Mo–Kan Teamsters
Health and Welfare Fund

Summary Plan Description/Plan Document

2019 Edition

Draft: Prepared by Segal Consulting
October 2018

Important Contact Information

The Plan is sponsored and administered by the Board of Trustees. However, the Trustees have delegated administrative responsibilities to other individuals or organizations. The chart that follows shows the contact information for the various organizations that provide services under the Fund.

Organization	Responsibility	Contact Information
Fund Office	■ Maintains eligibility records ■ Maintains accounts for Employer and Self-Payment contributions ■ Administers Medical, Dental, Vision, Hospice, Hearing Aid, Loss of Time, Death, and AD&D Benefit claims ■ Answers general inquiries ■ Updates personal information	Phone: 816-756-3313 Fax: 816-756-3659 *Send claims to:* Fund Administrator Mo-Kan Teamsters Health and Welfare Fund 3100 Broadway, Suite 805 Kansas City, MO 64111 Attention: Mark E. Myhrman
Blue Cross and Blue Shield of Kansas City	■ Provides access to *Preferred-Care Blue* PPO network providers for medical care in the Kansas City Metro area ■ Provides access to the nationwide *Blue Card* PPO network providers for medical care outside of the Kansas City Metro area ■ Provides access to transplant providers ■ Provides access to "*Blue Dental Choice / GRID+*" PPO dental network	800-340-0109 www.bluekc.com
OptumRx	■ Provides access to network pharmacies ■ Administers retail and mail order prescription drug programs ■ Administers Medicare prescription drug program	www.optumrx.com

Table of Contents

INTRODUCTION

The Mo-Kan Teamsters Health and Welfare Fund provides coverage to you and your eligible Dependents. The Plan is periodically reviewed to ensure that benefits are being provided to meet your needs while still maintaining a financially stable Fund.

The Health and Welfare Fund offers:

- Medical Benefits (Plan 1 and Plan 2);
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Hospice Benefits;
- Hearing Aid Benefits;
- Loss of Time Benefits (for Employees only);
- Death Benefits; and
- Accidental Death and Dismemberment (AD&D) Benefits.

Benefits described in this booklet are available to eligible active members, Retirees, and Dependents (see page __ for more information about eligibility). Please note that you must enroll Dependents for them to be covered.

This booklet is intended to give you an understanding of the benefits provided by the Health and Welfare Fund as of January 1, 2019.

Information in this booklet is organized in a way that will be useful to you. The booklet includes the following sections:

- A listing of **important contact information** (on the inside front cover), so when you need to contact someone, you will know where to look for the phone number, address, or website.
- **Schedules of benefits,** which give you a brief overview of all the benefits available through the Fund for active Employees and Retirees.
- An **eligibility** section that tells you how you become eligible for benefits, who in your family is eligible for coverage, what you need to do to continue to be eligible, when coverage under the Plan ends, and what you need to do to reinstate your eligibility.
- A **life events** section designed to show you how your benefits are affected by the different events that can occur in your life and how your benefits work, including information about what you need to do when those events occur.
- Several sections that provide **detailed information** about each of the different types of coverage provided through the Fund, as well as what is not covered under the Plan.
- **Claim filing** information, including what you need to do if a claim is denied.
- An **administrative information** section that includes general Plan information and your rights as a Participant in the Plan.
- A **glossary** that defines important terms used throughout this booklet.

If you are not familiar with the terms used in this booklet, please check the glossary at the back. **Terms defined in the glossary are capitalized throughout the booklet.**

We urge you to read this information and, if you are married, share it with your spouse. In addition, we recommend that you keep this booklet with your important papers so you can refer to it and update it when needed. Contact the Fund Office at 816-756-3313 if you have any questions about the benefits described in this booklet.

THE PLAN'S "GRANDFATHERED" STATUS

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

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

This Summary Plan Description (SPD)/Plan Document describes the Mo-Kan Teamsters Health and Welfare Fund benefits for eligible Participants as of January 1, 2019. The Board of Trustees determines the benefits provided in accordance with all Plan provisions. Benefits provided to different classes of Participants may vary. In addition, any required self-payment amount may vary depending on the benefits provided and other factors. The Trustees reserve the right, by written amendment to this SPD/Plan Document, to change, add, or delete benefits, self-payment amounts, eligibility rules, or any other provisions relating to the operation of the Fund. The Trustees also reserve the exclusive right to interpret coverage and benefit provisions of the Fund. This SPD/Plan Document replaces and supersedes any prior SPD and/or Plan Document. If the Plan is amended or modified, you will receive written notice of such change.

SCHEDULE OF BENEFITS

The following chart highlights key features of the Plan. These benefits are described in detail throughout this booklet. Deductible and coinsurance amounts shown under Plan 1 or Plan 2 apply unless otherwise noted.

You are eligible for Plan 1 or Plan 2 based on the hourly contribution rate paid by your Employer on your behalf. To determine which plan you are eligible for, contact the Fund Office.

ACTIVE PLAN

Medical Benefits	Plan 1	Plan 2
Calendar Year Deductible	$320 per person; $640 family maximum	$510 per person; $1,020 family maximum
Coinsurance (unless noted otherwise) PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%	After deductible (when applicable), Plan pays: 75% 60%
Calendar Year Out-of-Pocket Maximum PPO Non-PPO	 $2,890 per person $5,780 per person (The out-of-pocket maximum does not include amounts paid toward meeting the deductible)	 $4,820 per person $7,700 per person (The out-of-pocket maximum does not include amounts paid toward meeting the deductible)
Mental and Nervous Disorders Treatment PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%	After deductible (when applicable), Plan pays: 75% 60%
Chemical Dependency Treatment PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%	After deductible (when applicable), Plan pays: 75% 60%
Psychological Testing Maximum	$300	
Adult Restorative Speech Therapy Maximum	20 visits per calendar year	
Physical/Occupational Therapy Maximum	No maximum	
Speech Therapy for Childhood Developmental Speech Delays	20 visits per calendar year	
Ambulance Maximum	No maximum or limits	
Chiropractic Treatment Maximum Office visits	 Five visits per calendar year (includes x-rays)	
Corrective Appliances (prosthetic and orthotic devices, other than dental)	No maximum	
Durable Medical Equipment Maximum	One device per limb in any three consecutive calendar years	
Assistant Surgeon	Plan pays 20% of PPO allowance or the Reasonable and Customary Charges for the surgical procedure	
Certified Surgical/Physician Assistant	Plan pays 10% of PPO allowance or the Reasonable and Customary Charges	
Physical Exams	One exam every year Plan pays 100%, up to $350 per exam, subject to any PPO discounts	
Well Child Benefit Maximum	$500 per Child through age 18 (no deductible or coinsurance)	

