MO-KAN TEAMSTERS

Health and Welfare Fund

Kansas City, Missouri

SUMMARY PLAN DESCRIPTION

Effective January 1, 2004

MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

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MO-KAN TEAMSTERS HEALTH AND WELFARE FUND

To All Participants:

The Board of Trustees is pleased to present this revised booklet which describes the benefits provided by the Mo-Kan Teamsters Health and Welfare Fund, effective January 1, 2004.

The benefits are maintained and administered by a Board of Trustees on which labor and management are equally represented. A list of the Trustees is on the preceding page. The benefits provided by the Fund are self-funded and are limited to the Fund assets available for this purpose. The Trustees manage the Fund in a responsible manner to provide the highest level of benefits consistent with the Fund's financial resources.

Eligibility for Plan 1 or Plan 2 is determined by the hourly contribution rate paid by your employer. To determine which plan you are eligible for, contact the Fund Office.

This booklet describes the benefit provisions contained in the Plan document that governs the Fund. If anything has accidentally been misstated or left out, the Plan document will govern.

The Trustees reserve the right to change, modify or discontinue all or part of the benefits in this booklet at any time by action or amendment. **If the Plan makes inadvertent, mistaken, excessive, erroneous or fraudulent payment of benefits, the Trustees or their representative shall have the right to recover these types of payments.**

Please read this booklet carefully so that you understand your valuable Welfare Fund benefits. We suggest that you keep the booklet in a safe place for future reference.

Sincerely,

BOARD OF TRUSTEES

The Trustees reserve the right to change, modify or discontinue all or part of the benefits in this booklet at any time by action or amendment.

THIS BOOKLET IS THE SUMMARY PLAN DESCRIPTION AND PRESENTS A SUMMARY OF THE PLAN BENEFITS AND HOW YOU CAN RECEIVE THEM.

THE RULES AND REGULATIONS CONTAIN THE OFFICIAL DESCRIPTION OF THE BENEFITS PAYABLE. IN CASE OF ANY CONFLICT BETWEEN THE SUMMARY PLAN DESCRIPTION AND THE RULES AND REGULATIONS, THE RULES AND REGULATIONS WILL BE CONTROLLING.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

Benefit	Amount
Death Benefit	
(For Active Eligible Employees and Their Eligible Spouses)	
Employee	$15,000
Spouse	$2,000
Accidental Death and Dismemberment Benefit (For Active Eligible Employees Only)	
Full Benefit Amount	$7,500
Loss of Time Benefit (For Active Eligible Employees Only)	
Weekly Benefit Amount	$250
Maximum Number of Weeks Payable	13
Benefit Starting Date	
Disability due to an injury	First Day
Disability due to a sickness	Eighth Day
Comprehensive Major Medical Benefit	
Lifetime Maximum	
For Active Employees and their Eligible Dependents	$500,000
If you are covered under the Retiree Benefit Plan	$250,000

Plan 1

Active Eligible Employees and their Eligible Dependents and Those Covered by the Retiree Benefit Plan

Deductible per Calendar Year

Individual $250

Family $500

Coinsurance

In-Network 85%

Out-of-Network 70%

For the Treatment of Mental and Nervous Disorders 50%

Out-of-Pocket Maximum per Calendar Year (after deductible)

In-Network $2,250

Out-of-Network $4,500

Plan 2

Active Eligible Employees and Their Eligible Dependents

Deductible per Calendar Year

Individual $400

Family $800

Coinsurance

In-Network 75%

Out-of-network 60%

For the Treatment of Mental and Nervous Disorders 50%

Out-of-Pocket Maximum per Calendar Year
(after deductible)

In-Network $3,750

Out-of-Network $6,000

Preferred Provider Organization (PPO)

The Fund uses Freedom Network Select in metro Kansas City, HealthLink in outstate Missouri and Health Partners of Kansas in outstate Kansas. A list of PPO providers is available at no cost to you from the Fund Office. You may also visit the PPO website at www.phpkc.com, or you may call 800-544-3014 or 913-685-6300. The phone number for HealthLink is 1-800-624-2356, Links to the HealthLink and Health Partners of Kansas PPO's are available at the PHP website..

Mental and Nervous Disorder Treatment for Plan 1 or Plan 2

In-patient Limit ..... 30 days per Calendar Year

Out-patient Limit ..... 20 sessions per Calendar Year

Chemical Dependency Treatment for Plan 1 or Plan 2

Per Continuous Course of Treatment $6,000

Overall Lifetime Maximum $12,000

Human Organ and Tissue Transplants not Administered under the Centers of Excellence Program (see page 35 for Centers of Excellence Program) for Plan 1 or Plan 2.

Transplant Procedure	Maximum Benefit	Annual Follow-Up Benefit	Lifetime Follow-Up Benefit
Small bowel/liver	$150,000	$20,000	$100,000
Small bowel	125,000	20,000	100,000
Heart	100,000	15,000	75,000
Heart/Lung	150,000	20,000	100,000
Lung	150,000	20,000	100,000
Liver	125,000	15,000	75,000
Pancreas	50,000	10,000	50,000
Kidney	50,000	10,000	50,000
Bone Marrow	150,000	10,000	50,000
Cornea	10,000	No Further Coverage	

Organ Procurement Benefit $10,000

Physical Therapy/Occupational Therapy/Speech Therapy for Plan 1 or Plan 2

Maximum:

Per Calendar Year..... $5,000

Per Lifetime $10,000

Speech Therapy for Childhood Developmental Speech Delays for Plan 1 or Plan 2

Maximum:

Per Calendar Year..... $500

Chiropractic Treatment for Plan 1 or Plan 2

Maximum per Office Visit..... $15

Calendar year Maximum:

For Office Visits $150

For X-rays..... $50

Centers of Excellence Program for Plan 1 or Plan 2

Before scheduling transplant surgery, you must call the Fund Office.

Annual Deductible .....Transplant benefits are subject to a deductible of $1,000 per transplant

Coinsurance .....After satisfying the deductible, the Plan pays: 100% of covered charges up to the maximums outlined below.

Lifetime Maximums -

All Transplant charges..... $500,000 per person per lifetime

Organ Procurement Benefit .....$15,000 per organ transplant

Immunosuppressive (Anti-Rejection) Medications .....100% up to lifetime maximum if through mail order, otherwise 80%

Travel and Lodging Benefit Lifetime Maximum.....$20,000 per transplant if the covered individual must travel more than 100 miles from home to a LifeTrac facility. The Plan will pay all transportation, lodging, and meal costs for one adult to accompany the recipient (two adults if the recipient is under age 18).

If you do not use a Centers of Excellence Facility, your expenses will be covered under the current Comprehensive Major Medical Benefits to the maximums on page 3.

Dental Care Benefit

(For Active Eligible Employees and Their Eligible Dependents)

Calendar Year Deductible..... $25

Co-Payment Paid by the Fund

Type A..... 80%

Type B..... 60%

Type C..... 50%

Calendar year Maximum $1,250

Vision Care Benefit

(For Active Eligible Employees and Their Eligible Dependents)

Maximum per Two Consecutive Calendar Years $250

Hospice Benefit

Lifetime Maximum per person $10,000
(not subject to deductibles or co-insurance)

Physical Exam Benefit*
(For Active Eligible Employees and Their Eligible Spouses)

Under age 50, one exam every two years .....No cost to Employee

Over age 50, one exam each year .....No cost to Employee

*Employer Health Services, Inc. must be used

Well Child Benefit

(For Eligible Dependent Children of Active Employees)

Maximum per calendar year .....$300 per child through age 18
(not subject to deductible or co-insurance)

Prescription Drug Benefit

(Active Eligible Employees and Their Eligible Dependents and Those Covered by the Retiree Benefit Plan)

Retail Card Program

Brand Name.....20% employee co-pay at participating pharmacies

Generic .....20% employee co-pay at participating pharmacies

Maximum supply.....34 days or 100 units whichever is greater

If you choose to have your prescription filled at a pharmacy that is not included in the AdvancePCS National Network, you will be required to pay the entire cost of the medication when you receive it. You may then submit a claim form to AdvancePCS for the provider's allowed amount for the prescription less the co-pay. You may obtain a claim form from the Fund Office.

Mail Order Program

Brand Name.....20% employee co-pay

Generic .....20% employee co-pay

Hearing Aid Benefit

(For Active Eligible Employees and Their Eligible Dependents and Those Covered by the Retiree Benefit Plan

Co-Payment Paid by the Fund 100%

Maximum.....$1,000 every 5 years

ELIGIBILITY

INITIAL ELIGIBILITY

An employee is initially eligible on the first day of the second calendar month following any calendar month in which the Plan receives at least two hundred and fifty (250) hours of contributions from a contributing employer in three (3) or less consecutive calendar months.

In Order to be Eligible in:	The Fund must receive at least 250 hours reported for the months of:
January	September, October and November
February	October, November and December
March	November, December and January
April	December, January and February
May	January, February and March
June	February, March and April
July	March, April and May
August	April, May and June
September	May, June and July
October	June, July and August
November	July, August and September
December	August, September and October

For example, Joe worked for a contributing employer during the months of January and February, and has at least 250 hours of contributions during that time period. Joe will be covered under the Plan on April 1.

Dependent benefits become effective on the normal effective date except in the case where a dependent is eligible for benefits because of a Qualified Medical Child Support Order, benefits will be effective on the date in the Order, provided that the participant named in the Order is eligible for benefits during such dates.

CONTINUATION OF ELIGIBILITY

Once you meet the **Initial Eligibility** requirements above, you will remain eligible for benefits for succeeding months if you have the required hours of contributions made on your behalf as described in the **Hours of Employment** section.

