hospital has only private rooms, the Plan will cover 90% of the most common private room rate charged by the Hospital, unless a Physician determines that a private room is required for isolation due to a diagnosis or is required by the Hospital's public health regulations.
22. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or Employee.
23. **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.
24. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care practitioner was available to do so on a stand-by basis.

25. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in "Definitions" on page 63 or when you are on temporary work assignment for a Contributing Employer at a location outside the United States. Payment will be made to the employee only, once the necessary documentation is received, as an out-of-network claim.
26. **Failure to Comply with Medically Appropriate Treatment:** Expenses Incurred by any Covered Person who fails to comply with medically appropriate treatment, as determined by the Plan Administrator.
27. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other specialized health care facility expenses if you leave the facility against the medical advice of the attending Physician.
28. **Travel Contrary to Medical Advice:** Expenses Incurred by any Covered Person during travel if a Physician or other health care provider has specifically advised against such travel because of the health condition of the Covered Person.
29. **Telephone Calls:** Any and all telephone calls between a Physician or other health care provider and any patient, other health care provider or any representative of the Plan for any purpose whatsoever, including, without limitation:
    a. Communication with any representative of the Plan for any purpose related to the care or treatment of a Covered Person;
    b. Consultation with any health care provider regarding medical management or care of a patient;
    c. Coordinating medical management of a new or established patient;
    d. Coordinating services of several different health professionals working on different aspects of a patient's care;
    e. Discussing test results;
    f. Initiating therapy or a plan of care that can be handled by telephone;
    g. Providing advice to a new or established patient; and
    h. Providing counseling to anxious or distraught patients or family members.
30. **War or Similar Event:** Expenses Incurred as a result of an Injury or Illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.

Specific Medical Services And Supplies Exclusions

Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
3. Expenses for prayer, religious healing or spiritual healing.
4. Expenses for naturopathic, naprapathic and/or homeopathic services, treatments or supplies.

Behavioral Health Care Exclusions

1. Expenses for diagnosis, treatment and prevention of Behavioral Health Disorders, including, but not limited to, adoption counseling, custody counseling, developmental disabilities, dyslexia, learning disorders, family planning counseling, genetic testing and counseling (see also the exclusion regarding genetic testing and counseling on page 40), marriage, couples and/or sex counseling, mental retardation, pregnancy counseling, transsexual counseling and vocational disabilities.
2. Expenses for residential care services for Behavioral Health Disorders.
3. Expenses for hypnosis, hypnotherapy and/or biofeedback.
4. Expenses for tests to determine the presence of, or degree of, a person's dyslexia or learning disorder.

Corrective Appliances, Durable Medical Equipment And Nondurable Supplies Exclusions

Expenses for corrective appliances except those specifically covered on page 23.

Cosmetic Services Exclusions

Surgery or medical treatment to improve or preserve physical appearance. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator.

Fertility And Infertility Services Exclusions

Expenses for the diagnosis and treatment of infertility and complications thereof, including, but not limited to, services, prescription drugs procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

Foot/Hand Care Exclusions

1. Expenses for routine foot care including, but not limited to:
   a. Trimming of toenails;
   b. Removal of corns and callouses;
   c. Treatment of:
      (1) Corns, bunions except capsular or bone surgery;
      (2) Calluses;
      (3) Nails of the feet except surgery for ingrown nails;
      (4) Flat feet;
      (5) Fallen arches;
      (6) Weak feet;
      (7) Chronic foot strain or symptomatic complaints of the feet except when surgery is performed; and
   d. Preventive care with assessment of pulses, skin condition and sensation.
2. Expenses for hand care, including manicure and skin conditioning.

Genetic Testing And Counseling Exclusions

1. Expenses for genetic tests such as obtaining a specimen and laboratory analysis, detecting or evaluating chromosomal abnormalities or genetically transmitted characteristics, including:
   a. Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to the child; and
   b. Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except when those tests are performed using fluid or tissue samples obtained through amniocentesis when medically necessary as determined by the Plan Administrator.
2. Expenses for genetic counseling.

Hair Exclusions

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

Hearing Care Exclusions

1. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including implantable hearing devices except when provided as the result of an accident.
2. Special education and associated costs in conjunction with sign language education for a Covered Person or family members.

Home Health Care Exclusions

1. Charges for Home Health Care services, other than for private duty nursing services of a registered graduate nurse who ordinarily does not reside with the person or is not a member of the person's immediate family.
2. Expenses for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, Custodial Care, child care, adult care or personal care attendant, except as provided under the Plan's hospice coverage.

Maternity/Family Planning Exclusions

1. **Termination of Pregnancy:** Elective abortion, except where Medically Necessary.
2. **Home Delivery:** Expenses for pre-planned home delivery.
3. **Services of a Midwife:** Expenses for care and services rendered by a midwife.
4. **Dependent Pregnancy:** Pregnancy, resulting childbirth, abortion or miscarriage or conditions resulting from such conditions for Dependent children;
5. **Expenses related to cryostorage of umbilical cord blood or other tissue or organs.**

Nutrition Exclusions

1. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, vitamins, weight reduction/control special foods, food supplements, liquid diets, diet plans or any related products, herbs and minerals, whether they can be purchased over-the-counter or require a prescription (except when provided during Hospitalization and except for prenatal vitamins) or minerals requiring a prescription.
2. Medical Foods (as defined in "Definitions" on page 66).

Prophylactic Surgery Or Treatment Exclusions

Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, when prescribed or performed for the purpose of:

a. Avoiding the possibility or risk of an Illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
b. Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

Rehabilitation Therapy Exclusions (Inpatient Or Outpatient)

1. Expenses for educational, job training or vocational rehabilitation and/or special education for sign language; excluding approved Work Hardening programs.
2. Expenses for massage therapy, rolfing and related services.
3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose or is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to, coma stimulation programs and services.
4. Expenses for Maintenance Rehabilitation as defined in "Definitions" on page 66.
5. Expenses for adult speech therapy (that is not restorative therapy) for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin or for developmental speech delays.