Adult Vaccine Benefit & Immunizations and Vaccines for Children	
PPO	100% (no deductible or coinsurance), including flu shots
Non-PPO	100% (no deductible or coinsurance) for flu shots; 100% after deductible (up to $100), for vaccines
Transplant Benefits – Centers of Excellence Program	
Deductible	None
Annual Transplant Maximum	No maximum
Coinsurance	After deductible, Plan pays 100%
Organ Procurement Maximum	No maximum
Travel and Lodging Maximum	None
Prescription Drug Benefits	**Active and Non-Medicare-Eligible Participants Only**
Retail Pharmacy Program Generic Medication Brand Name Medication	For up to the greater of a 34-day supply or 100-unit dose, you pay: 20% coinsurance per prescription 20% coinsurance per prescription
Mail Order Program Generic Medication Brand Name Medication	For up to a 90-day supply, you pay: 20% coinsurance per prescription 20% coinsurance per prescription
Dental Benefits	**Active and Non-Medicare-Eligible Participants Only**
Calendar Year Maximum Dependent Children under age 19 All others	 No maximum $1,750 per person
Calendar Year Deductible (waived for preventive services)	$25 per person
Coinsurance Type A Expense Type B Expense Type C Expense	After deductible, Plan pays: 80% 60% 50%
Orthodontia – Type D Expense	No deductible, Plan pays 50% up to $1,500 lifetime maximum
Vision Benefits	Active Plan Participants Only
Exam, Lenses, Frames, and Contact Lenses Dependent Children under age 19 All others	 One exam; one pair of eyeglasses or contacts per year Plan pays 100% of Covered Charges up to $250 maximum during two consecutive calendar years
Hospice Benefit	**Active and Retired Plan Participants**
Maximum	Six month benefit in three-year period (no deductible)
Hearing Aid Benefit	~~Active and Retired Plan Participants~~
Exam and Hearing Aid	No deductible, Plan pays 100% of Covered Charges

Loss of Time Benefit	Employee Only
Weekly Benefit	$250
Benefit Payable	13 weeks per occurrence
When Benefits Begin	
Injury/Hospital Confinement	First day
Illness	Eighth day
Death Benefit	**Employee Only**
Employee	$15,000
Spouse	$2,000
AD&D Benefit	**Employee Only**
Employee – Full Amount	$7,500

Retiree Benefit Plan

Medical Benefits	Non-Medicare-Eligible Retired Participants
Calendar Year Deductible	$320 per person; $640 family maximum
Coinsurance (unless noted otherwise) PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%
Calendar Year Out-of-Pocket Maximum PPO Non-PPO	 $2,890 per person $5,780 per person (The out-of-pocket maximum does not include amounts paid toward meeting the deductible)
Mental and Nervous Disorders Treatment PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%
Chemical Dependency Treatment PPO Non-PPO	After deductible (when applicable), Plan pays: 85% 70%
Psychological Testing Maximum	$300
Physical Exams	One exam every year Plan pays 100%, up to $350 per exam, subject to any PPO discounts
Adult Restorative Speech Therapy Maximum	20 visits per calendar year
Physical/Occupational Therapy	No maximum
Speech Therapy for Childhood Developmental Speech Delays	No maximum
Ambulance	No maximum or limits
Chiropractic Treatment Maximum Office visits	 Five visits per calendar year (includes x-rays)
Corrective Appliances (prosthetic and orthotic devices, other than dental)	No maximum
Durable Medical Equipment Maximum	One device per limb in any three consecutive calendar years
Assistant Surgeon	Plan pays 20% of PPO allowance or the Reasonable and Customary Charges for the surgical procedure
Certified Surgical/Physician Assistant	Plan pays 10% of PPO allowance or the Reasonable and Customary Charges
Adult Vaccine Benefit & Immunizations and Vaccines for Children PPO Non-PPO	 100% (no deductible or coinsurance), including flu shots 100%, up to $100; except Plan pays 100% of flu shots (no maximum)
Transplant Benefits	**Non-Medicare-Eligible Retired Participants**
Deductible	None
Annual Transplant Maximum	No maximum
Coinsurance	After deductible, Plan pays 100%
Organ Procurement Maximum	No maximum
Travel and Lodging Maximum	None

Medicare Supplement Benefits	Medicare-Eligible Retired Participants
Calendar Year Deductible	$250 per person; $500 family maximum
Benefits	Plan pays Medicare deductibles and copayments not paid by Medicare Part A and Part B. This Plan is secondary to Medicare.
Prescription Drug Benefits	**Medicare-Eligible Retired Participants**
Calendar Year Out-of-Pocket Maximum	$5,000
Retail Pharmacy Program Generic Medication Brand Name Medication	For up to the greater of a 34-day supply or 100-unit dose, you pay: 20% coinsurance per prescription 20% coinsurance per prescription Once $5,000 out-of-pocket maximum is reached, copays will be: Generic/preferred multi-source medications: $3.35 All others: $8.35
Mail Order Program Generic Medication Brand Name Medication	For up to a 90-day supply, you pay: 20% coinsurance per prescription 20% coinsurance per prescription Once $5,000 out-of-pocket maximum is reached, copays will be: Generic/preferred multi-source medications: $3.35 All others: $8.35
Specialty Medication	20% coinsurance per prescription
Hospice Benefit	**Medicare- and Non-Medicare-Eligible Retired Participants**
Maximum	Six month benefit in three-year period (no deductible)
Hearing Aid Benefits	**Medicare- and Non-Medicare-Eligible Retired Participants**
Exam and Hearing Aid	No deductible, Plan pays 100% of Covered Charges

ACTIVE PLAN ELIGIBILITY

This section describes eligibility provisions for active Employees; refer to page __ for information about Retired Employee 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 fewer consecutive calendar months.