HOURS OF EMPLOYMENT

You must meet one of the following requirements for hours contributed to the Fund on your behalf for your eligibility to continue:

1. 250 hours of contributions for the last three consecutive months before the lag month;

2. 500 hours of contributions for the last six consecutive months before the lag month; or

3. 1,000 hours of contributions for the last twelve consecutive months before the lag month.

CONTINUED ELIGIBILITY DURING DISABILITY PERIODS

If you are unable to perform work because of a certified disability after you become eligible, you will be credited with disability hours to maintain your eligibility. You will be credited with eight (8) hours for each day of disability up to a maximum of five (5) days (40 hours) per week or for a total of 520 hours per disability. You will be credited with these disability hours for a maximum of thirteen (13) weeks.

A certified disability is one for which you are being paid the Loss of Time Benefit through the Fund or any workers' compensation benefit.

REINSTATEMENT OF ELIGIBILITY

If your eligibility ends because you do not have the required hours of contributions, you may become eligible again by meeting the requirements described in the **Initial Eligibility** section on page 7.

WHEN YOU RETIRE

If you retire while eligible under this Plan, you and your spouse will be eligible for the Retiree Benefit Plan if you are:

1. receiving a pension from the Mo-Kan Teamsters Pension Plan;

2. have 10 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);

3. for those under the age of 65 (pre-Medicare), must have 20 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);

4. not working at a job where you receive health benefits; and

5. at least fifty (50) years old unless you retired because of a total and permanent disability.

You must sign an authorization form instructing the Pension Plan Trustees to deduct the required premium each month from your pension payment and to remit the premium to the Health and Welfare Fund. This authorization form must be signed at least fifteen (15) days before your pension payments begin.

If you die while you and your spouse are covered under the Retiree Benefit Plan, your surviving spouse may continue to be covered under the Retiree Benefit Plan if your spouse is receiving the Joint and Survivor Benefit under the Mo-Kan Teamsters Pension Plan.

You can choose the Retiree Benefit Plan or COBRA, but not both.

The Retiree Benefit Plan provides the Comprehensive Major Medical Benefit until eligibility for Medicare. After you or your spouse become eligible for Medicare, the Retiree Benefit Plan provides a Medicare Supplement Plan. For more information, see the **Retiree Benefit Plan** section on page 51.

SURVIVING SPOUSES

If you die, while you are an active eligible employee, your surviving spouse will be eligible for the Retiree Benefit Plan if:

1. you are working in covered employment when you die;

2. have 10 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);

3. for those under the age of 65 (pre-Medicare), must have 20 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);

4. your spouse is at least age fifty (50); and

5. your spouse is receiving the Joint and Survivor Benefit under the Mo-Kan Teamsters Pension Plan.

Your surviving dependent children may continue coverage under the **Continuation of Coverage** section below.

Your surviving spouse must instruct the Pension Plan Trustees to deduct the required amount each month from the pension payment. This payment must be remitted to the Health and Welfare Fund.

The Retiree Benefit Plan will provide your surviving spouse who is not eligible for Medicare with coverage under the Comprehensive Major Medical Benefit. Once your surviving spouse becomes eligible for Medicare, coverage will be provided under the Medicare Supplement Benefit. For more information, see the **Retiree Benefit Plan** section on page 51.

CONTINUATION OF COVERAGE

Under certain circumstances, coverage for you or your eligible dependents under the Mo-Kan Teamsters Health and Welfare Plan can be temporarily continued after it would normally end. The Plan's continuation provisions comply with the requirements of Federal law under the Comprehensive Omnibus Budget and Reconciliation Act (COBRA).

The continuation coverage will be identical to the coverage you have under the Plan. However, the Death, Accidental Death and Dismemberment and Loss of Time benefits may not be continued. You may continue medical only or medical, dental and vision benefits. You will be required to make self-payments for continuation coverage.

WHO MAY ELECT CONTINUATION OF COVERAGE

You or your eligible dependents are "qualified beneficiaries" eligible to elect continuation of coverage. A "qualified beneficiary" is any individual who, on the day before a qualifying event, is covered under this Plan as (a) an Employee (b) the spouse of an Employee, or (c) the dependent child of an Employee. In addition, a child born to or placed for adoption with a covered Employee during the continuation period is a "qualified beneficiary."

Each qualified beneficiary has an independent right to elect continuation of coverage. For example, your spouse or dependent children may elect continuation of coverage even if you chose not to elect coverage for yourself.

WHEN COVERAGE CONTINUES FOR 18 MONTHS

You may elect to purchase continuation coverage for yourself and your eligible dependents for up to eighteen (18) months if coverage ends for one of the following reasons or "qualifying events":

1. your employment with a contributing employer ends, including retirement, but not including termination due to gross misconduct;

2. you are no longer eligible for coverage due to a reduction in your hours of work; or

3. you fail to return from a leave granted under the Family and Medical Leave Act of 1993 (FMLA).

WHEN COVERAGE CONTINUES FOR 29 MONTHS

If your employment ends due to one of the above "qualifying events" and at the time of the event or within 60 days of the event, you or one of your eligible dependents is totally disabled (as determined by the Social Security Administration), benefits will continue for an additional eleven (11) months, for a total of twenty-nine (29) months for all eligible family members.

You must notify the Fund Office of the determination of a disability award from the Social Security Administration within sixty (60) days after the determination and before the end of the first eighteen (18) months of continuation coverage.

WHEN COVERAGE CONTINUES FOR 36 MONTHS

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

1. your death;

2. your divorce; or

3. your dependent child no longer qualifies for dependent coverage under the Plan.

WHEN COVERAGE MAY BE EXTENDED BECAUSE OF A SECOND QUALIFYING EVENT

An 18-month extension of continuation of coverage is available to your eligible dependents who elect continuation coverage if a second

qualifying event occurs during the first 18 months of continuation of coverage. The maximum amount of continuation of coverage available when a second qualifying event occurs is 36 months. Such "qualifying events" include the following:

1. your death;
2. your divorce or legal separation;
3. your enrollment in Medicare;
4. your dependent child no longer qualifies for dependent coverage under the Plan.

It is the qualified beneficiary's responsibility to notify the Fund Office of the second qualifying event within 60 days after the qualifying event. Failure to timely notify the Fund Office of a second qualifying event may result in a loss of the right to an extension of the continuation of coverage period.

LOSS OF CONTINUED COVERAGE

The period of continuation coverage for you or your eligible dependents may be cut short for any of the following reasons:

1. you or your dependents become covered under another group health medical plan. However, coverage will continue if you or your eligible dependent become covered under a group medical plan that contains an exclusion or limitation with respect to a preexisting condition;
2. the required self-payments are not timely made;
3. the Plan is terminated;
4. you or your eligible dependents reach the end of the eighteen (18) month, twenty-nine (29) month or 36-month continued coverage period;
5. you become entitled to Medicare. However, your eligible dependents who are not entitled to Medicare are entitled to continue coverage for up to thirty-six (36) months from your entitlement to Medicare, or eighteen (18) months from the date of the first qualifying event, whichever period is longer; or
6. your dependent becomes entitled to Medicare.

COVERAGE PROVIDED

You can make self-payments for either:

1. Comprehensive Major Medical Benefit, Dental Care Benefit and Vision Care Benefit; or

2. Comprehensive Major Medical Benefit only.

If you make self-payments, you will have the same deductible for the Comprehensive Major Medical Benefit that you had when you began making self-payments.

NOTIFYING THE FUND OFFICE

Generally, the Fund Office will identify your loss of employment or reduction in work hours when your name does not appear on remittance reports from a contributing employer. In order to maintain your right to continuation of coverage, you or your eligible dependents are responsible for notifying the Fund Office if you divorce, are legally separated, your dependent child no longer qualifies for dependent coverage, or your enrollment in Medicare. This must be done within sixty (60) days of the "qualifying event." You or your eligible dependent will then have sixty (60) days from the later of the date when the continuation coverage election form is received or from your loss of coverage due to the qualifying event to elect continuation coverage. You will be given an additional forty-five (45) days from the date you elect continuation coverage to make any back payments necessary to avoid a gap in coverage.

It is your responsibility to keep the Fund Office informed of any changes in your address or the address of any of your eligible dependents. You should keep a copy, for your records, of any notices you send to the Fund Office.

The Fund Office may be contacted at the address and phone numbers listed in this Summary Plan Description.

PAYMENT REQUIREMENT FOR CONTINUATION OF COVERAGE

The Fund Administrator may require payment for continuation of coverage in an amount equal to but not greater than 102 percent of the cost to the Plan for such coverage based upon a reasonable actuarial estimate of said cost and in accordance with the maximum payment permitted by law. If coverage is extended to 29 months due to disability, the payment may be as much as 150 percent of the applicable cost for the 19th through 29th months of continuation coverage.

Payment for the period beginning on the date of the qualifying event and ending on the date of the election is made within 45 days after such election. All other payments for succeeding months are to be made within 30 days from the first day of the month.

FAMILY AND MEDICAL LEAVE ACT

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you and your eligible dependents if you are an active participant, if you have been granted leave by your employer according to the FMLA and if your employer makes the required contributions to the Fund.

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.

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

If you have been granted FMLA leave, your employer must notify the Fund Office at least fourteen (14) days before the onset of the leave, except in an emergency, and then no later than seven (7) days after the leave begins, to prevent a loss of eligibility. You may wish to notify the Fund Office yourself when you are granted FMLA leave, but you are not required to do so. Your employer will be asked to complete some forms to verify your eligibility for benefits while you are on leave. **Your employer must pay for your extended eligibility before the Fund will provide benefits.**

Your employer will be required to pay the cost of coverage in an amount actuarially determined by the Fund's Consulting Actuary for each week you are on FMLA leave. Your employer must make payment for each month of leave, upon billing by the Fund Office.