Transplant (Organ And Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigative, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines.
2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
3. Expenses for insertion and maintenance of an artificial heart or other organ or related device, except heart valves and kidney dialysis and complications thereof.

Weight Management And Physical Fitness Exclusions

1. Medical or surgical treatment for weight-related disorders including, but not limited to, surgical interventions, dietary programs and prescription drugs.
2. Expenses for memberships in, or visits to, health clubs, exercise programs, gymnasiums and/or any facility for physical fitness programs, including exercise equipment.

How To File Claims And Appeals

If a claim is denied or reduced, you may file an appeal to have your claim reconsidered.

If you or an eligible Dependent has coverage under more than one health care plan, benefits are coordinated (see page 49).

In case of an Emergency, have the Hospital or a relative call the Fund Office as soon as possible. The person who calls should be able to provide your or your Dependent's:

- Name and address;
- Social Security Number; and
- Group Number or Name.

Filing Claim Forms

When you receive medical treatment at a PPO provider, you should present your medical benefits identification card at the time of treatment. Generally, if you use a PPO provider, the provider will submit a claim directly to the Plan Administrator.

Most health care providers will file claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not, follow the procedures listed in this section.

You should file your initial claim for Plan benefits **within 90 days** after the date you received services. If this is not possible, you must file your claim no later than one year from the date you received the services or your claim will be denied. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees.

If you need to submit a claim for a non-PPO provider medical, non-preferred pharmacy prescription drug, dental or vision expense submit an itemized statement or bill that details charges to:

Plan Administrator
Carpenters' District Council Of Kansas City
and Vicinity Health Plan Fund Office
Penn Tower Building
3100 Broadway, Suite 805
Kansas City, Missouri 64111

Claim forms are available at the Fund Office. When filing your claim:

- If your claim is for health care that is also covered by Medicare, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits should be submitted.
- If the claim is for an eligible Dependent, provide the name of the Dependent.
- If you or a Dependent has coverage under more than one plan, be sure to include the name of the other plan(s).

Claims And Appeal Procedures

This section describes how benefit claims are reviewed and processed. The Fund will:

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

Days

For the purpose of the claim and appeal processes, "days" refers to calendar days, not business days.

General Information

Discretionary Authority Of Plan Administrator

In carrying out their respective responsibilities under the Fund, the Plan Administrator, which is the Board of Trustees and the Claims Appeal Committee, and other individuals to whom responsibility for the administration of the Fund has been delegated, have discretion and authority to interpret the terms of the Summary Plan Description/Plan Document and Agreement and Declaration of Trust and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authorized Representative

An Authorized Representative is a person with authority to act on the claimant's behalf in accordance with the Fund's claims and appeals procedures. In the case of a claimant under the age of 18, the parent or stepparent of the claimant will automatically be deemed an Authorized Representative. Subject to the written statement requirement listed below, the following individuals may be recognized as the claimant's Authorized Representative:

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

An assignment of payment to a health care provider is not a designation of the provider as an Authorized Representative.

The Fund requires a written statement from the claimant that he or she has designated one of the above individuals as the Authorized Representative, along with the Authorized Representative's name, address and telephone number. If the claimant is unable to provide a written statement, the Fund requires written proof (e.g., power of attorney for health care purposes, court order of guardian/conservator) that the proposed Authorized Representative has been authorized to act on the claimant's behalf. A duly designated Authorized Representative will be able to make any decision or take any action or inaction that is available to the claimant regarding the claim.

Once the claimant names an Authorized Representative, the Fund will send all future claims and appeal related correspondence to the Authorized Representative and not the claimant. The Fund will honor the designated Authorized Representative for one year, or as mandated by a court order, before requiring a new authorization. The claimant may revoke a designated Authorized Representative by submitting a signed statement to the Fund stating the intent to revoke the designation. A duly Authorized Representative will be able to make any decision or take any action or inaction that is available to the claimant regarding the claim.

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

Definition Of A Claim

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

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

Definition Of Disability Claims

A disability claim is a claim for Weekly Accident and Sickness or Accidental Death and Dismemberment Benefits. Any other type of claim is considered a non-disability claim.

Claim Elements

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

- Be **written or electronically** submitted in accordance with Electronic Data Interchange (EDI) standards under the Health Insurance Portability and Accountability Act (HIPAA);
- Be **received by the Fund Offic**e or applicable Preferred Provider Organization (PPO) within one year of the date service was provided;
- Name a specific individual (claimant);
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which payment is requested and an itemized list of charges;
- Identify the provider's name, address, phone number, professional degree or license and federal tax identification number (TIN);
- When another plan is primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement; and
- When accidental Injury is involved, details of the accident.

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

- Not made in accordance with the Fund's claims filing procedures described in this section;
- Made by someone other than the claimant or his/her Authorized Representative;
- Made by a person who will not identify himself (anonymous);
- A casual inquiry about benefits, such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- For prior approval where prior approval is not required by the Fund;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the claimant or their Authorized Representative will be notified of the decision and allowed to file an appeal; and
- The presentation of a prescription to a pharmacy that the pharmacy denies (where the pharmacy/pharmacy benefits manager has no discretion to make decisions on claims). After the denial by the pharmacy, a person may file a claim with the Fund.

Timing Of Decisions For Non-Disability Claims

Non-disability claims are decided within 30 days of the Fund's receipt of the claim. The time for deciding the claim may be extended by the Fund for 15 days, upon notice to the claimant. The notice will be sent prior to the expiration of 30 days. The notice will state the circumstances that are beyond the control of the Fund and that require the extension and the date by which the Fund expects to render a decision. This is the "initial determination period."