To be Eligible in:	**The Fund must receive at least 250 hours of contributions 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

Example: *Joe started working for a Contributing Employer in January. During the months of January and February, he accumulated at least 250 hours of contributions. Joe will be covered under the Plan on April 1.*

The Plan complies with federal rules governing special enrollment, as described on page __.

DEPENDENT ELIGIBILITY

Generally, your Dependents are eligible for coverage on the date you become eligible—or, if later, on the date you acquire a Dependent, provided:

- You enroll your Dependent;
- Your Dependent's enrollment is approved.

If your Dependent spouse or Child is eligible for benefits as an Employee under this Plan, he or she cannot be covered as your Dependent under the Plan.

To be eligible for coverage, your Dependents must meet the Plan's definition of Dependent (see page __). When 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 the Participant named in the Order is eligible for benefits during such dates.

Special Enrollment

If you do not enroll yourself or your Dependents when initially eligible, you may be able to enroll later if you experience a special enrollment event.

To request a special enrollment or for more information, contact the Fund Office.

If you are declining enrollment for (or do not enroll) yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops Contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). You must complete an enrollment card to enroll in this Plan. Coverage will become affective **[Question: When will coverage begin?]**. If you do not request enrollment within 30 days, you will have to wait until the next open enrollment period.

If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your Dependent. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. You will be required to complete an enrollment card and provide appropriate documentation as requested. If your request is timely made, coverage will become effective as of the date you acquired a Dependent. If you do not notify the Plan Administrator within 30 days of the date of your marriage, or the birth, adoption, or placement of adoption of your child, then enrollment will be denied and you will have to wait until the next open enrollment period to enroll your new dependent(s).

You may enroll yourself or your Dependent if you or your Dependent had coverage under Medicaid or the State Children's Health Insurance Program (CHIP) and later lose eligibility for such coverage. You may also enroll in this Plan if you or your Dependent become eligible for financial assistance through Medicaid or CHIP for coverage under the Plan. You or your Dependent must request enrollment within 60 days after losing eligibility or becoming eligible for financial assistance under Medicaid or the CHIP program. Coverage will become effective **[Question: When will coverage begin?]**.

Continued Eligibility

Your work months provide eligibility for coverage in the corresponding benefits month. The benefits month is separated from the work months by a lag month.

Generally, once you are initially eligible, coverage continues on a month-to-month basis. To continue your eligibility and coverage, your Employer must contribute to the Plan on your behalf. To allow the Fund time to receive Employer contributions, the Plan uses a lag month process for continuing eligibility. This means the Plan looks at:

- ***Work months:*** The period during which contributions are required on your behalf.
- ***Lag month:*** The month that the Plan actually receives the required contributions on your behalf.
- ***Benefits month:*** The month in which you are eligible for coverage.

The following chart illustrates the Plan's continuing eligibility provisions. You must meet one of the following requirements for hours contributed to the Fund on your behalf for your eligibility to continue:

If you have at least this many hours contributed on your behalf by your Employer:	During this many consecutive months before the lag month:	Then:
250 hours	3 months	You will be eligible for coverage for the benefits month after the lag month.
500 hours	6 months	
1,000 hours	12 months	

Example

Luke has 250 hours of contributions made on his behalf by his Employer for July, August and September (work months). The Fund receives the contributions in October (lag month) for coverage in November (benefits month).

There is no break in coverage during lag months, provided you continue to meet the Fund's eligibility requirements.

When Eligibility Ends

For You

In general, coverage ends on the last day of the benefit month that corresponds to the last work month for which contributions are made on your behalf.

Your eligibility, and therefore your coverage, will end on the last day of the benefit month that corresponds to the last work months for which Employer contributions are made on your behalf. In addition, your eligibility will end on the day:

- You work for an Employer whose contractual obligation to contribute to the Fund has terminated;
- The Fund ends; or
- You enter the armed forces, subject to USERRA, as described on page __.

For Your Dependents

Your Dependents' eligibility ends on the earliest of:

- The date your spouse or Child no longer meets the Plan's definition of Dependent;
- The date your coverage ends;
- The date your spouse or Child enters the armed forces on full-time active duty; or
- The date the Plan ends.

In the event of your death, your surviving spouse may be eligible for Surviving Spouse benefits under the Retiree Benefit Plan. See page __ for eligibility details.

Your spouse may terminate eligibility for coverage under the Plan provided it is for the sole purpose of enrolling in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) maintained by his or her Employer. You and your spouse must provide the Plan with a written request to terminate your spouse's eligibility due to your spouse's intent to enroll in an HDHP. Your spouse may resume Plan eligibility if he or she provides the Plan with a written request to resume eligibility, is a Dependent under the Plan, and provides written substantiation that he or she is no longer covered under the HSA.

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 Plan's initial eligibility requirements to reinstate eligibility.

Changes in Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the Plan's eligibility rules or the benefits provided under the Plan, at any time. The Trustees also establish contribution rates and Self-Payment rules and reserve the right to change them at any time.

RETIREE BENEFIT PLAN ELIGIBILITY

At retirement, you may be eligible to continue coverage as a Retiree for yourself and your spouse. You may elect coverage under the Retiree Benefit Plan or COBRA, but not both. Your Dependent Children may continue coverage under **COBRA Continuation Coverage** as described beginning on page __.

It is a good idea to contact the Fund Office as you prepare for retirement. The Fund Office will guide you through the retirement process and answer any questions you may have about benefits.