Your eligibility will not be extended during the FMLA leave if your employer does not make the required contributions to the Fund. The usual procedures for continuing eligibility will be followed if your employer does not make timely contributions.

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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

(a) Definitions

Health Coverage means Hospital, surgical, medical, dental, vision, prescription or hearing aid coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

Covered Person means an Employee or Dependent as defined in the Plan.

Services 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 a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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

(b) Continuation of Group Health Coverage

(i) If Health Coverage ends because of service in the uniformed services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

(A) the end of the period during which the Employee is eligible to apply for reemployment in accordance with USERRA; or

(B) 18 consecutive months after coverage ended.

(ii) To continue coverage, a Covered Person must pay the required premium, unless service in the uniformed service is for fewer than 31 days. The Fund Office shall inform a Covered Person of procedures to pay premiums. USERRA premium shall be equal to the COBRA premium.

(iii) A Covered Person's continued Health Coverage will end at midnight on the earliest of:

(A) the day the Plan is terminated;

(B) the day premium is due and unpaid;

(C) the day the Covered Person again becomes covered under the Plan;

(D) the day Health Coverage has been continued for the period of time provided in part (i)(A) or (B) above (or any longer period provided in the Plan).

(c) Important Notice

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

(ii) 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.

(iii) 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.

(iv) 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.

In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

CERTIFICATE OF COVERAGE

When your coverage under this Plan ends, the Fund Manager will give you and your dependents a certificate of coverage that indicates the period of time you were covered under the Plan and certain additional information that is required by federal law. The certificate will be sent by first class mail shortly after your coverage under this Plan ends. If you elect COBRA Continuation Coverage, another certificate will be provided shortly after the COBRA Continuation Coverage ends. In addition, a certificate will be provided upon receipt of a request for a certificate if that request is received by the Fund Manager within two years after the later of the date of coverage under this Plan ended or the date COBRA Continuation Coverage ended.

DEPENDENT ELIGIBILITY

For purposes of dependent coverage provided under this Plan, your eligible dependents include your spouse and unmarried children including stepchildren, foster children, adopted children, and children "placed for adoption," who are under age 19.

The term "placed for adoption" means the assumption and retention by a participant of a legal obligation of a child in anticipation of the adoption of the child prior to that child's eighteenth (18th) birthday. The child's placement with the participant ends upon the termination of such legal obligation.

Foster children and step-children means children who otherwise meet the age requirement shown above and who are dependent due to a court order showing that you have legal guardianship for them and reside with you.

Also, your 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.

If an unmarried dependent child is incapable of self-sustaining employment because of physical handicap or mental retardation and resides with you, the dependent child's benefits will be continued provided such incapability began before the dependent became age nineteen (19) and proof of such incapability is furnished to the Fund Office no later than thirty-one (31) days after the dependent became age nineteen (19). Proof of the continued existence of such incapability may be requested by the Trustees from time to time.

Eligible dependents also includes children for whom coverage must be provided because of a Qualified Medical Child Support Order ("QMCSO"). 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.

DEATH BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES AND THEIR DEPENDENT SPOUSES ONLY)

BENEFIT

If you die, the Fund will pay the Death Benefit of $15,000 to your named beneficiary when proof of your death is received. If your spouse dies, the Fund will pay the Death Benefit of $2,000 to you when proof of death is received.

BENEFICIARY

You may name any person or persons as the designated beneficiary or beneficiaries. You may change your designation at any time by filling out the proper form. Forms for this purpose may be secured from the Fund Office.

If you do not designate a beneficiary or beneficiaries, the Death Benefit will be paid equally to the members of the first of the following classifications that apply:

1. your spouse; or
2. your children; or
3. your parents; or
4. your siblings; or
5. your estate.

The Death Benefit for your spouse will not be paid to any person other than the Employee or the spouse's children.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES ONLY)

If you suffer any of the following losses as the result of an accident on or off the job, the Accidental Death and Dismemberment Benefit will be paid to you, if you are living, or otherwise to your beneficiary. The benefit will be paid in addition to any other benefits payable under the Plan.

For:	The Benefit is:
Loss of Life	$7,500
Loss of both hands; both feet; sight of both eyes; or one hand and one foot; or one hand or foot and sight of one eye	$7,500
Loss of one hand or foot or sight of one eye	$3,750

If more than one of the described losses is suffered as a result of one accident, a maximum benefit of $7,500 will be paid.

LOSS OF TIME BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES ONLY)

The Loss of Time Benefit will be payable to you if you are prevented from working at your job because of a non-occupational injury or sickness. The amount of the Loss of Time Benefit is $250 per week. During a partial week of disability, payment will be made at the daily rate of one-fifth of the weekly benefit.

The Fund is required to withhold and pay Social Security and Medicare Taxes on Loss of Time benefit payments. Federal Income Taxes are also payable, and at the end of the year, an employee who has received Loss of Time Benefits will receive a W-2 Form from the Fund, which will show the amounts paid and withheld.

Benefits begin with the first day of disability caused by accidental bodily injury or the eighth day of disability caused by sickness. The maximum benefit for any one continuous period of disability is thirteen (13) weeks.

Successive periods of disability due to the same or related causes, which are not separated by a return to active employment for one week or more, will be considered the same period of disability.

The Trustees may require an investigation of any Loss of Time Benefit claims. The investigation may include an examination by a physician selected by the Board of Trustees.

No benefits are payable for the Loss of Time Benefit for any period of disability during which you are not under the regular care and attendance of a physician. A written statement from your physician confirming your disability is required.

Any benefits under this Section are subject to subrogation.

To file a claim for Loss of Time Benefits, see the Claims and Appeals section on page 61.

COMPREHENSIVE MAJOR MEDICAL BENEFIT

The Comprehensive Major Medical Benefit Plan pays benefits to you and your eligible Dependents, at the co-payment levels for the two Plans of Benefits shown in Schedule of Benefits, based on the reasonable and customary charges for the services received, after you pay the deductible amount. Lifetime maximums and other limitations apply to certain coverages.

If you are an active employee, your Plan of Benefits is determined by the contribution rate in the current collective bargaining agreement negotiated with your employer. Call the Fund Office to find out which Plan of Benefits you are eligible for.

If you are covered under the Retiree Benefit Plan, you are covered by Plan 1.

DEDUCTIBLE AMOUNT

The deductible is the amount that you must pay before the Comprehensive Major Medical Benefit is payable. The deductible applies once each calendar year. The deductible also has these special features:

1. A family deductible of two times the individual deductible. This means once you and your eligible dependents satisfy the family deductible, the deductible for all members of your family will be satisfied for that calendar year.

2. A common accident feature. If two or more eligible members of your family are injured in the same accident, the medical expenses which result from the accident will be combined and only one deductible will apply towards related expenses, regardless of the number of family members injured.

COVERED EXPENSES

Covered expenses include the reasonable and customary charges for the following services and supplies. The Trustees have the discretion of limiting the quantities of the following items:

1. Hospital services and supplies, including:

    a. room and board at the semi-private room rate. If the hospital only has private rooms, the Plan will pay the most common rate for that hospital. In addition, the Plan will pay for a private room when medically necessary based on the patient's symptoms.

b. intensive care unit, coronary care unit and similar specialty care units.

c. medically necessary hospital services and supplies while hospital confined.

d. outpatient treatment services and supplies for an injury or for outpatient surgery.

e. medical treatment by a physician.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

2. Professional services provided by a physician, surgeon or podiatrist except for the services of a chiropractor as specifically stated in the Schedule of Benefits.

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

3. Treatment for mental and nervous disorders subject to the following limitations:

a. the co-payment level is 50%.

b. inpatient treatment is limited to a total of thirty (30) days in any calendar year. Such treatment must be received in a hospital or a licensed residential treatment facility that is licensed to provide treatment for mental & nervous disorders.

c. outpatient treatment is limited to twenty (20) sessions per calendar year for psychiatric services for a recognized mental or nervous disorder. Services must be provided by a licensed psychologist, psychiatrist, mental health counselor or social worker who has a Master's Degree and who is legally licensed and acts within the scope of that license.

4. Professional services and supplies for the treatment for chemical dependency by a physician, hospital or a specialized treatment facility subject to the following maximums:

   a. $6,000 for each continuous complete course of treatment.

   b. $12,000 lifetime maximum for any one eligible person.

   Two (2) courses of treatment must be separated by at least six (6) months.

5. Services of legally licensed occupational/ physical/speech therapists when ordered by a physician and, who are not a member of the individual's family, subject to the following maximums:

   a. $5,000 per calendar year.

   b. $10,000 per lifetime.

6. Speech therapy to restore normal speech lost due to illness or injury or as a result of congenital deformity (i.e. cleft palate) is covered to the maximums shown above. Speech therapy for childhood developmental speech delays is limited to $500 per calendar year.

7. Drugs and medicines requiring a physician's prescription.

8. Anesthesia and its administration, blood plasma and oxygen including equipment for its administration.

9. X-ray and laboratory examinations or X-ray, radium, radioactive isotope and chemotherapy except those performed by or authorized by a chiropractor or podiatrist.

10. Medically necessary transportation to or from the hospital including air ambulance service to a local hospital, when

medically required, up to a maximum of $750 ($5,000 for air ambulance) except service by railroad, ship, bus, airplane or any other common carrier are not covered.

11. Oral surgery performed by a dentist or dental surgeon except for simple extractions.

12. Psychological testing if recommended by a medical physician and performed by an accredited psychologist for a maximum of $300 per calendar year.

13. Treatment by a licensed chiropractor, subject to the following maximums:

    a. $15 per visit.

    b. $150 for all visits per calendar year.

    c. $50 per calendar year for X-rays authorized by a chiropractor.

14. Human organ and tissue transplant expenses that are not through the Centers of Excellence Program up to the maximums shown in the Schedule of Benefits, on page 3.