If a claim cannot be processed due to insufficient information, the Fund will suspend the initial determination period and notify the claimant of the information required and the time period for providing the information to the Fund. The claimant will then have 45 days to provide the additional information. The suspension ends at the earlier of the Fund's receipt of the requested information or the end of the 45-day period. The initial determination period then begins to run again. If the information is not provided within the time period required by the Fund, the claim will be denied. The Fund will notify the claimant of the determination no later than the end of the initial determination period.

Timing Of Decisions On Disability Claims

Disability claims will be decided within 45 days of the Fund's receipt of the claim. The time for deciding the claim may be extended by the Fund for two periods of 30 days each, upon notice to the claimant. The notice for the first extension will be sent prior to the expiration of the initial 45-day period. The notice for the second extension, if necessary, will be sent prior to the expiration of the first 30-day extension period. The notices will state the circumstances that are beyond the control of the Fund that require the extension and the date by which the Fund expects to render a decision. This is the "initial determination period."

If a claim cannot be processed due to insufficient information, the Fund will suspend the initial determination period and notify the claimant of the information required and the time period for providing the information to the Fund. The claimant will then have 45 days to provide the additional information. The suspension ends at the earlier of the Fund's receipt of the requested information or the end of the 45-day period. The initial determination period then begins to run again. If the information is not provided within the time period required by the Fund, the claim will be denied. The Fund will notify the claimant of the determination no longer than the end of the initial determination period.

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

Denial (Adverse Benefit Determination)

For the purpose of the claim and appeal processes, an adverse benefit determination is:

- A denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit;
- A determination after service occurred of an individual's eligibility to participate in this Fund;
- A benefit denial resulting from failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate; and
- Payment in accordance with the Plan, but less than the total amount of expenses submitted with regard to a claim; for example, application of deductible or copayment requirements.

If the claim is wholly or partially denied, a notice of this initial denial (adverse benefit determination) will be provided to the claimant in writing or electronically, as applicable, within the timeframe required to make a decision on that claim. This notice of initial denial will:

- State the specific reason(s) for the denial;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
- Provide an explanation of the Fund's appeal procedure along with time limits;

- Contain a statement that the claimant has the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that the rule, guideline, protocol or criteria will be provided free of charge, upon request;
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigative), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and
- Inform the claimant that if the claim is denied and the claimant disagrees with that decision, the claimant or the claimant's Authorized Representative may appeal, that is, request the Fund review its decision. The claimant will have 180 calendar days following receipt of an initial denial to request this review. The Fund will not accept appeals filed after this 180-day period.

Claims Appeal Procedures

This Fund maintains a one-level appeal process. Appeals must be submitted in writing to the Fund Office within 180 calendar days following receipt of an initial adverse benefit determination. The claimant will be provided with:

- The opportunity, upon request and without charge, to receive reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits;
- The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- A full and fair review that takes into account all comments, documents, records and other information submitted, without regard to whether such information was submitted or considered in the initial benefit determination;
- A review that does not afford deference to the initial adverse benefit determination, treats similarly situated claimants consistently and that is conducted by an appropriate Named Fiduciary of the Fund, who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual;

In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigative, Medically Necessary or appropriate, the appropriate Named Fiduciary will consult with a health care professional who:

- Has appropriate experience in the field of medicine involved in the medical judgment;
- 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 that individual; and
- Provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.

The Board of Trustees is the Plan Administrator and the Named Fiduciary responsible for all benefit determinations on appeal. The Board of Trustees may delegate all fiduciary responsibility for claims determination on appeal to the Claims Appeal Committee. The Claims Appeal Committee will meet at least once each calendar quarter at regularly scheduled times.

The Claims Appeal Committee will make a benefit determination on appeal no later than the date of the quarterly Claims Appeal Committee meeting that immediately follows the Fund's receipt of a request for review, unless the request for review is filed within 30 days before the date of the meeting. In this case, a benefit determination will be made no later than the date of the second quarterly Claims Appeal Committee meeting following the Fund's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time, a benefit determination will be rendered not later than the third quarterly Claims Appeal Committee meeting following the Fund's receipt of the request for review. If an extension is necessary, the Fund will notify the claimant in writing, describing the special circumstances and date the benefit determination will be made. A written notice of the appeal determination will be provided to the claimant within five days after the determination has been made. The notice will:

- State the specific reason(s) for the appeal review decision;
- Reference the specific Plan provision(s) on which the denial is based;
- Include a statement that the claimant is entitled to receive, upon request, free access to and copies of documents relevant to the claim;
- Include a statement that the claimant has the right to bring civil action under ERISA Section 502(a) following the appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that the rule, guideline, protocol or criteria will be provided free of charge, upon request; and
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigative), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial, applying the terms of the Plan to the claim, will be provided free of charge, upon request.

This Fund does not offer a voluntary appeal process.

Time Frames

All post-service claims must be submitted to the Fund within one year from the date of service. No benefits will be paid for any claim not submitted within this period. The following chart summarizes the timeframes for the claim and appeal processes:

	NON-DISABILITY CLAIM	DISABILITY CLAIMS
Fund will make an initial claim benefit determination (adverse or not) as soon as possible but not later than:	30 days from receipt of the claim (unless additional information is requested)	45 days from receipt of the claim (unless additional information is is requested)
If necessary, the initial determination period may be extended up to:	15 days	Two extensions of 30 days each
If a claimant appeals an adverse benefit determination, an appeal must be submitted to Plan within:	180 days	180 days
Fund will make a determination on an appeal not later than:	Next quarterly Claims Appeal Committee meeting date	Next quarterly Claims Appeal Committee meeting date
If necessary, the appeal determination	As described on page 46	As described on page 46

Hearing Procedures

The following procedures are established for hearings by the Board of Trustees or the Claims Appeal Committee:

1. The claimant and/or duly Authorized Representative will, upon written request, have an opportunity to appear before the Board of Trustees or the Claims Appeal Committee and have the right and opportunity to examine witnesses and/or present documents and other evidence material to the claim.
2. The proceedings of the hearing will be preserved by tape recordings, stenographic or court reporter's records.
3. In conducting the hearing, the Board of Trustees or the Claims Appeal Committee will not be bound by the usual common law or statutory rules of evidence.
4. The claimant and/or duly Authorized Representative has the right, free of charge and on request, to review the tape recording of the hearing and obtain a reproduced copy and obtain a copy of all documents and records introduced or referred to.
5. There will be copies made of all documents and records introduced at the hearing, and the same will be attached to the record of the hearing and made a part of the records. As an alternative to attaching copies of the documents and records, reference may be made to them on the tape recording and the same may be retained in the claim file.
6. All information upon which the Board of Trustees or the Claims Appeal Committee bases its decision will be disclosed to the claimant or the claimant's Authorized Representative at the hearing.
7. In the event that additional evidence is introduced by the Board of Trustees, which is not made available to the claimant before the hearing, the claimant will be granted a continuance of up to 30 days. For the purposes of this section, evidence discovered upon examination of the claimant's own witness will not be considered "new evidence."
8. The claimant will have the opportunity of presenting evidence. If the claimant offers new evidence, the hearing may be adjourned for a period of not more than 30 days so that the Board of Trustees or the Claims Appeal Committee may investigate the additional evidence and determine the accuracy of the claimant's new evidence.

The written decision of the Board of Trustees or the Claims Appeal Committee is final, binding and conclusive upon the claimant. All review procedures described above must be followed and exhausted before a claimant may initiate any legal action, including an action or proceeding before any court, administrative agency or arbitrator, unless the Fund fails to follow the claims and appeal procedures, as stated in this section.

Coordination Of Benefits

When members of a family are covered under more than one plan of group benefits, there may be instances of duplication of coverage — two plans paying benefits for the same medical expenses. The Coordination of Benefits (COB) provision coordinates the benefits payable by this Plan with similar benefits payable under other plans, excluding Weekly Accident and Sickness, Death and Accidental Death and Dismemberment (AD&D) Benefits.

Under the COB provision, if you and/or your Dependent are covered by this Plan as well as by another plan, which provides group health benefits, benefits will be coordinated between the two plans. If you or any of your Dependents are covered under any other group plan, the total payment received for any one person from all programs combined may not be more than 100% of the "Covered Expenses" (excluding Weekly Accident and Sickness, Death and Accidental Death and Dismemberment (AD&D) Benefits).

The Plan can never pay more on any claim than it would if the COB provision did not exist.

"Covered Expenses" are any necessary and Reasonable and Customary Charge for medical, dental or vision services, treatment or supplies covered by one of the plans under which you are eligible.

Benefits are coordinated with other plans, which include:

- Group blanket or franchise insurance coverage;
- Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;
- Coverage under labor-management trusteed plans, union welfare plans, employer organization plans or any other arrangement of individuals of a group;
- Coverage under governmental programs and any coverage required or provided by any statute.

Benefits are also coordinated with Medicare. If you or your Dependent is covered under another plan, you may contact the Fund Office to find out if the plan meets the definition of an other plan.

Who Pays First

If you or your Dependents are covered by another plan(s), the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays full benefits first, then the other plan(s) pay(s). When both you and a Dependent are covered under different group health plans as Employees, both you and your Dependent should file the claim with your own plan. Make sure you both provide all requested information on the claim forms about your Dependent's employment. The claim departments will then decide which plans have "primary" and "secondary" responsibility (see below). If you and your Dependent are both covered as Employees under this Plan, the Plan will coordinate benefits on your and your Dependent's claims. You and your Dependent must each submit a claim form.

The primary plan is the plan that must pay benefits on the claim first. The secondary plan is the plan that makes payments after benefits have been provided by the primary plan. When your claims are coordinated, you not only receive payments from the primary plan, but additional payments from the secondary plan (which may provide up to 100% payment for your claim).

If you or your Dependents are eligible under another plan(s) the following rules apply:

- If you are covered by another group plan that does not have a COB provision, the other plan will always pay first.
- When a person is covered by another group plan, the plan that covers the person as an active employee will pay first. The plan covering the person as an inactive employee or retiree will pay second.

- When another plan does have a COB provision, the plan covering the person as an Employee will pay first, and the plan covering the person as a Dependent will be second.
- If the parents of an eligible Dependent child are married (i.e., not divorced or separated), the plan of the parent whose birthday is earlier in the calendar year will pay first. If both parents' birthdays are on the same day, the plan covering the parent for the longer period of time will pay first.
- If one parent's plan uses another rule and the other parent's plan coordinates benefits as described above, the plan of the parent using the other rule pays benefits first.
- If the parents of an eligible Dependent child are divorced or legally separated, then the following rules apply:
  - If a court decree establishes financial responsibility for medical/health care for a child, the plan covering the parent with that responsibility will pay first and the plan covering the other parent will pay second (or as otherwise specified in the court decree);
  - If there is no court decree and the parent with custody has not remarried, the plan covering the parent who has custody will pay first and the plan covering the other parent will pay second; or
  - If there is no court decree and the parent with custody has remarried, benefits on a claim will be payable as follows:
    - The plan covering the parent who has custody will pay first;
    - The plan covering the spouse of the parent who has custody (the step-parent of the child) will pay second; and
    - The plan covering the parent without custody will pay third.

If none of the above rules applies, the plan that has covered the parent for the longer period of time pays first, except when one plan covers the parent as a laid-off or retiree (or a Dependent of the Employee) and the other plan includes this same rule for laid-off or retirees (or is issued in a state that requires this rule by law), then the plan that covers the parent as other than a laid-off or retiree (or as a Dependent of an Employee) will pay first.