RETIREE COVERAGE

The Retiree Benefit Plan provides Medical, Prescription Drug, Transplant, Hospice, and Hearing Aid Benefits until you are eligible for Medicare. After you or your spouse become eligible for Medicare, prescription drug benefits are provided through a self-funded Employer Group Waiver Plan (EGWP). Retiree coverage does not include Dental, Vision, Loss of Time, Death, or AD&D Benefits.

INITIAL ELIGIBILITY

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

- Eligible for Mo-Kan Teamsters Health and Welfare Plan benefits at the time of your retirement or eligible under another plan at the time of your retirement (based on your employment with a Union that participates with the Plan); or
- Receiving a pension from the Mo-Kan Teamsters Pension Plan, in accordance with the following requirements;
  - you must have continued to work for a Contributing Employer until you reached age 50 or, if later, the age at retirement, unless your termination of work in such employment was the result of total and permanent disability. You must not be working in any employment that makes you eligible for group health insurance coverage;
  - you must sign an authorization form at least 15 days before pension payments begin, which instructs the Pension Plan Trustees to deduct the required amount each month from your monthly pension payments to be remitted to the Health and Welfare Plan; and
  - if you elect coverage and have payments deducted from your pension, you may subsequently terminate the coverage. However, you may not then reinstate the benefits unless the termination is caused by a return to Covered Employment and you became eligible for active employee benefits.

If you are not receiving a pension from the Mo-Kan Teamsters Pension Plan and you were not eligible for Health and Welfare Plan benefits at the time of your retirement, in order to be eligible for Retiree benefits, the following applies:

- If you retired before reaching age 65, you must have had 20 years of 1,000 hours of contributions made to the Health and Welfare Plan; and
- If you retired on or after age 65, you must have 10 years of 1,000 hours of contributions to the Health and Welfare Plan.

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

Special Enrollment

If you are a Retiree participating in the Plan and you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your Dependent. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage will begin as described on page __.

To request a Special Enrollment or for more information, contact the Fund Office.

Dependent Eligibility

Generally, your spouse becomes eligible for Retiree coverage on the date you become eligible, or if later, on the date you marry your spouse. Your Dependent Children are not eligible for coverage under the Retiree Benefit Plan, but may be eligible to continue under COBRA Continuation Coverage when you retire.

Paying for Retiree Coverage

When you retire, if you are eligible and elect Retiree coverage (instead of COBRA Continuation Coverage), you must make the required monthly contributions for this coverage.

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.

The Trustees, based on the cost of providing coverage, establish the Retiree coverage rate. The Trustees reserve the right to change the amount of the monthly contribution at any time.

Continued Eligibility

Once you are eligible for Retiree coverage, your coverage will continue as long as the required monthly contributions are made by the due date.

If the required contribution for Retiree coverage is not made within 30 days of the due date, Retiree coverage will end for you and your spouse.

When Eligibility Ends

For You

Your eligibility ends on the earliest of the following dates:

- The date of your death;
- The date any required contribution is due and unpaid; or
- The date the Fund ends.

For Your Spouse

Your spouse's eligibility ends on the earliest of the following dates:

- The date your spouse no longer meets the Plan's definition of Dependent;
- The date any required contribution is due and unpaid;

- The date the Plan ends; or
- The date of your death.

When your spouse's coverage ends, he or she may have the right to elect COBRA Continuation Coverage as described on page __.

Reinstatement of Eligibility

Once your eligibility and coverage end under the Retiree Benefit Plan, you cannot be reinstated unless your termination was caused by your return to Covered Employment and you again became eligible for active Employee benefits.

Surviving Spouse

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

- You are working in Covered Employment when you die;
- You have at least 10 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);
- For those under the age of 65 (pre-Medicare), you must have at least 20 pension credits under the Mo-Kan Teamsters Pension Fund (excluding pension credits earned before a permanent break in service);
- Your spouse is at least age fifty (50); and
- Your spouse is eligible to receive the Joint and Survivor Benefit under the Mo-Kan Teamsters Pension Plan.

Your surviving Dependent Children may continue coverage under the COBRA Continuation Coverage described beginning on page __.

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 a surviving spouse who is not eligible for Medicare with coverage under the Medical, Prescription Drug, Transplant, Hospice, and Hearing Aid Benefits. Once your surviving spouse becomes eligible for Medicare, coverage will be provided under the Medicare Supplement Benefit.

Medicare Supplement Benefit

Retired Employees and/or their eligible spouses who are eligible for Medicare are eligible for the Medicare Supplement Benefit. Benefits are paid as if Medicare is the primary coverage, even if the person did not enroll for Medicare or did not submit a claim for benefits under Medicare.

The Medicare Supplement pays the deductibles and copayments not paid by Medicare, and covers benefits in accordance with that shown in the *Schedule of Benefits*.

Exclusions and Limitations

No benefits are paid under the Medicare Supplement Benefit for:

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

LIFE EVENTS

At some point in your life, you will probably experience a life event that affects your welfare benefits. It is important that you understand what you or your Dependents need to do when you experience a change in family status.

NOTIFY THE FUND OFFICE

Notify the Fund Office of any change in your family status.

You can help avoid delays in payment of benefits by notifying the Fund Office:

- Of new Dependents; or
- When a Dependent is no longer eligible for coverage (you may want to continue his or her coverage through COBRA).

When you experience a change in family status, you should contact the Fund Office within 30 days of the event to provide any required information. It is important that you provide any requested information to the Fund Office because it helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep your updated marital status, Dependent information, and information about whether you or your Dependents have other benefits coverage. This information helps in processing your claims quickly and accurately.

You should also contact the Fund Office to update your:

- Beneficiary information, if you experience a change in family status; or
- Address, if you move.

ADDING A DEPENDENT

You will need to contact the Fund Office to enroll your Dependents, and you must pay the required payment for their coverage. Adding a Dependent could result from any of the following:

- Having a baby;
- Adopting a Child or having a Child placed with you for adoption; and
- Getting married.

Coverage will begin as described on page __.

IF YOUR DEPENDENT LOSES ELIGIBILITY FOR COVERAGE

If your Dependent loses eligibility for coverage because of a loss of Dependent status under the Plan, and wants to continue coverage under COBRA, you must contact the Fund Office within 60 days from the date your Dependent loses eligibility. See page __ for more information about COBRA Continuation Coverage.