    The following requirements apply to all human organ and tissue transplant expenses:

    a. no other transplant procedures are covered.

    b. there is medical documentation that conventional treatment would be unsatisfactory, unavailable and/or more hazardous than a transplant.

    c. the patient's condition is life threatening.

    d. the patient must be legally required to pay for the transplant operation.

    e. the transplant maximum benefit amount will begin five (5) days prior to the procedure and will continue for the twelve (12) month period immediately following the procedure.

    f. the use of temporary mechanical equipment, pending the acquisition of matched human organs if covered.

    g. multiple transplant procedures during one surgical procedure are covered.

h. follow-up benefits are for each successive twelve (12) month period beginning on the anniversary of the transplant surgery.

i. the organ procurement benefit is payable at 100% with no deductible up to the maximums shown in the Schedule of Benefits for the following:

i. testing suitable donors;

ii. acquisition of an organ from a donor;

iii. life support of a donor pending the removal of a usable transplant organ; and

iv. expenses for transportation of transplant organ(s) or a donor on life support.

15. Human growth hormone only when recommended by a medical physician for dwarfism.

16. Mammograms once a year for women over 50 years old and once every 2 years for women under 50.

17. Pap smears.

18. 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 is $10,000 per person per limb or device for the appliance including necessary supplies, repair and servicing over any three consecutive calendar years.

19. Durable Medical Equipment is equipment which:

a. can withstand repeated use and is not a consumable or disposable item.

b. is exclusively and customarily used to serve a medical purpose.

c. is not useful to a person in the absence of injury or illness; and

d. is appropriate for use in the home.

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.

PREFERRED PROVIDER ORGANIZATION

A Preferred Provider Organization (PPO) is a network of providers who have an agreement with the Plan to charge a "preferred" or negotiated rate. The Plan pays a higher percentage of covered expenses when you use a PPO provider. Please see the Schedule of Benefits for the appropriate co-insurance levels.

Additional providers are added to the PPO network on a monthly basis. Check with the Fund Office to see if PPO providers are available where you live. You may also visit the PPO website for Freedom Network Select at www.phpkc.com, or call the Freedom Network Select PPO at 800-544-3014 or 913-685-6300. The HealthLink phone numbers are 800-624-2356 or 314-989-6300. Links to the HealthLink and Health Partners of Kansas PPO's are also available at the PHP website.

CASE MANAGEMENT

Cases of catastrophic illness or long-term care – cancer, stroke, transplants, severe disability and other serious afflictions – usually require the services of many health care specialists. Associated costs can – and typically do – accumulate beyond what is expected or necessary.

Case Management Coordinators work closely with the patient, family members and all health care providers involved in the case. They coordinate health care activities to facilitate proper and timely care, while eliminating duplication services, unnecessary services and excessively expensive treatments when appropriate, alternative methods exist.

The services provided by Case Management Coordinators include:

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

LIMIT ON OUT-OF-POCKET EXPENSES

The Comprehensive Major Medical Benefit pays your or your eligible dependents covered expenses at the appropriate co-payment levels shown in the Schedule of Benefits, after the deductible is satisfied. You must pay the remainder of covered expenses for yourself and/or your eligible dependents.

OUT-OF-POCKET EXPENSES

You can reduce your out-of-pocket expenses by using a PPO provider. If you receive all of your medical treatment from a PPO provider, your out-of-pocket maximum will be determined by your Plan of Benefits as shown in the Schedule of Benefits. However, if all of your medical treatment is received from non-PPO providers, your out-of-pocket maximum will be higher as shown in the Schedule of Benefits.

Once you or your eligible dependents reach your out-of-pocket maximum during a calendar year, the Plan will pay 100% of that person's covered expenses for the remainder of that calendar year. **HOWEVER, EXPENSES FOR THE TREATMENT OF MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY DO NOT COUNT TOWARD THIS OUT-OF POCKET LIMIT AND WILL REMAIN AT THE APPROPRIATE CO-PAYMENT LEVEL.**

MAXIMUM ON THE BENEFITS YOU CAN RECEIVE

The Plan has a lifetime maximum of $500,000 for all benefits provided under the Comprehensive Major Medical Benefit for you and each of your eligible dependents if you are an active employee. The lifetime maximum for you and/or your spouse is $250,000 if you are covered under the Retiree Benefit Plan. Certain other benefits have calendar year maximums or lifetime maximums. These maximums are shown in the Schedule of Benefits and/or listed in the **Covered Expenses** section on pages 22-27.

Each January 1st up to $5,000 will be automatically restored to your and each of your eligible dependent's lifetime maximum. However, under no circumstances will any person's lifetime maximum be restored to more than $500,000 under the active Plan or $250,000 under the Retiree Benefit Plan.

EXCLUSIONS AND LIMITATIONS

No benefits are payable under the Plan for:

1. Any sickness resulting from an occupational disease. For purposes of this Plan, the term "occupational disease" means a disease arising out of or in the course of the employment of the person for whom a claim is submitted.

2. Any accidental bodily injury arising out of or in the course of the employment of the person for whom the claim is submitted.

3. Hospitalization, surgical or medical treatment provided or paid by the United States Government or any instrument thereof.

4. Hospitalization, surgical or medical treatment provided outside the United States of America, except if approved by the Trustees on the basis of medical advice.

5. Any charges the person is not required to pay.

6. Any charges for a sickness or injury resulting from war or any act of war, declared or undeclared, including armed aggression from military, naval or air service.

7. Any charges for an injury or sickness resulting from the participation in a public disturbance or terrorist act, or riot or resulting from the commission of a felony.

8. Services or supplies that are compensated for or furnished by the local, state or federal government or any agency thereof, and that part of the charges for any services or supplies for which payment is provided or available from the local, state or federal government whether or not that payment is received.

9. Services of supplies that are experimental or investigative or do not meet accepted standards of medical practice. For purposes of this Plan, experimental or investigative means a service or treatment on which the consensus of expert medical opinion, based on reliable evidence (i.e. published reports and/or articles) indicates that further trials or studies are needed to determine the safety, efficacy and outcomes of such treatment or services compared to standard treatment. Experimental or investigative also means such services or treatments not yet recognized as having proven beneficial

outcomes, those still primarily confined to a research setting and those that are not appropriate based on medical circumstances and/or given the advance stage of an individual's sickness or the likelihood that the service or treatment will measurably improve the individual's sickness or medical condition.

The Trustees have the sole authority to determine whether a treatment, service or supply is experimental or investigative.

10. Any treatment or service by a dentist or dental surgeon except as specifically provided for in the Plan.

11. Any treatment or service by a dentist, dental surgeon or physician related to the temporomandibular joint (TMJ), except surgical treatment when medically necessary.

12. Charges for custodial care, which will include services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist such individual in activities of daily living.

13. Services or supplies received during an in-patient stay when the stay is primarily for behavioral problems or social maladjustment or other antisocial actions which are not specifically the result of a mental & nervous disorder.

14. Cosmetic surgery except for the treatment of an injury.

15. Group therapy, occupational therapy and speech therapy, except as specifically provided in the Plan.

16. Penile prosthesis, except when medically necessary.

17. Charges for failure to keep a scheduled visit or charges for completion of a claim form.

18. Supplies or equipment for personal hygiene, comfort or convenience such as air conditioners, humidifiers, physical fitness and exercise equipment, hot tubs, water beds and corrective shoes.

19. Supportive devices for flat-footed conditions (orthotics) and services and supplies for routine foot care.

20. Special home construction or special transportation vehicles except wheelchairs.

21. Experimental or investigative drugs, drugs which may be dispensed without a prescription, over-the-counter products and contraceptives.

22. Organ transplants and any related services, except as specifically provided for in the Plan.

23. Charges for the services or treatment of a chiropractor or podiatrist, except as specifically provided for in the Plan.

24. Charges for services, supplies, treatments and/or confinements which are not medically necessary. For purposes of this Plan, such services, supplies, treatments and or confinements must meet the following standards:

    a. Be effective and essential for the treatment of the patient's condition, disease, ailment or injury;

    b. Be at the appropriate level of care in the appropriate setting based on the diagnosis and the generally recognized and accepted standards of medical practice in the United States;

    c. Be the type of care that could not have been omitted without an adverse affect on the patient's condition or the quality of care; and

    d. Not be solely for the comfort, convenience or administrative ease of the provider or the patient (or family) and/or caretaker.

    The Trustees have the sole discretion to determine if a service, supply, treatment and/or confinement (or a portion of a confinement) is medically necessary. The Trustees may rely on an independent reviewer for such determination. The fact that a physician or any other health care provider may order or recommend a service, supply, treatment or confinement does not, of itself, make it medically necessary.

25. Charges over the reasonable and customary level.

26. Expenses for the diagnosis and treatment of infertility and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate

parenting, donor semen, adoption, and reversal of sterilization procedures.

27. Expenses for prescription drug (i.e. Viagra) treatment for sexual dysfunction or inadequacy.

28. Any treatment for weight loss. However, weight loss prescriptions may be covered if there is a diagnosis of morbid obesity for the Employee or Dependent.

    Morbid obesity means that the patient must be twice the patient's ideal weight or greater than 100 pounds overweight.

    The patient must demonstrate an inability to control weight through diet over a minimum period of three years. This must be documented by medical records or detail of treatment over a three-year period, as related by the attending Physician.

    The patient must suffer from a documented separate condition which is aggravated by obesity (i.e., severe diabetes mellitus, hypertension, alveolar hyperventilation, chronic back condition, etc.). This must be documented by objective evidence provided by the Physician who is treating the claimant for the condition which is aggravated by obesity.