Coordination Of Benefits With Medicare

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

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

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

When coordinating with Medicare, this Plan and Medicare together will not cover more than 100% of Covered Expenses for an accident or Illness.

Who Pays First When Coordinating With Medicare

This Plan will have primary responsibility for your or your Dependent's expenses if you meet the following qualifications:

- You are at least age 65;
- You are eligible for Medicare solely because of age; and
- With respect to the Employee only, you are actively employed by an Employer who pays all or part of the required contributions for your eligibility.

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

- You are not actively employed by an Employer, which pays all or part of the required contributions for eligibility; and
- You are eligible for Medicare because of age.

If, while you are actively employed, you or any of your eligible Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months, starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. After the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Information About Medicare

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

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

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

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

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

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

Subrogation is substitution of the Fund to one's legal right to collect damages from a third party.

Subrogation

In the event the Fund provides benefits for Injury, Illness or other loss to any Covered Person, the Fund is subrogated to all rights of recovery to any funds or monies you, your spouse, Dependents, parents, heirs, guardians, conservators, next friend, executors, assignees, personal representative or other representatives may have arising out of an Injury, Illness or other loss.

The recovery is not limited by characterization of loss and includes recovery for personal Injury, lost wages, loss of service, disability and claims for wrongful death and survivor or other claims under any state or federal law. The Fund is not limited or bound by any judgment or settlement that divides up recovery among the various elements of damage. The Fund is entitled to first dollar reimbursement from any recovery, regardless of whether the Covered Person is made whole by said recovery.

The Fund is entitled to assert a lien against third parties, insurers, attorneys and other appropriate person or entities to protect its right of subrogation.

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

- Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the Injury;
- From any fund, 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.

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend will execute and deliver documents and papers (including, but not limited to, a benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund as the Fund may require. The Covered Person will do whatever else is necessary to protect the rights of the Fund, including allowing the intervention by the Trustees or Fund or the joinder of the Trustees or Fund in any claim or action against the responsible party or parties. The Fund Trustees are vested with full discretionary authority to determine eligibility for benefits, to construe subrogation and other Plan provisions and to reduce the amount of the Fund's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, is binding on the Fund without the Fund's written approval and the Fund expressly reserves the right to collect the entire amount of its subrogation interest in all cases.

The amount of the Fund's subrogation interest will be deducted first from any recovery from any entity or source by, or on behalf of, the Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Fund, pursuant to the subrogation right, will not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common/state law doctrine purporting to reduce the amount of the Fund's recovery.

The Fund reserves the right to initiate an action in the name of the Covered Person, his or her guardian, conservator or next friend to recover its subrogation interest, and the Covered Person, his or her guardian, conservator or next friend will cooperate fully with the Fund in such instances.

The Fund may withhold payment of benefits or deduct the amount of any payments made from future claims of a Covered Person in the event of any failure or refusal by the Covered Person to:

- Execute the Subrogation Agreement or any other document requested by the Fund; or
- To take any other action requested by the Fund to protect the interest of the Fund.

The Covered Person will not do any act or engage in any negotiations that would reduce, compromise or prejudice the Fund's rights to first recovery from any third party. If the Covered Person recovers any amount by settlement or judgment from any person, corporation, insurance carrier, governmental agency, or other responsible party:

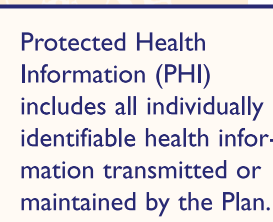
- The Fund will be repaid in an amount equal to the full amount of benefits paid by the Fund; and
- No further benefits for treatment or services related to the Injury leading to the settlement or recovery will be paid by the Fund.

If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Fund's right to subrogation, the amount of the Fund's claim will be held in constructive trust, and the Fund will be entitled to seek restitution, impose a constructive trust or seek any other legal or equitable remedies available (including recovery of the Fund's attorneys' fees and costs) by instituting legal action against the Covered Person or other party. In addition, the Fund reserves the right to offset and/or deduct any amounts paid as benefits against future claims submitted by the Covered Person or his/her Dependents.

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

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

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



Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan.

Privacy Policy

The Plan is required to protect the confidentiality of your protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

1. Receive confidential communications of your health information, as applicable;
2. Copy your health information at a cost;
3. Receive an accounting of certain disclosures of your health information;
4. Amend your health information under certain circumstances; and
5. File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

Use And Disclosure Of Protected Health Information (PHI)

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

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

1. Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for your or your Dependent's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health Plan); and
13. Reimbursement to the Plan.

Health Care Operations

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

1. Quality Assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
7. Business management and general administrative activities of the entity, including, but not limited to:
   - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
   - Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
   - Resolution of internal grievances; and
   - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports (SAR's), and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. For purposes of this section, the Board of Trustees of the Carpenters District Council of Kansas City and Vicinity Welfare Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

9. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law;
10. 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;
11. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
12. 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,
13. 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;
14. Make PHI available to the individual in accordance with the access requirements of HIPAA;
15. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
16. Make available the information required to provide an accounting of disclosures;
17. 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
18. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

    Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employers or classes of employees may be given access to PHI:
19. The Plan Administrator; and
20. Staff designated by the Plan Administrator.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described above do not comply with this Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Important Information About The Plan

Name Of Plan

The name of the Plan is the Carpenters' District Council of Kansas City and Vicinity Health Plan.