IN THE EVENT OF DIVORCE OR LEGAL SEPARATION

In the event of a divorce or legal separation, if your ex-spouse was covered under the Plan and wants to continue coverage under COBRA, you or your ex-spouse must contact the Fund Office within 60 days from the date of the divorce or legal separation to request COBRA information from the Fund Office. See page __for more information about COBRA Continuation Coverage.

Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order that requires you to provide medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. This Plan provides benefits according to the extent required by a QMCSO, the Plan's terms, and by federal law. The Plan Administrator will notify you and any alternate recipients affected if a QMCSO is received.

The Plan Administrator also has the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA and related regulations, constitutes a QMCSO.

You or your beneficiary may request a free copy of the Fund's QMCSO procedures from the Plan Administrator.

IF YOU TAKE LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks (or 26 weeks, if applicable) of unpaid leave during any 12-month period due to the:

- Birth, adoption, or placement with you for adoption of a Child;
- Care of a seriously ill spouse, parent, or Child;
- Your serious Illness; or
- A qualifying exigency, or urgent need for leave because your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent, or next of kin;
- Undergoing medical treatment, recuperation, or therapy for a serious Illness or Injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

Your Employer will be asked to complete some forms to verify your eligibility for benefits while you are on leave. During your leave, you will maintain all the coverage offered under the Plan. You will remain eligible until the end of the leave, provided your Contributing Employer properly grants the leave and makes the required notification and payment to the Fund. Your Employer must pay the cost of coverage in an amount determined by the Fund for each week you are on FMLA leave.

Your eligibility for FMLA leave and benefits will be determined by your Contributing Employer. You are eligible for a leave under FMLA if you:

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

The Fund will maintain your prior eligibility status until the end of the leave, provided your Contributing Employer properly grants the leave under federal law and the Employer makes the required notification and payment to the Fund.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during FMLA leave on the same basis as other similarly situated Employees.

Call your Employer to determine if you are eligible for FMLA leave. During your leave, you will maintain all the coverage offered through the Fund, provided your Employer makes the required contribution to the Fund.

If You Enter Active Military Service

If you are on active duty in the military for 31 days or less, you will continue to receive health care coverage for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on duty in the military for more than 31 days, your coverage under this Plan will normally end. However, USERRA permits you to continue medical and prescription drug coverage for you and your Dependents at your own expense for up to 24 months. Your Dependent(s) may be eligible for military health care coverage under TRICARE.

Coverage under this Fund will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

If you receive an honorable discharge, the eligibility that you had remaining before entering military service will be reinstated on the day you return to work with a Contributing Employer, if you report back to work or return to employment:

- Within 90 days from the date of discharge if your service lasted more than 180 days;
- Within 14 days from the date of discharge if your service lasted 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if your service lasted less than 31 days.

If you are hospitalized or convalescing from an Injury caused by active duty, these time limits can be extended for up to two years.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave affects your benefits, please contact the Fund Office.

Your USERRA coverage may be terminated if:

- You do not pay any required Self-Payment;
- You exhaust the 24-month coverage period;
- The Plan ceases to provide group health coverage;

If you are called to active duty, you should:

- Notify your Employer and the Fund Office that you want to elect COBRA Continuation Coverage for yourself and/or your family under the provisions of USERRA; and
- Make any required Self-Payments to the Fund Office to continue your coverage.

Reemployment

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

- You lose your rights under USERRA (for instance, for a dishonorable discharge); or
- You fail to return to work or apply for reemployment within the time required under USERRA.

In the Event You Become Disabled

If you are an Employee covered under the Active Plan, become disabled, and begin receiving Workers' Compensation benefits, you and your Dependents are eligible to continue coverage if your Employer is required, under the collective bargaining agreement, to contribute to the Fund during your disability. You may also qualify for coverage under the Retiree Benefit Plan. See Retiree eligibility, as described on page __.

In the Event of Your Spouse's Death

Contact the Fund Office to notify them of your spouse's death. The Fund Office will provide you with information on how to apply for the Spousal Death Benefit.

In the Event of Your Death

In the event of your death, your surviving Dependents should contact the Fund Office for information on how to apply for the Death Benefit, and if they would like to continue coverage by electing COBRA Continuation Coverage.

COBRA CONTINUATION COVERAGE

You and your family members may continue medical and prescription drug benefits if your coverage ends due to a qualifying event, as described below. For example, your Children are eligible to continue coverage under COBRA when they no longer satisfy the Plan's definition of Dependent due to age.

If you have questions about COBRA Continuation Coverage, contact the Fund Office. To maintain your COBRA Continuation Coverage, you must make monthly payments to the Fund Office on time.

QUALIFYING EVENTS

You and/or your covered Dependents may be eligible to continue your coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 if your coverage under the Plan ends due to a qualifying event.

By making monthly payments, you and/or your Dependents may continue the same medical and prescription drug coverage that was available to you before termination of your coverage.

If you (as the Employee) and/or your Dependent(s) lose coverage, you may continue coverage under COBRA for up to 18, 29, or 36 months, depending on the qualifying event, as shown below:

Qualifying Event	Who is Eligible	Maximum Coverage Period
Your termination or reduction in hours of employment (including retirement), unless due to gross misconduct	You, spouse, and/or Dependent Children	18 months
Your termination or reduction in hours and during your continuation period, you or your Dependent is disabled and entitled to Social Security Disability benefits	You, spouse, and/or Dependent Children	29 months
Your enrollment in Medicare; and you voluntarily drop Plan coverage	Spouse and/or Dependent Children	36 months
Your death	Spouse and/or Dependent Children	36 months
Your divorce or legal separation	Spouse and/or Dependent Children	36 months
Your Child is no longer a Dependent as defined by the Plan	Dependent Child	36 months

See page __ for information on COBRA Continuation Coverage provisions in the event of a second qualifying event occurring while covered under COBRA Continuation Coverage.