29. Treatment leading to or in connection with transsexual surgery.

30. Care in a penal institution.

31. Complication of non-covered services.

32. Court ordered care unless required by Federal law.

33. Chelation therapy except in cases of heavy metal poisoning.

34. Marriage counseling.

35. Acupuncture except for pain relief when other methods are unsuccessful.

36. Hypnosis, hypnotherapy or biofeedback.

37. Drugs, medicines or devices for:

- antiviral drugs used for prevention of influenza (flu);
- drugs to enhance athletic performance such as anabolic sterioids;
- prescription contraceptives, non-prescription contraceptives;
- hair removal or hair growth products (*i.e.*., Propecia, Rogaine, Minoxidil, Vaniqa)
- tobacco/smoking cessation;
- Vitamin A derivatives
- immunizations and vaccinations except as specially provided under the Well Child Benefit.

38. Genetic testing. Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics.

39. 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 individual.

40. Expenses for massage therapy.

CENTERS OF EXCELLENCE

This program which is administered by LifeTrac Network, is designed to take advantage of organizations that specialize in providing services for organ and bone marrow transplants.

LifeTrac is a "centers of excellence" network that currently includes many of the nation's leading organ and bone marrow transplant facilities. With LifeTrac, you have access to experienced medical institutions and surgical teams throughout the country. Transplant facilities are subject to change; to obtain the most up-do-date list of facilities, contact the Fund Office or you may visit LifeTrac's website at www.lifetracnetwork.com.

COVERED EXPENSES

The Plan provides coverage for non-experimental organ and bone marrow transplant surgeries. Ttransplant surgeries that will be covered under this benefit are:

1. heart;
2. lung;
3. heart/lung;
4. liver;
5. kidney;
6. pancreas;
7. kidney/pancreas;
8. small bowel/liver;
9. small bowel; and
10. bone marrow, including autologous, related and unrelated allogenic, and stem cell.

If you do not use a Centers of Excellence Facility, your expenses will be covered under the current Comprehensive Major Medical Benefits, subject to the maximums shown in the Schedule of Benefits on page 3.

The LifeTrac Network provides case management services that will help you manage the care received through the LifeTrac Network. If you or an eligible dependent becomes a candidate for an organ or bone marrow transplant, contact the Fund Office. Professional staff will work with you and LifeTrac to gather information and assist you in selecting an appropriate course of action. By contacting the utilization management provider as soon as you or

an eligible dependent becomes a candidate for an organ or bone marrow transplant, you help maximize your benefits and the level of care you receive.

DENTAL CARE BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES AND DEPENDENTS ONLY)

The Dental Care Benefit will pay the stated percentage shown in the Schedule of Benefits of covered dental charges up to a maximum of $1,250 per calendar year per covered person after the deductible is met.

COVERED CHARGES

Covered dental charges are the reasonable and customary charges made for dental treatment up to the stated maximum and are listed below:

Type A - Preventive and diagnostic procedures and services include:

1. Oral examination and diagnosis; once in a consecutive six (6) month period.
2. Prophylaxis, which may be performed by a dental hygienist; once in a consecutive six (6) month period.
3. Topical application of sodium or stannous fluoride for eligible Dependents under age nineteen (19); once per Calendar Year.
4. Space Maintainers used to replace prematurely lost teeth for eligible Dependents under age nineteen (19). This includes adjustments made to the original space maintainer more than six months after it is installed.
5. Emergency palliative treatment.
6. Full mouth X-rays; once in a consecutive twenty-four (24) month period.
7. Bitewing X-rays; once in a consecutive twelve (12) month period.
8. X-rays required to diagnose and treat a specific condition.
9. Dental sealants, one application to the permanent first and second molars of eligible Dependents under age nineteen (19).

Type B - Minor restorative procedures and services include:

1. Restorations of diseased teeth with amalgam, silicate, acrylic, synthetic porcelain or composites.

2. Endodontic treatment, including root canal therapy. Root canal treatments and/or apicoectomies are only payable once per tooth.

3. Treatment of periodontal and other gum and mouth tissue diseases, including gingival tissue or alveolar processes. Gingival curettage is limited to four (4) quadrants in any twelve (12) consecutive month period.

4. Extractions, including local anesthesia and routine post-operative care.

5. Oral surgery, including local anesthesia and routine post-operative care.

6. General anesthetics, when needed as part of oral or dental surgery.

7. Antibiotic injections by the attending dentist.

8. Repair or recementing of crowns, inlays, onlays, bridgework or dentures.

9. Relining or rebasing of present dentures - but only if they were installed more than six (6) months earlier and if they have not been relined or rebased during the past twelve (12) months.

Type C - Major restorative and prosthetic procedures and services include:

1. Gold restorations when the teeth cannot be restored with another filling material.

2. Inlays, onlays or crowns when the teeth cannot be restored with a filling material.

3. First installation of removable dentures. Also included are adjustments of these dentures more than six (6) months after they are installed.

4. First installation of fixed bridgework, including inlays and crowns as supports.

5. Replacement of crowns, inlays or onlays with new ones - but only if the existing ones are at least five (5) years old and cannot be made serviceable.

6. Replacement of partial dentures, full removable dentures or fixed bridgework with new ones, or teeth added to the existing dentures or bridgework - but only if:

   A. the existing denture or bridgework is at least five (5) years old and cannot be made serviceable; or

   B. the existing denture is a temporary denture that cannot be made permanent and is replaced within twelve (12) months by a permanent denture.

EXTENSION OF BENEFITS

If you or your eligible Dependent incur Covered Dental Expenses after eligibility ends, the Fund will continue Dental Care Benefits under the following circumstances:

1. for appliances and their modifications:

   A. the dentist must have taken the master impression while the individual was eligible under the Plan;

   B. the appliance must be delivered or installed within sixty (60) days after eligibility ended; and

   C. the appliance must not be related to an orthodontic service.

2. for crowns, bridges, inlays, onlays or cast restorations:

   A. the teeth must be prepared while the individual was eligible under the Plan; and

   B. installation must be within sixty (60) days after eligibility ended.

3. for root canal therapy:

   A. the pulp chamber must be opened while the individual was eligible under the Plan; and

   B. therapy must be completed within sixty (60) days after eligibility ended.

EXCLUSIONS AND LIMITATIONS

The Dental Care Benefit does not pay for:

1. Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.

2. Dental services for which you or your eligible Dependent incur no charge.

3. Dental services for you or your Dependent either provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the individual is legally obligated to pay. This exclusion extends to any benefits provided under the United States Social Security Act and its amendments.

4. Dental care for a congenital or developmental malformation.

5. Cosmetic services, including:

   A. veneers, facings or similar properties of crowns or pontics placed on or replacing teeth in back or the second bicuspid; and

   B. personalization or characterization of dentures.

6. Loss or theft of a denture.

7. Services covered under the Medical Benefit.

8. Realignment of teeth (orthodontics).

9. Expenses for root canal treatment and/or apicoectomies when previously paid under another benefit.

10. Examinations and/or prophylaxis performed within six (6) months of the last examination.

ALTERNATIVE PROCEDURES

The Fund only considers the least costly dental procedure that meets nationally established standards as Covered Dental Expense. If you decide upon a more costly procedure or treatment, the Fund will only reimburse the amount of the less costly procedure, at the appropriate Type A, Type B or Type C co-payment level, subject to the Calendar Year maximum.

PRE-ESTIMATION OF BENEFITS

For any dental treatment or service which is expected to exceed $150, an individual may submit a claim form showing the recommended treatment plan and fees to the Fund Office.

The Fund Office will then notify the dentist and individual of the amount payable for each approved service.

VISION CARE BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES AND DEPENDENTS ONLY)

If you or your eligible dependent require an eye examination or glasses, the Plan will pay the covered charges during a two consecutive calendar year period up to the amount shown in the Schedule of Benefits.

COVERED CHARGES

Covered Vision Care Charges are the charges which you or your eligible Dependent are required to pay for the following services and supplies as ordered by a legally qualified ophthalmologist or optometrist:

1. Examination which includes dilation of pupil and/or relaxing of muscle by drops, refraction of vision, and examination for pathology.
2. New or replacement frames and/or lenses prescribed by an ophthalmologist or optometrist and including the fitting cost; or
3. Contact lenses prescribed by an ophthalmologist or optometrist, including the fitting cost and supplies.

EXCLUSIONS AND LIMITATIONS

1. Any vision care services or supplies received from a mutual benefit association, labor union, trustee or other similar group.
2. Any eye examination required by an employer as a condition of employment.
3. Any vision care services or supplies which are payable or furnished by any group policy or prepayment plan.
4. Any medical or surgical treatment of the eye.
5. Sunglasses, plain or prescription.
6. Safety lenses or goggles.
7. Orthoptics, vision training or aniseikonia.

8. Repairs of any kind.
9. Loss or theft.

HOSPICE BENEFIT

If you or your eligible dependent have covered expenses for Hospice Care, payment will be made as shown in the Schedule of Benefits. Benefits are payable for the reasonable and customary expenses up to the stated maximum. Hospice Care must be rendered as part of a Hospice Care Program through a licensed Hospice Care Agency. The recipient must be assessed by their Physician to have a life expectancy of 6 months or less.

COVERED EXPENSES

Covered expenses include the reasonable and customary charges for the following:

1. Home Care
   a. physician services
   b. physical, respiratory and occupational therapies
   c. drugs, medications and medical supplies when provided under the Hospice Care Program through a Hospice Care Agency
   d. private duty nursing services by a Registered Nurse or Licensed Practical Nurse, if certified by a Physician
   e. rental of Durable Medical Equipment (DME)
   f. oxygen and rental of related equipment
2. Inpatient Care – Care received while the individual is an admitted patient in a hospice facility.
   a. room and board which may include overnight visits by family
   b. nursing services
   c. all other related Hospital expenses
   d. physician services
   e. ambulance service or alternative types of transportation
3. Other Services
   a. visits by a licensed social worker to evaluate the social, psychological and family problems related to

the terminal illness. In addition, this professional will help develop a plan to assist in resolving these problems.

b. emotional support services to help relieve stress, cope with the anticipated loss, complete unfinished family business and maintain the patient in the most appropriate environment;

c. special incidental services for the patient, such as special dietary requirements, transportation between home and other sites of care; and

d. bereavement counseling for the immediate family following the death of the Hospice patient. (Coverage is limited to six visits at a maximum expense of $50 per visit.)