Board Of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of Employer and Union representatives selected by the Builders' Association and the Union, which have entered into Collective Bargaining Agreements relating to this Plan. If you wish to contact the Board of Trustees, use the address and phone number on the inside front cover. The Trustees of this Plan as of September 1, 2003 are:

Board Of Trustees

Union Trustees

Mr. Terry Davis
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Mr. John Batye
404 Tiger Lane
Columbia, Missouri 65203

Mr. Jack O. Earley
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Mr. Thomas Garrison
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Mr. Patrick D. Masten
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Mr. Todd A. Vie (Alternate Trustee)
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Employer Trustees

Mr. Jeffrey Chaikin
The Builders' Association
632 West 39th Street
Kansas City, Missouri 64111

Mr. Douglas Firebaugh
Firebaugh Construction, Inc.
9393 West 110th Street, Suite 120
Overland Park, Kansas 66210

Mr. Brett Gordon
McCown Gordon Construction
One West Armour Boulevard, Suite 200
Kansas City, Missouri 64111

Mr. Rory O'Connor
Walton Construction Co., Inc.
3252 Roanoke Road
Kansas City, Missouri 64111

Mr. Thomas F. Whittaker
J.E. Dunn Construction Company
929 Holmes
Kansas City, Missouri 64106

Contract Fiduciary

Mr. Gary Smith
Carpenters District Council
625 West 39th Street
Kansas City, Missouri 64111

Plan Sponsor And Plan Administrator

The Board of Trustees is both the Plan Sponsor and the Plan Administrator.

Identification Numbers

The number assigned to this Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 48-6201422.

Agent For Service Of Legal Process

Mr. Michael C. Arnold is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Mr. Arnold at:

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

Legal documents may also be served upon any individual Trustee at:

3100 Broadway, Suite 805
Kansas City, Missouri 64111

Source Of Contributions

All contributions to the Plan are made by Employers in accordance with their Collective Bargaining Agreements with the Carpenters' District Council of Kansas City and Vicinity of the United Brotherhood of Carpenters and Joiners of America, by Employers in other jurisdictions in accordance with applicable Collective Bargaining Agreements and reciprocal agreements in effect, or by Employees with respect to certain self-payment privileges. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per hour worked.

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

If your eligibility terminates, you may be allowed under certain circumstances to continue coverage for a limited period of time by making self-payments to the Plan.

Type Of Plan

The Plan, considered a welfare plan, is maintained for the purpose of providing medical, prescription drug, dental, vision, disability and death benefits. The Plan benefits are shown in the "Schedule Of Benefits" on page 2. All benefits are provided on a self-insured basis directly from the Fund's assets.

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

Eligibility

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

Claim Procedure

The procedures to follow for filing a claim for benefits are listed on pages 42-48 of this booklet. If all or any part of a claim is denied, you have the right to request that the Board of Trustees review the matter and that the matter be submitted to a hearing.

Plan Year

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on April 1 and ends on March 31 of the following calendar year.

Plan Amendment Or Termination

The Board of Trustees and the parties to the Agreement and Declaration of Trust (the Carpenters' District Council of Kansas City and Vicinity and the Builders' Association) have the authority, in their sole discretion and without prior notice to participants, Employees, Contributing Employers, the Union and others affected hereby, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time by execution of an instrument in writing should conditions so warrant. If the Plan is modified or terminated, you will be notified in writing or as required by law.

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

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

The Board of Trustees of the Fund have the authority to revise, interpret, construe and apply the provisions of the Summary Plan Description/Plan Document including, but not limited to, provisions relating to the eligibility for, entitlement to and/or nature, amount and duration of benefits.

Statement Of ERISA Rights

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

Receive Information About Your Plan And Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to:

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

  You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing 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 the Summary Plan Description/Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

Assistance With Your Questions

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

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

For more information or to request publications about your rights and responsibilities under ERISA:

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

Ambulatory Medical-Surgical Facility — A freestanding ambulatory surgical center or a facility offering ambulatory medical services 24 hours a day, seven days a week, provided such facilities:

- Are not part of a Hospital; and
- Have been reviewed and approved by the Missouri Board of Health, or other appropriate licensing body, to provide medical treatment.

Association — The Builders' Association of Missouri.

Behavioral Health Disorder — Any Illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on, or addiction to, alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral Health Disorder includes autism, depression, schizophrenia and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by a Behavioral Health Practitioner.

Behavioral Health Practitioner — A psychiatrist, psychologist or a mental health or substance abuse counselor or social worker who has a Master's degree and who:

- Is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered;
- Acts within the scope of his or her license; and
- Is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Brand Name Drug or Brand Name Medication — A prescription drug that is, or was at one time, under patent protection.

Collective Bargaining Agreement — An agreement between the United Brotherhood of Carpenters and Joiners of America, or a subordinate body, and an Employer or Association of Employers that requires contributions to the Carpenters' District Council of Kansas City and Vicinity Health Fund.

Contributing Employer or Employer — An Employer who, pursuant to the terms of a Collective Bargaining Agreement or other written agreement that is approved by the Board of Trustees, agrees to contribute to the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund on behalf of individuals employed by the Employer.

Cosmetic or Reconstructive Surgery — Any surgical procedure performed primarily to:

- Improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- Prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Expense — An expense for which benefits are payable under the Plan.

Covered Person — Any participant (or Dependent) while the participant or Dependent meets the eligibility requirements under this Plan.

Custodial Care — Any care intended primarily to help a disabled person meet basic personal needs when there is no plan of active medical treatment to reduce the disability.

Dependent — Under the Plan, eligible Dependents include your:

- Legal spouse;
- Unmarried children under the age 19;
- Unmarried children between the ages of 19 and 22 who are primarily dependent on you for full support and maintenance and who are full-time students. To be eligible for coverage, your Dependent must provide proof of full-time student status to the Fund Office;
- Your unmarried children for whom you are required to provide medical coverage for under a Qualified Medical Child Support Order (QMCSO) and who fulfill the requirements of a Dependent under the Plan; and
- Unmarried children over age 19 who are incapable of self-sustaining employment because of mental or physical handicap provided:
  - The children depend on you primarily for support and maintenance; and
  - You provide proof of incapability to the Fund Office within 31 days after the Dependent reaches age 19, or within 31 days of the date your eligibility is established, whichever is later. Proof of continuing incapability may also be required from time to time, but not more often than once a year.