QUALIFIED BENEFICIARIES

Under the law, only Qualified Beneficiaries are entitled to COBRA Continuation Coverage independent of your enrollment for COBRA Continuation Coverage. Qualified Beneficiaries include you, your spouse, and your Dependent Child(ren) who were covered by the Plan on the day before the qualifying event.

If you marry, have a newborn Child, adopt a Child, or have a Child placed with you for adoption while covered under COBRA Continuation Coverage, you may enroll that spouse or Child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new Dependent within 31 days of the marriage, birth, adoption, or placement for adoption.

It is a good idea to notify the Fund Office of any qualifying event. Failure to provide notice within 60 days of the qualifying events of divorce or separation or loss of Dependent status will prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or Dependent Child loses coverage under another group health plan, you may enroll that spouse or Child for coverage for the balance of the period of COBRA Continuation Coverage within 31 days after the termination of the other coverage. To be eligible for this special enrollment right, your spouse or Dependent Child must have been eligible for coverage under the terms of the Plan, but declined when enrollment was previously offered because they had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or Dependent Child may cause an increase in the amount you pay for COBRA Continuation Coverage. To find out about COBRA Continuation Coverage rates, contact the Fund Office.

One or more of your family members may elect COBRA Continuation Coverage even if you do not. However, to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event. A parent may elect or reject COBRA Continuation Coverage on behalf of Dependent Children living with him or her.

If you change your marital status or add new Dependents, or if you or your spouse or other Dependents change addresses, please notify the Fund Office immediately.

ELECTING COBRA CONTINUATION COVERAGE

To elect COBRA Continuation Coverage, you (or your Employer) must notify the Fund Office within 60 days from the date the qualifying event occurs, or the date that you would lose coverage under the Fund because of the qualifying event, whichever is later.

In some cases, your Employer will notify the Fund Office. In other cases, you or your Dependent must notify the Fund Office, as shown below:

Your Employer Should Notify the Fund Office of Your:	You (or your Dependent) Must Notify the Fund Office of:
■ Termination of employment ■ Reduction in hours ■ Retirement ■ Enrollment in Medicare ■ Death	■ Divorce ■ Legal separation ■ A Beneficiary ceasing to be covered under the Plan as your Dependent Child, either because of reaching age limit or death. ■ The occurrence of a second qualifying event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum of 18 (or 29) months. This second qualifying event could include an Employee's death, enrollment in Medicare, divorce or legal separation, or a Beneficiary ceasing to be covered under the Plan as your Dependent.

Notice of any of the qualifying events or situations listed above must be provided in writing. You may use the Fund's *COBRA Notice Form for Covered Employees and Other Qualified Beneficiaries* to provide notice to the Fund. You may also send a letter to the Fund including:

- Your name;
- The qualifying event or situations listed above under which you are providing notice; and
- The date of the event.

The period to provide notice does not begin until you have been informed of the responsibility to provide notice and the notice procedures through the furnishing of this Summary Plan Description or a general (initial) notice by the Plan.

You, a Qualified Beneficiary, or any representative acting on your behalf may provide notice of a qualifying event. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same qualifying event. For example, if an Employee, spouse, and Child are all covered by the Plan, and the Child ceases to be a Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

When you or your Dependents have provided notice to the Fund Office of a divorce or legal separation, a Dependent ceasing to be covered under the Plan as a Dependent, or a second qualifying event, but are not entitled to COBRA Continuation Coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA Continuation Coverage. This will be provided within 14 days of receiving your notice.

To protect your family's rights, you should keep the Fund Office informed of any changes in address of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

When the Fund Office receives notice of a qualifying event, you will be provided with a COBRA election form, information about COBRA, and the date on which your coverage will end. Under the law, you and/or your covered Dependents have 60 days from the later of the date:

- You would have lost coverage because of the qualifying event; or
- You and/or your covered Dependents received the election form and COBRA Continuation Coverage information.

If you and/or any of your covered Dependents do not elect COBRA Continuation Coverage within 60 days of the qualifying event (or, if later, within 60 days after receiving that notice), you and/or your Dependents will not have any group health coverage from this Fund after your coverage ends.

Each Qualified Beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation Coverage. For example, both you and your spouse may elect COBRA Continuation Coverage, or only one of you. A parent or legal guardian may elect COBRA Continuation Coverage for a minor Child.

If you lose coverage due to a qualifying event:

- Inform the Fund Office of the qualifying event and request a COBRA Continuation Coverage election form.
- Complete and return the election form within 60 days of the date you received it, or 60 days of the date the qualifying event occurred, whichever is later.
- Make your first payment to the Fund Office within 45 days from the date you make your COBRA Continuation Coverage election.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your Dependents become eligible for this coverage, the Fund Office will notify you of the COBRA Continuation Coverage Self-Payment amount.

Your COBRA Continuation Coverage Self-Payment may be as much as 102% of the Plan's cost. If you are eligible for the 11-month extension due to a determination of disability by the Social Security Administration, your COBRA Continuation Coverage premiums may be as high as 150% of the Plan's cost for the additional 11 months.

You must make Self-Payments so that your COBRA Continuation Coverage is continuous. To prevent a lapse in coverage, you must send the first COBRA Continuation Coverage Self-Payment to the Fund Office within 45 days from the date on which you or your Dependent make your COBRA Continuation Coverage election, as determined by postage cancellation. Payments for subsequent months are due on the first day of the month for which COBRA Continuation Coverage is provided. You will have a 30-day grace period to submit payments. If you do not make payment by the end of the grace period, your COBRA Continuation Coverage will end, retroactive to the last day of the previous month, and you will lose all rights to COBRA Continuation Coverage under the Plan.

If you choose COBRA Continuation Coverage within the election period but after the date your eligibility ended, you must pay the required COBRA Continuation Coverage Self-Payment retroactive to cover the elapsed period.