PHYSICAL EXAM BENEFIT

(ACTIVE ELIGIBLE EMPLOYEES AND THEIR DEPENDENT SPOUSES ONLY)

This physical exam will be available at no cost to you and will be provided by Employer Health Services, Inc., which has developed a special, comprehensive "wellness examination".

The examination is a series of tests designed to help you understand your current health status, which will aid you in realizing your full wellness potential. The tests also help identify risk factors, which may lead to illness in the future. Eligible active employees and spouses age 50 and over may schedule such an exam once a year, and eligible active employees and spouses under age 50 may schedule their exams once every two years.

The examination consists of the following for both men and women:

1. Back, hamstring and upper body strength and flexibility testing.
2. Urinalysis (for possible diabetes or urinary tract/kidney disease).
3. Lung function spirometry (if indicated).
4. Laboratory series, including lipid profile (HDL, LDL, total cholesterol), triglycerides, blood sugar, complete blood count (CBC), TSH (females), PSA (males), chemistry profile, and a colorectal cancer screen hemocult test.
5. Blood pressure and heart rate measurements.
6. Body fat analysis and body mass index.
7. Height and weight.
8. Resting EKG.
9. Exercise stress (graded Bruce Treadmill test/physician supervised).
10. General physical examination.
11. Physician consult and goal setting.

Physical Exam:

Men	Examination of skin, head, eyes, ears, nose, throat, neck, thyroid, spine, lungs, nervous system, heart, breasts, abdomen, arms, legs, groin, genitalia, rectum and prostate (optional).
Women	Examination of skin, head, eyes, ears, nose, throat, neck, thyroid, spine, lungs, nervous system, heart, mammogram (optional), abdomen, arms, legs, groin, pelvic exam and pap (optional), rectal exam (optional).

Employer Health Services will include mammograms and pap smears as a part of the physical exam at no cost to the participant. **For those women preferring to have these tests performed through their personal Physician or Gynecologist, the Plan will cover mammograms and pap smears under the Comprehensive Major Medical Plan subject to the deductible and co-payments.** Mammograms will be covered once a year for women over 50 years and once every two calendar years for women under age 50.

The complete physical examination consists of two appointments. The first appointment will be about 20 minutes long. At this appointment, you will be asked to fill out some paperwork and blood samples and urine tests will be taken. If convenient, you can schedule this first appointment early in the morning since **you will be required to fast for 12 hours (only water may be consumed).** During the first appointment, your second examination will be scheduled. The second appointment will take approximately two hours.

All examinations will take place at

HealthPlus Fitness and Rehabilitation Facility

4500 West 107th Street

Overland Park, Kansas

(at I-435 and Roe)

Employer Health Services has early morning appointments available Monday through Saturday for blood work, and has evening or Saturday appointments for the second examination. **You may call HealthPlus, (913) 649-7433, ext. 233 to schedule your physical exam or you may call the Fund Office to receive a form listing times and dates of available appointments.**

WELL CHILD BENEFIT

(FOR ELIGIBLE DEPENDENT CHILDREN OF ACTIVE EMPLOYEES)

Under this benefit, expenses for outpatient newborn and routine office visits and routine childhood immunizations (for example, DPT, polio, MMR, chickenpox) are covered for eligible dependent children through age 18 up to $300 per child per year. Deductibles and coinsurance do not apply to these benefits, although charges are subject to reasonable and customary standards. Receipts for these services should be sent to the Fund Office for reimbursement.

HEARING AID BENEFIT

(FOR ELIGIBLE EMPLOYEES AND ELIGIBLE DEPENDENTS AND THOSE COVERED BY THE RETIREE BENEFIT PLAN)

If you or your eligible dependent require a hearing aid, the Plan will pay the covered charges up to the amount shown in the Schedule of Benefits.

COVERED CHARGES

Covered Hearing Aid Charges are the charges which you or your eligible dependent are required to pay for the following:

1. Hearing exam performed by a Physician or a licensed audiologist.
2. Hearing aid device furnished or dispensed by a Physician or a licensed audiologist.

EXCLUSIONS AND LIMITATIONS

The Hearing Aid Benefit does not pay for:

1. Amplifiers.
2. Hygienic cleaning of the aid.
3. Lip reading.
4. Speech therapy.

PRESCRIPTION DRUG BENEFIT

(ELIGIBLE ACTIVE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS AND THOSE COVERED BY THE RETIREE BENEFIT PLAN)

The Prescription Drug Benefit will be managed and administered by AdvancePCS and will be subject to the co-pays shown in the Schedule of Benefits.

COVERED EXPENSES

Covered expenses include the following prescription drugs:

1. federal legend drugs.
2. state restricted drugs.
3. compound medications that are FDA approved.

IDENTIFICATION CARDS

AdvancePCS will be providing you and your eligible dependents with identification cards. You may use your prescription drug card to receive prescriptions at any pharmacy in the AdvancePCS National Network.

The AdvancePCS logo will normally be displayed on the pharmacy counter. If you cannot locate a participating pharmacy near your home or work, contact AdvancePCS at 800-838-5346.

If you choose to have your prescription filled at a pharmacy that is not included in the Advance PCS National Network, you will be required to pay the entire cost of the medication when you receive it. You may then submit a claim form to AdvancePCS for the provider's allowed amount for the prescription, less the co-pay. You may obtain a claim form from the Fund Office.

RETIREE BENEFIT PLAN

The Retiree Benefit Plan is available to you and your spouse if you meet the eligibility requirements explained in the **When You Retire** section (see page 8). Surviving spouses are also eligible if they meet the eligibility requirements in the **Surviving Spouses** section (see page 9).

The Retiree Benefit Plan provides medical, prescription drug and hearing aid benefits. The Death Benefit, Accidental Death and Dismemberment Benefit, Loss of Time Benefit, Dental Care Benefit and Vision Care Benefit are not provided. Upon retirement, an individual may choose either the Retiree Plan or COBRA.

BENEFITS BEFORE ELIGIBILITY FOR MEDICARE

The Retiree Benefit Plan provides the Comprehensive Major Medical Benefit under Plan 1 as shown in the Schedule of Benefits if the covered person is not eligible for Medicare. The coverage provided under the Comprehensive Major Medical Benefit is identical to the coverage provided to active employees under Plan 1 except that the lifetime maximum is $250,000 from the date of participation in the Retiree Benefit Plan.

BENEFITS AFTER ELIGIBILITY FOR MEDICARE

Once a covered person becomes eligible for Medicare, the Retiree Benefit Plan provides a Medicare Supplement Benefit for that person. The Medicare Supplement Benefit pays the deductibles and co-payments not paid by Medicare after an annual deductible.

No benefits are payable under the Medicare Supplement Benefit for:

1. In-Hospital costs after the 90th day of confinement.
2. The cost of full-time nursing services connected with home health care.
3. Personal comfort items, private nurses and private rooms in skilled nursing facilities.
4. Out-patient psychiatric care.
5. Items not covered under Medicare.
6. Charges over Medicare's "limiting charge."

Medicare's "limiting charge" is the amount, by law, that a provider can charge a Medicare eligible person. You are not required to pay any charges over the "limiting charge." The Explanation of Benefits (EOB) you receive from Medicare will provide the amount of Medicare's "limiting charge" for the care you received.

The Medicare Supplement Plan will pay benefits as if Medicare is the covered person's primary coverage, even if you or your spouse are not enrolled in Medicare Part A and Part B or do not file a claim for Medicare benefits. The Coordination With Medicare section explains how to enroll in Medicare (see page 55).

Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

COORDINATION WITH OTHER BENEFIT PLANS

This Plan has been designed to help you meet the cost of sickness or injury. Because it is not intended that greater benefits be received than the actual medical expenses incurred, the amount of benefits payable under this Plan will take into account any coverage you or your eligible dependent has under "other plans"; that is, the benefits under this Plan will be coordinated with the benefits payable to you or your dependents under "other plans."

Specifically, in a calendar year, this Plan will always pay to you either its regular benefits in full, or a reduced amount which, when added to the benefits payable to you by the other plan or plans, will equal 100% of "allowable expenses." Coordination is after the deductible.

"Allowable expenses" means any necessary, reasonable and customary expenses, incurred by you or your dependents during a calendar year and while eligible for benefits under this Plan, part or all of which would be covered under any of the "plans."

"Other plan" means any plan providing benefits or services for or by reason of medical, dental, vision care or treatment, which benefits or services are provided by group insurance or any other arrangement or coverage for individuals in a group whether on an insured or uninsured basis or automobile reparations (no-fault insurance required under any law of a government and provided through arrangements other than those under a group plan but only to the extent of benefits required under such no-fault law).

"Other plan" also includes dependents' benefits payable under this Plan when a spouse is covered both as an employee and as a dependent and when a child is covered as a dependent of more than one employee.

To determine the amount of benefits payable under this Plan and the amounts to be paid by other plans, the following order of coordination of benefits will be used:

1. A plan without coordination of benefit rules will pay benefits before a plan which contains coordination of benefit rules.

2. A plan that covers a person other than as a dependent will pay benefits before a plan which covers the person as a dependent.