In addition to your natural born child, children covered under the Plan include your stepchildren living in your home, adopted children, children placed for adoption and Foster Children, provided the children are dependent on you for support and maintenance and fulfill the requirements of a Dependent under the Plan.

Doctor, Physician or Surgeon — A legally qualified doctor, physician or surgeon, provided he or she is a Doctor of Medicine (M.D.) or Doctor of Osteopath (D.O) (that is licensed to practice medicine in all of its branches), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropody (D.P.M., D.S.C.), Doctor of Medical Dentistry (D.M.D.)The term also includes clinical psychologist, clinical social worker (provided the individual is licensed in the state where the treatment or services are provided and is practicing within the scope of his or her license), clinical professional counselor, certified mental health counselor, certified registered nurse anesthetist (CRNA), speech therapist, occupational therapist, physical therapist, optometrist, orthoptic technician and licensed nurse-practitioners working under the supervision of a licensed Physician. . Benefits will be payable for services performed within the scope of each individual's specialty and only within the provisions and limitations of the Plan.

Durable Medical Equipment — Durable Medical Equipment is equipment that:

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

Emergency — A situation in which the sudden onset of a severe medical condition requires immediate medical attention to prevent the individual from:

- Putting their health in permanent jeopardy;
- Incurring other serious medical consequences;
- Having a serious impairment of bodily functions; or
- Incurring serious permanent dysfunction of any bodily organ.

Employee — Any person who is employed by an Employer for whom the Employer is required to make contributions to the Fund, and for whom the Employer has paid contributions to the Fund.

Experimental or Investigative — A service or treatment on which the consensus of expert medical opinions (based on reliable evidence such as published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficacy and outcomes of such treatment or service compared to standard treatment. Experimental or Investigative also means those services or treatments that are:

- Not yet recognized as having proven beneficial outcomes;
- Still primarily confined to a research setting; and
- Not appropriate based on:
  - Medical circumstances and/or given the advanced stage of a person's Sickness; or
  - The likelihood that the service or treatment will measurably improve the person's Sickness or medical condition.

Extended Care Facility — An institution that is licensed as an Extended Care Facility or long-term nursing facility and that is qualified to participate in and is eligible to receive payments under the United States Medicare Program, but that is not, other than incidentally, a home for the aged or a domiciliary care home.

Foster Child — A child:

- You are raising as your own;
- Who lives in your home;
- Who is chiefly dependent on you for support; and
- For whom you have taken full parental responsibility and control.

A Foster Child is not a child:

- Temporarily living in your home;
- Placed with you in your home by a social service agency that retains control of the child; or
- Whose natural parent is in a position to exercise or share parental responsibility and control.

Generic Drug or Generic Medication — Drug products that are approved by the FDA to be manufactured and distributed after the patent of the brand-name drug has expired. The generic drug must have the same active ingredient, strength, and dosage form as its brand-name counterpart.

Home Health Care — A program of care provided by a public agency or private organization, or subdivision of such an agency or organization, that:

- Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;
- Has policies, established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more graduate Registered Nurses (RN) or Licensed Practical Nurses (LPN) to govern the services that it provides, and provides for the supervision of such services by a Physician, an RN or an LPN;
- Maintains clerical records of all patients; and
- Is licensed according to the applicable laws of the state and of the locality in which it is located or provides services.

Hospital — Any institution that:

- Maintains permanent and full-time facilities for bed care of five or more resident patients;
- Has a Doctor in regular attendance;
- Continually provides 24-hour-a-day nursing service by registered nurses;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of Injured and Sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged or a place for drug addicts or for long-term residential care; and
- Is operating lawfully in the jurisdiction where it is located.

Hospital does not include psychiatric Hospitals and general Hospitals where more than 15% of the beds are for psychiatric patients, unless the average length of stay for the Hospital or all units within the Hospital is less than 60 days.

Hospice Care Agency — A licensed agency or organization that keeps a medical record of each patient that:

- Has hospice care available 24 hours a day, seven days a week;
- Provides skilled nursing services, medical social services and psychological and dietary counseling primarily in a home setting using a hospice team;
- Has a full-time administrator and at least one Physician, one registered nurse (RN), one licensed or certified social worker employed by the agency and one counselor; and
- Has established policies governing the provision of hospice care.

Hospice Care Program — A written plan of hospice care that:

- Is established and periodically reviewed by a Physician attending the Terminally Ill Person or family member and appropriate personnel of a Hospice Care Agency;
- Is designed to provide palliative and supportive care to Terminally Ill Persons and supportive care to their families; and
- Includes an assessment of the Terminally Ill Person's or family member's medical and social needs and a description of the care to be rendered to meet those needs.

The Hospice Care Program may provide care and or services in the Terminally Ill Person's or family member's residence, licensed medical facility or inpatient care in a hospice facility or Hospital.

Illness or Sickness — A disease, mental, emotional or nervous disorder or covered pregnancy. A recurrent Sickness is considered as one Sickness. All related Sicknesses are considered as one Sickness. Concurrent Sicknesses are considered to be one Sickness unless such Sicknesses are totally unrelated.

Injury — Under the Plan, Injury refers only to an accidental bodily Injury. All Injuries sustained by a Covered Person in connection with any one accident are considered one Injury.

Intensive Care Unit — A room with permanently established facilities for two or more patients in which critically ill or Injured patients requiring continuous nursing services are temporarily confined. In no event will Intensive Care Unit be construed to include the post-operative recovery room of a Hospital.

Maintenance Rehabilitation — Therapy in which a patient actively participates after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support and/or preserve the patient's functional level. Active rehabilitation is therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Medical Food — Modified low protein foods and metabolic formulas. Medical Foods are not natural foods low in protein and/or galactose, spices, flavorings or foods or formulas required by persons who do not have inherited metabolic disorders.