Disability COBRA Continuation Coverage

If you are covered under COBRA Continuation Coverage for 18 months, and at the time of the qualifying event or within the first 60 days of coverage you (or your covered Dependent) are determined to be disabled, you (or your Dependent) may be eligible to continue COBRA Continuation Coverage for an additional 11 months for a total of 29 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your Dependent) are disabled and therefore entitled to Social Security Disability benefits. If you are providing notice of a Social Security Administration determination of disability, the notice must be made before the end of the first 18 months of COBRA Continuation Coverage and must be postmarked no later than 60 days after the latest of the date:

- Of the disability determination by the Social Security Administration;
- On which the qualifying event occurs; or
- On which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event.

This extended period of COBRA Continuation Coverage will end on the earlier of:

- The last day of the month that occurs 30 days after the Social Security Administration has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months of COBRA Continuation Coverage; or
- For the disabled person, the date the disabled person becomes enrolled in Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:

- The date that you receive a final Social Security determination that you and/or your Dependent(s) are no longer disabled; or
- The date that the disabled person becomes enrolled in Medicare.

Additional Qualifying Events While Covered Under COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is 36 months, even if you experience another qualifying event while you are already covered under COBRA Continuation Coverage. If you are covered under COBRA Continuation Coverage for 18 months because of your termination of employment or reduction in hours, your spouse and/or Dependent may extend coverage for another 18 months if:

- You get divorced or legally separated;
- You become enrolled in Medicare and drop Plan coverage;
- You die; or
- Your Child no longer meets the Plan's definition of Dependent.

You, as an Employee, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is *not* treated as a second qualifying event and you may not extend your coverage.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your Physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the Physician or provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA Continuation Coverage, or you have elected COBRA Continuation Coverage but have not yet paid for it.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage will end on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- The required COBRA Continuation Coverage Self-Payment is not made by the due date;
- The person receiving the coverage becomes covered by another group health plan;
- The person receiving the coverage enrolls in Medicare; or
- The Plan terminates and no longer provides group health insurance coverage.

If COBRA Continuation Coverage ends before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the determination that COBRA Continuation Coverage will end. The notice will explain why

coverage will end early, the date it will end, and your rights, if any, to alternative individual or group coverage.

When you retire, you will be given an opportunity to elect either COBRA or Retiree Benefit Plan coverage. If you choose Retiree Benefit Plan coverage, you waive your right to COBRA.

Other Available Coverage

If you, your spouse or dependents lose coverage under the Plan, you may be able to enroll in coverage other than COBRA Continuation Coverage. One alternative is the Health Insurance Marketplace. Generally, an Employee or dependent has 60 days after the loss of coverage to enroll in a plan in the Marketplace. You or your dependents may be eligible for cost-sharing subsidies or tax credits to pay all or part of the monthly premium.

Another option may be to enroll in your spouse's plan if he or she has coverage through their employer. Generally, an employer-sponsored group health plan has to allow a spouse who loses employment-based coverage to enroll within 30 days after losing coverage.

These alternatives may be less expensive than COBRA Continuation Coverage, but it is important to remember that there are deadlines for all of these options, including COBRA Continuation Coverage.

MEDICAL BENEFITS

For Active and Retiree Benefit Plan Participants

The Plan pays Medical Benefits to you and your eligible Dependents, at the copayment levels for the two active Plans of Benefits or the Retiree Benefit Plan shown in the *Schedule of Benefits*, based on the Reasonable and Customary Charges for the services received, after you pay the deductible amount. Limitations may apply to certain benefits.

The Plan offers two levels of coverage–Plan 1 and Plan 2, as well as Retiree coverage. 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 for which Plan of Benefits you are eligible.

If you need to see a Physician…

- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- File a claim with the Fund Office if your provider does not file claims for you. It is a good idea to make a copy of the claim form and any supporting materials for your records before submitting the claim.

HOW MEDICAL BENEFITS WORKS

Each year between January 1 and December 31, the Plan pays benefits as follows:

- **Deductible:** The deductible is the amount of medical Covered Charges that you and your family pay each calendar year before the Plan's Medical Benefits begin to pay Covered Charges.
  - You are responsible for meeting the individual or family deductible. No one family member can apply more than the individual deductible amount toward meeting the family maximum. However, once payments toward the individual deductible for all family members reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year.
  - If two or more covered family members incur Covered Charges due to the same accident, only one deductible applies to those expenses.
- **Coinsurance:** Once you or your family meet the annual deductible, the Plan pays a percentage of Covered Charges and you pay the rest. The amount the Plan pays varies depending on whether you use PPO or non-PPO providers, as shown in the *Schedule of Benefits* and explained on page __.
- **Out-of-Pocket Maximum:** The Plan limits the amount you pay out-of-pocket in a calendar year toward medical Covered Charges. Once the coinsurance amounts you pay for most Covered Charges, excluding the amounts you paid toward your annual deductible, reach the individual or family out-of-pocket maximum, the Plan pays 100% of most Covered Charges for that individual or family, as applicable, for the remainder of the year.

The deductible and out-of-pocket maximums do not apply to every covered service, as shown in the *Schedule of Benefits*. Some expenses may be covered differently or are subject to benefit maximums.

MAXIMIZING YOUR MEDICAL BENEFITS

PPO

A network of Hospitals, Physicians, and other providers that have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for you and the Plan when you use PPO providers.

The Plan's Medical Benefits include three cost management programs designed to help manage certain health care costs:

- Preferred Provider Organization (PPO);
- Case Management; and
- Telehealth Services.

Preferred Provider Option (PPO)

The Plan provides benefits through a Preferred Provider Organization (PPO). When you use a PPO provider (a provider that participates in the network), you save money for yourself and the Plan because PPO providers have agreed to charge negotiated rates. In addition, you pay less when you use a PPO provider because the Plan pays a higher percentage of Covered Charges provided by PPO providers. However, it is your decision whether to use a PPO or Non-PPO provider. You always have the final say about the providers you and your family use.