3. For claims on behalf of dependent children, the plan which covers the parent whose birthday (month and day) falls first in the calendar year will pay first, and the plan of the parent whose birthday falls later in the year pays second. If the parents have the same birthday, the plan covering the parent

for the longer period of time will pay first. However the following exceptions apply for dependent children of separated or divorced parents:

a. where there is a court decree which established financial responsibility for medical expenses, the plan covering the dependent children of the parent who has the responsibility will be primary.

b. if there is no court decree, the plan which covers the parent with custody will be primary.

c. if there is no court decree and the parent with custody has remarried the order of benefits will be:

i. the plan of the parent with custody;

ii. the plan of the step-parent with custody;

iii. the plan of the parent without custody.

4. If one plan uses the gender rule and the other plan coordinates benefits by the parent's birthday, the rules of the gender plan will determine which plan pays first. If the gender plan rules, the male employee's plan pays benefits for a dependent before the female employee's plan.

In some cases, the order of payment may be unclear. Priority then goes to the plan which has covered the person for the longest continuous time.

Effective August 10, 1993, your eligibility under the Plan will not be affected in any way by the fact that you may be eligible for or provided benefits from a medical assistance plan under a state plan approved under Title 19 of the Social Security Act, or Medicaid. Furthermore, this Plan will pay benefits on your behalf if you are Medicaid eligible, only in accordance with a state plan for medical assistance approved under Title 19 of the Social Security Act as in effect August 10, 1993, including any assignment of rights you are required to give to be Medicaid eligible.

COORDINATION WITH MEDICARE

Medicare (Title XVIII of the Social Security Act, as amended) provides a program of health insurance. It is a two-part program - Parts A and B. In most cases, Part A, which primarily covers hospital benefits, is free. Medicare Part B mainly covers physicians bills. There is a monthly premium that Medicare charges each eligible individual for Part B coverage.

The Health and Welfare Plan pays benefits according to the Plan's rules and schedule of benefits for all active employees and their eligible spouses age sixty-five (65) and over. However, if you or your spouse are also eligible and enrolled for Medicare, you may also receive benefits payable under Medicare which are not be covered by the Plan. In other words, all active employees and their eligible spouses age 65 and over enrolled in Medicare, would have the protection of both this Plan and Medicare, with this Plan primary and Medicare secondary.

If, as an active employee, you do not enroll for Part B coverage within three months of becoming age sixty-five (65), and you stop working or lose eligibility for plan benefits after age sixty-five (65), 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 and Welfare Plan. If you do not enroll for Part B coverage within the seven (7) 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 July 1 thereafter. Your monthly premium will be assessed a 10% increase for each full twelve (12) months that you are not enrolled in Part B coverage. However, the months during which you were covered by the Health and Welfare Plan are not counted in determining the increase.

As you and your spouse near age sixty-five (65), you should definitely plan to enroll in Part A since there is no cost to you.

You should also give some consideration whether to enroll in Medicare Part B. If you are still working at age sixty-five (65) and do not want the additional coverage the Medicare Part B offers, be sure to enroll in Part B when you stop working in order to limit your premium penalties and to be covered as quickly as possible. Please note that a spouse who is eligible for Medicare must file an application separate from your application to become entitled to Medicare coverage.

If, while you are actively employed, you or any of your covered 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.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

This Plan will be secondary when coordinating benefits with Medicare for persons covered under the Medicare Supplement Benefit of the Retiree Benefit Plan. Benefits paid under the Medicare Supplement Benefit are described in the Retiree Benefit Plan section of this booklet (see page 51).

Medical expenses covered by this Plan will be reduced by the benefits Medicare pays or would have paid if you had applied for Medicare when eligible and paid the premium.

SUBROGATION

Subrogation of claims applies to situations where the Fund has a right to recover any benefits it is paid, or may be obligated to pay, on behalf of an eligible covered person because of the liability of another person, corporation, insurance carrier, governmental agency or any other entity or party.

EXAMPLE A

While walking across the street, John Jones is struck by an automobile driven by Mr. White. Mr. Jones submits his claim to the Mo-Kan Teamsters Health and Welfare Fund for payment and the Fund pays $1,000 in benefits for medical and hospital expenses. Mr. White or his automobile insurance company is liable for Mr. Jones' damages, including his medical and hospital bills. Mr. Jones will be contacted by the Fund and requested to complete a questionnaire. Mr. Jones will also be requested to sign a **subrogation agreement**. The Fund will request the payment of the $1,000 from Mr. White or his automobile insurance carrier. If Mr. Jones files a claim or action against Mr. White or his insurance company, the Fund may intervene or join in the action. If Mr. Jones does not file a claim or action, the Fund may file a claim or action in its own name for the amount of benefits paid. If Mr. Jones settles his claim or suit against Mr. White, the Fund will request repayment of the $1,000. Should Mr. Jones refuse to reimburse the Fund for the amount of benefits paid by the Fund, the Fund may sue Mr. Jones for the $1,000 in benefits paid, or that amount will be deducted from any future claims Mr. Jones or his dependents submit.

EXAMPLE B

While at work, John Jones is struck by a forklift driven by a co-employee. Mr. Jones submits his claim to the Mo-Kan Teamsters Health and Welfare Fund for payment, but does not inform the Fund that the claim is the result of an on-the-job accident, and the Fund pays $1,000 in benefits for medical and hospital expenses. Mr. Jones' employer and workers' compensation insurance carrier are responsible for his medical and hospital bills. Mr. Jones will be contacted by the Fund and requested to complete a questionnaire. Mr. Jones will also be requested to sign a subrogation agreement. The Fund will request the payment of the $1,000 from the employer or the employer's workers' compensation insurance carrier. If Mr. Jones does not file a claim, the Fund may file a claim in Mr. Jones name for the amount of benefits paid. If Mr. Jones settles his claim against his employer and workers' compensation insurance carrier, the Fund will request repayment of the $1,000. Should Mr. Jones refuse to reimburse the Fund for the amount of benefits paid by the Fund, the Fund may sue Mr. Jones for the $1,000 in

benefits paid, or that amount will be deducted from any future claims Mr. Jones or his dependents submit.

The Fund will contact you and request the completion of a questionnaire if it appears that your or your eligible dependent's claim may involve liability of another person, corporation, insurance carrier or governmental agency. You will be required to complete the questionnaire and return it to the Fund before any benefits are paid by the Fund. No benefits will be paid until completion of the Fund's questionnaire and subrogation agreement. The injured person or legal guardian will be required to sign a subrogation agreement.

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

The Fund's subrogation rights include, without limitation, priority to first dollar 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:

1. Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the injury;

2. From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;

3. Under uninsured or underinsured motorist insurance;

4. Under motor vehicle medical payment insurance and;

5. Under specific risk accident and health coverage or insurance, including with 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 shall execute and deliver such documents and papers (including, but not limited to a benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund as the Fund may require. The Covered Person shall do whatever else is necessary to protect the rights of the Fund, including allowing the intervention by the Trustees or Fund or the joinder of the Trustees or Fund in any claim or action against the responsible party or parties.

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

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

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

The Covered Person shall not do any act or engage in any negotiations that would reduce, compromise or prejudice the Fund's right to first recovery from any third party. In the event the Covered Person recovers any amount by settlement or judgment from any person, corporation, insurance carrier, governmental agency, or other responsible party, (1) the Fund shall be repaid in an amount equal to the full amount of benefits paid by the Fund; and (2) no

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

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

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

In an action brought by the Fund, the reasonable cost of recovery, including Fund's attorneys' fees, shall 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, shall next be deducted with the balance paid to the Covered Person.

CLAIMS AND APPEALS PROCEDURES

How to File a Claim

A Claim for benefits is a request for payment of benefits from the Fund made in accordance with the Fund's reasonable Claims procedures. A Claim must be filed within one year of the date of service. In order to file a claim for benefits, if your provider does not file a Claim with the Fund, you must submit an itemized bill to the Fund Office detailing services and charges. The Fund Office will at various times answer inquiries from participants or dependents who are eligible or who may become eligible to participate in the Fund. Inquiries may also be made by providers. While the Fund Office will try to answer questions regarding eligibility and coverage, these questions are not considered Claims. An individual must incur medical expenses before a Claim can be filed. Any answers to questions provided by the Fund Office are not legally binding. Simple inquiries about benefit provisions that are unrelated to a specific Claim will not be treated as a Claim. A telephone call will not be considered a Claim. In addition, a request for prior approval of a benefit that does not require prior approval by the Fund is not a Claim.

The following information must be provided to the Fund in order for your request for benefits to be a Claim, and for the Fund to be able to decide your Claim.

- Participant name,
- Patient name,
- Patient Date of Birth,
- Social Security Number of patient and participant,
- Date of Service,
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association),
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services),
- Billed charge,
- Number of Units (for anesthesia and certain other claims),
- Federal taxpayer identification number (TIN) of the provider,
- Billing name and address of provider, and

- If treatment is due to accident, accident details.

When you present a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a "Claim" under these procedures. However, if your request for a prescription is denied by a pharmacy, in whole or in part, you may file a Claim and appeal with the Fund regarding the denial by using these procedures.

When Claims Must Be Filed

Claims must be filed within one year after service was provided.

For the purpose of the Claims and Appeal procedures, "days" refers to calendar days, not business days.

Where To File Claims

Your claim will be considered to have been filed as soon as it is received at the Preferred Provider Organization ("PPO") Network Claims Office or at the Fund Office at the following address:

Fund Administrator

Mo-Kan Teamsters Health and

Welfare Trust Fund

3100 Broadway, Suite 805

Kansas City, Missouri 64111

Attn: Mark E. Myhrman

(816) 756-3313

Fax: (816) 756-3659

Providers should file claims directly with the PPO.