Modified low protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract and are processed or formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.

Metabolic formulas are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because a person has limited ability to properly metabolize food or nutrients and such Medical Food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.

Medically Necessary or Medical Necessity — A service or supply that is ordered by a Physician and that the Fund or a party or entity selected by the Fund determines is:

- Provided for the diagnosis or direct treatment of an Injury or Illness;
- Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the person's Injury or Illness;
- Provided in accord with generally accepted medical practices on a national basis; and
- The appropriate supply or level of service that can be provided on a cost-efficient basis (including, but not limited to, inpatient versus outpatient care, electric vs. manual wheelchair, surgical vs. medical and other types of care).

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

Medicare — The programs established by Title 1 of Public Law 89-98 (79 Statutes 291) as amended entitled Health Insurance for the Aged Act, and that includes Parts A, B and C and Title XVIII of the Social Security Act (as amended by Public Law 89-98, 79), as such programs are amended from time to time.

Named Fiduciary — The entity or persons who have the authority to control and manage the operation and administration of this Plan. The Named Fiduciary for this Plan is the Board of Trustees of the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund.

Non-Occupational Disease — A disease that does not arise from, is not caused or contributed to, by, or as a consequence of, any course of any employment or occupation for compensation or profit. If evidence satisfactory to the Trustees is furnished that the individual concerned is covered as an Employee under any Workers' Compensation law, occupational disease law, any other legislation or similar purpose or under maritime doctrine of maintenance, wages and cure, but that the disease involved is one not covered under the applicable laws or doctrine, then the disease will, for the purposes of this Plan, be regarded as a Non-Occupational Disease.

Non-Occupational Injury — An accidental bodily Injury that does not arise from and is not caused or contributed to by, or as a consequence of, any Injury that arises out of or in the course of any employment or occupation for compensation or profit.

Pension Credits — Credits used to determine your eligibility for pension benefits. Generally, if you are a participant in the Carpenters' District Council of Kansas City Pension Fund, you earn one pension credit for each Plan year in which you work at least 400 hours in covered employment, subject to break-in-service rules.

Plan — The Carpenters' District Council of Kansas City and Vicinity Health Plan, as it may be amended from time to time.

Plan Administrator — The persons responsible for the day-to-day functions and management of the Plan. The Plan Administrator is the Board of Trustees of the Carpenters' District Council of Kansas City and Vicinity Health Plan.

Plan Year — A 12-month period ending December 31.

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

The discounted rates charged by PPO providers are considered Reasonable and Customary by the Plan. For charges incurred by a non-PPO provider, the Fund's claim payor determines Reasonable and Customary Charges.

Retiree — A person who is receiving pension benefits from the Carpenters' District Council of Kansas City Pension Fund.

Terminally Ill Person — A Person whose medical records indicate a life expectancy of six months or less.

Totally Disabled or Total Disability — You are considered Totally Disabled for purposes of this Plan if you are wholly and continuously disabled by a Sickness or accidental bodily Injury that prevents you from being gainfully employed in your own occupation.

All disability absences will be considered as having occurred during a single period of Total Disability unless acceptable evidence is furnished that:

- The causes of the latest Total Disability cannot be connected with the causes of any prior Total Disability and the latest Total Disability occurs after return to active work full-time for at least one day; or
- A connection with prior Total Disability can be established, but between the last of the previous Total Disabilities that are connected and the latest one there was a return to a active work on a full-time basis for at least two consecutive weeks.

Trust Agreement — The Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund Agreement and Declaration of Trust, as amended. The Trust Agreement and any amendments will form a part of this Plan as if all terms and provisions were incorporated in the Plan.

Trust Fund or Fund — The Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund and the entire assets, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of the contracts), all investments made and held by the Trustees, all income, increments, earnings and profits and any and all other property or funds received and held by the Trustees under the Amended Agreement and Declaration of Trust.

Trustees or Board of Trustees — The Trustees of the Carpenters' District Council of Kansas City and Vicinity Health & Welfare Fund.

Union — The Carpenters' District Council of Kansas City and Vicinity of the United Brotherhood of Carpenters and Joiners of America, and any other Union that may became party to the established Agreement and Declaration of Trust.

Work Hardening — A program designed to help an injured employee return to work that incorporates physical conditioning, work simulation and education to build strength and endurance, and improve function, while helping to prevent re-injury.

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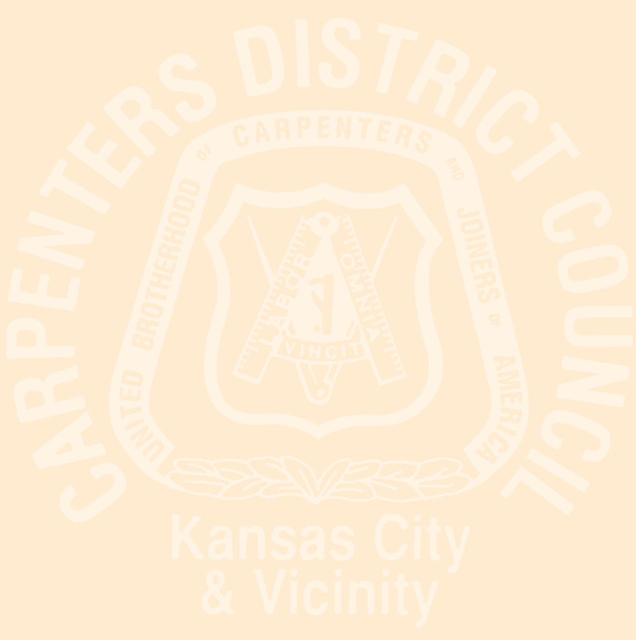
CARPENTERS DISTRICT COUNCIL
UNITED BROTHERHOOD OF CARPENTERS AND JOINERS OF AMERICA
Kansas City
& Vicinity