Authorized Representatives

An Authorized Representative, such as your spouse, may complete the Claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf, or if you have a court order, such as a conservatorship or guardianship, that allows someone to act on your behalf. A form can be obtained from the Health and Welfare Fund Office to designate an Authorized Representative. In the case of a Claimant under the age of 18, the parent or step-parent of the Claimant will automatically be deemed an Authorized Representative, unless the Fund receives a written, signed notice from the Claimant requesting otherwise. The Fund may request additional information to verify that this person is authorized to act on your

behalf. An assignment of payment to a health care provider is not a designation of the provider as an Authorized Representative. A duly Authorized Representative shall be able to make any decision or take any action or inaction that is available to the Claimant regarding the Claim. A duly Authorized Representative will receive any correspondence regarding the Claim or Appeal for one year, unless the Claimant notifies the Fund, in writing, of intent to revoke a designated Authorized Representative. The Claimant will not receive any correspondence regarding the Claim or Appeal if there is a valid designation of Authorized Representative in the Fund's records.

Claims for Medical Services

The following procedure applies to **Claims for Medical Services (Non-Disability Claims).**

1. Have your Physician either complete the Attending Physician's Statement section of the Claim form, submit a completed health insurance Claim form, or submit an electronic Claim that complies with the Electronic Data Interchange (EDI) Standards of the Health Insurance Portability and Accountability Act (HIPAA).

2. If your provider does not file your Claim, then you or your Authorized Representative must complete the Claim form and attach all itemized Hospital bills or doctors' statements that describe the services rendered.

Please be sure that you have submitted all itemized bills. By doing so, you will speed the processing of your Claim. If the Claim is delayed, delays in payment will result.

Ordinarily, you will be notified of the decision on your **Non-Disability Claim** within *30 days* of the Fund's receipt of the Claim. This period may be extended one time by the Fund for up to *15 days* if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed and your time period for providing the information. You will have *45 days* from receipt of the notification to supply the additional information. **If the information is not provided within that time, your Claim will be denied.** During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice for either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has the balance of

the original *30 days* to make a decision on a **Non-Disability Claim** and notify you of the determination. If the Fund has applied the 15-day extension, then the Fund has this additional 15 days to determine the **Non-Disability Claim.**

Disability Claims

A **Disability Claim** is a claim for weekly accident and sickness benefits.

For **Disability Claims**, the Fund will make a decision on the Claim and notify you of the decision within 45 days of the Fund's receipt of the Claim. If the Fund requires an extension of time due to matters beyond the control of the Fund, it may extend the decision period by 30 days. The Fund will notify you of the reason for the delay and when the Fund expects to render a decision. This notification will occur before the expiration of the 45-day period. The period for making a decision may be delayed an additional *30 days*, provided the Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed and the time period for providing the information. In that case you will have *45 days* from receipt of the notification to supply the additional information. **If the information is not provided within that time, your claim will be denied.** During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice for either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has the balance of the original 45 days to make a decision on the **Disability Claim** and notify you of the determination. If the Fund has applied either of the 30-day extensions, then the Fund has the additional time to determine the **Disability Claim.**

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

Notice of Decision

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

- The specific reason(s) for the determination;
- Reference to the specific benefit provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your Claim, you will receive a statement that a copy of the rule, guideline, or protocol is available, upon request, at no charge;
- If the determination was based on medical judgment (the absence of medical necessity or because the treatment was experimental or investigational), or other similar exclusion, you will receive a statement that an explanation of the medical judgment, applying the terms of the Fund to your Claim, is available upon request at no charge;
- If your Claim was denied, in whole or in part, you or your Authorized Representative may appeal (request a review of the decision) within 180 days following receipt of the notice of denial.

REQUEST FOR APPEAL OF DENIED CLAIM

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

Claims Appeal Process

The Appeal process works as follows:

You have the right to review and copy documents relevant to your Claim on request, and free of charge. A document, record or other information is relevant if it was relied upon by the Fund in making the decision; it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

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

The Board of Trustees or the Claims Appeal Committee designated by the Board of Trustees will review your Claim. The Claims Appeal Committee will hold regularly scheduled meetings each calendar quarter. The Claims Appeal Committee will not give deference to the initial Adverse Benefit Determination. The decision will not be made by the same people who made the initial benefit denial, or the subordinate of those people. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The person consulted will not be the same person consulted in the initial denial, or the subordinate of that person.

Timing of Notice of Decision on Appeal

Ordinarily, decisions on appeals involving Claims will be made at the next regularly scheduled meeting of the Board of Trustees or the Claims Appeal Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, such as if you request a hearing, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised, in writing, in advance, if this extension will be necessary. Once a decision on review of your Claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Hearing Procedures

For an explanation of the Fund's Hearing Procedures, please contact the Fund Office.

Notice of Decision on Review

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

- The specific reason(s) for the determination;
- Reference to the specific benefit provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your Claim, upon request, and free of charge, and
- A statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review;
- If an internal rule, guideline or protocol was relied upon by the Fund, you will receive a statement that a copy of the rule is available, upon request, at no charge, and
- If the determination was based on medical judgment (medical necessity), experimental, investigational, or other similar decision, you will receive an explanation of the scientific or clinical judgment for the denial, upon request, at no charge.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested an Appeal and a final decision has been reached on review, or until the Fund has failed to follow the reasonable Claims and Appeal Procedures.

IMPORTANT INFORMATION ABOUT THE HEALTH AND WELFARE FUND

1. **NAME OF PLAN.** This Plan is known as the Mo-Kan Teamsters Health and Welfare Fund.

2. **BOARD OF TRUSTEES.** A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of employer and union representatives. If you wish to contact the Board of Trustees, you may use the address and phone number on the inside front cover. The Trustees of this Plan as of January 1, 2003 are shown on the inside front cover of this booklet.

3. **PLAN SPONSOR AND ADMINISTRATOR.** The Board of Trustees is both Plan Sponsor and Plan Administrator. The Board of Trustees has delegated daily administrative responsibilities to a contract administrator, currently Wilson-McShane Corporation., 3100 Broadway, Suite 805, Kansas City, Missouri 64111.

4. **IDENTIFICATION NUMBERS.** When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to identify the Mo-Kan Teamsters Health and Welfare Fund:

   Employer Identification Number (EIN) assigned by the Internal Revenue Service is: 43-6124888.

   Plan Number is: 501

5. **AGENT FOR SERVICE OF LEGAL PROCESS.** Michael Arnold, Esq. is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Fund arise, any legal documents should be served upon Mr. Arnold of Arnold, Newbold, Winter, Jackson & Jacoby, P.C. at 1125 Grand Boulevard, Suite 1600, Kansas City, Missouri 64106 or upon any Trustee at the Fund Office, 3100 Broadway, Suite 805, Kansas City, Missouri 64111.

6. **SOURCE OF CONTRIBUTIONS.** The benefits described in this booklet are provided through employer contributions. Contributions to the Plan are made by employers in accordance with their collective bargaining agreements with Local Union No. 541 or participating unions of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers. All agreements must be approved and accepted by the Trustees.

   The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on

behalf of Participants working under the collective bargaining agreements.

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

7. **TYPE OF PLAN.** The Plan is maintained for the purpose of providing loss of time and medical benefits in the event of sickness, or accident and benefits in the event of death. The Plan benefits are shown in the Schedules of Benefits on pages 1 and 6 of this booklet.

All benefits are provided on a self-insured basis directly from the Fund's assets.

8. **TRUST FUND.** All assets are held in trust by the Board of Trustees for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

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

10. **CLAIM PROCEDURE.** The procedures to follow for filing a claim for benefits are set forth on pages 61 and 67 of this booklet. If all or any part of your claim is denied, you have the right to request that the Board of Trustees review the matter and that the matter be submitted to a hearing. The details of these procedures are outlined on pages 61 and 67 of this booklet.

11. **PLAN YEAR.** The Plan year and the fiscal year for your Fund are the same and begin on January 1 of each year. Each twelve (12) month period commencing on January 1 consists of an entire Plan year and fiscal year for the purposes of accounting, as well as the filing of all reports required by the U.S. Department of Labor, the Internal Revenue Service and other regulatory bodies.

12. **EVENTS UPON PLAN TERMINATION.** While the Trustees intend to maintain the Plan indefinitely, they reserve the right to terminate the Plan at any time. In the event of the termination of this Plan, the Trustees shall apply the Fund to pay or provide for the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purpose of the Fund.

No part of the assets or income of the Fund shall be used or diverted to purposes other than the exclusive benefit of the eligible employees,

their families, beneficiaries or dependents, or for the administrative expenses or other expenses or covered benefits under the Fund.

THE TRUSTEES HAVE SOLE AUTHORITY AND DISCRETION TO INTERPRET THE PLAN'S PROVISIONS.

NO EMPLOYER, EMPLOYER ASSOCIATION OR UNION, NOR ANY REPRESENTATIVE OF ANY EMPLOYER OR UNION, IS AUTHORIZED TO INTERPRET THIS PLAN ON BEHALF OF THE BOARD NOR CAN AN INDIVIDUAL TRUSTEE, AN EMPLOYER OR THE UNION ACT AS AN AGENT OF THE BOARD OF TRUSTEES.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Mo-Kan Teamsters Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

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

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

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

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

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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $200 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, after you have filed an administrative appeal in accordance with the Plan, you may file suit in the State or 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. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

In order that the Trustees may carry out their obligation to maintain within the limits of the funds available to them a sound and economical program dedicated to providing the maximum benefits for eligible Employees

and their families, the Trustees expressly reserve the right in their sole discretion and without notice to Employees, Employers, the Union or others affected thereby, but upon a non-discriminatory basis to:

1. Terminate or to amend either the amount or conditions with respect to any benefit; and
2. Alter the method or payment of any benefits; and
3. Amend any other provisions of the Health and Welfare Plan; and
4. Interpret the provisions of the Health and Welfare Plan.