Example: How Using PPO Providers Saves Money

Let's compare what Joe in Plan 1 pays when using a PPO provider versus a non-PPO provider (this assumes Joe has met his deductible):

	PPO Provider	***Non-PPO Provider***
Covered Charges	*$4,000*	*$5,000*
Percent Joe Pays	*x 15%*	*x 30%*
Amount Joe Pays	***$600***	***$1,500***
Covered Charges	*$4,000*	*$5,000*
Percent Plan Pays	*x 85%*	*x 70%*
Amount Plan Pays	***$3,400***	***$3,500***

Joe saves $900 by using a PPO provider; plus the Plan pays less as well.

This example, which is for illustrative purposes only, assumes a PPO savings of 20%.

A listing of providers that participate in the network is available free of charge upon request. For the most up-to-date list of PPO providers, or to find out if your provider is in the PPO network, contact the PPO (see the *Important Contact Information* at the beginning of this booklet).

Case Management

Cases of catastrophic Illness or long-term care (for things such as 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; and
- Ongoing monitoring and management of long-term cases.

Telehealth Services

Telehealth services are provided by Blue Cross and Blue Shield of Kansas City through American Well® (Amwell). Amwell is an urgent care provider that brings health care to where you are, through your mobile device or computer. You can access Telehealth through any mobile device by downloading the Amwell app from the App Store or Google Play. You can also access Telehealth on your computer through amwell.com. Set up the profile for each member of your family so that, when the need arises, you can get help quickly and easily.

You can use Amwell to interact with a doctor for common conditions such as cold, flu, fever, rash, stomach pain, sinus infection, pink eye, ear infection, and migraine. You can choose your own Physician or therapist for your visit from a list of U.S. board-certified provider profiles, including Physician certifications, licenses, and online patient ratings. The service is available 24 hours a day, seven days a week, 365 days a year. If a medication is prescribed, you can pick it up at your local pharmacy.

Your visit records are securely maintained and you can access them as needed. This ensures that both you and the Physician on your next visit will have the information needed to provide care.

Amwell also offers behavioral health and counseling services with a licensed therapist for conditions such as anxiety, Attention-deficit hyperactivity-disorder (ADHD), stress, bereavement, Obsessive-compulsive disorder (OCD), panic attacks, depression, and trauma/post-traumatic stress disorder.

Telehealth is easier and less costly than other alternatives. For example, the average Physician office visit charge is $92, and the average Emergency room visit charge is $742. The cost of an Amwell "visit," however, is only $49 for 2018. Effective January 1, 2018, to help increase the use of Amwell Telehealth services, the Fund will pay the full amount of your telehealth visit—so you will pay $0 for 2018. The amount that the Fund will subsidize for this program will be evaluated annually. **[Will info here re: copay still apply in 2019?]**

COVERED MEDICAL EXPENSES

Charges for services or supplies that are not Medically Necessary or are in excess of the Plan's Reasonable and Customary amount, are not covered under the Plan.

Covered expenses include the Medically Necessary and 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.

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*.

3. Treatment for Mental and Nervous Disorders, subject to the deductible and coinsurance shown in the *Schedule of Benefits*:

   a. inpatient treatment must be received in a Hospital or a licensed residential treatment facility that is licensed to provide treatment for Mental and Nervous Disorders.

   b. outpatient treatment 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 of chemical dependency by a Physician, Hospital, or a specialized treatment facility, subject to the deductible and coinsurance shown in the *Schedule of Benefits*.

5. Services of a legally licensed occupational/physical/speech therapist when ordered by a Physician, and who is not a member of the individual's family.

6. Speech therapy to restore normal speech lost due to Illness or Injury or as a result of congenital deformity (i.e., cleft palate) or for childhood developmental speech delays, as shown in the *Schedule of Benefits*.

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, except service by railroad, ship, bus, airplane, or any other common carrier is not covered.

11. Oral surgery performed by a Dentist or dental surgeon except for simple extractions. Such oral surgery includes outpatient oral surgery performed on Dependent Children who are permanently and totally disabled, even if such Dependent Children have reached the age of 26.

12. Psychological testing if recommended by a Physician and performed by an accredited psychologist, up to the maximum shown in the *Schedule of Benefits*.

13. Treatment by a licensed chiropractor, subject to the limitations shown in the *Schedule of Benefits*.

The Plan does not restrict benefits for any covered Hospital length of stay in connection with childbirth for the mother and/or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Plan does not require a health care provider to obtain pre-authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours, or 96 hours, as applicable.

14. Human organ and tissue transplant expenses. Transplant services that covered under this benefit are for:

    a. heart;

    b. lung;

    c. heart/lung;

    d. liver;

    e. kidney;

    f. pancreas;

    g. kidney/pancreas;

    h. small bowel/liver;

    i. small bowel;

    j. bone marrow, including autologous, related and unrelated; and

    k. allogenic and stem cell.

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

    a. a Participant must use a Designated Transplant Provider, as defined by the medical Preferred Provider Organization (PPO), for organ transplant services. Otherwise the Participant will be charged the full cost;

    b. no other transplant procedures are covered;

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

    d. the patient's condition is life threatening;

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

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

    g. the use of temporary mechanical equipment, pending the acquisition of matched human organs, are covered;

    h. multiple transplant procedures during one surgical procedure are covered;

    i. follow-up benefits are for each successive 12-month period beginning on the anniversary of the transplant surgery; and

    j. the donor benefit is payable at 100%, with no deductible, 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 Physician for dwarfism.

16. Mammograms once a year for women 50 years old or over 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 a 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.

19. Durable Medical Equipment, which is equipment that:
    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.

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

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

20. Well-Child care for outpatient newborn routine office visits and routine well-Child care for eligible Dependent Children through age 18.

    Flu shots are covered the same for adults and Children, at 100% (no deductible or coinsurance), regardless of whether they are administered by a contracted PPO network provider or a non-contracted PPO provider. The Plan covers other immunizations and vaccines the same for adults and Children, at 100% (no deductible or coinsurance), when they are administered by a contracted PPO network provider. However, a maximum benefit limit applies when services are **not** administered by a contracted PPO network provider, as shown in the *Schedule of Benefits*.

    The Plan does not cover immunizations or vaccines for foreign travel.

21. Immunizations and vaccines.

22. Physical exams, up to the amount shown in the *Schedule of Benefits*.

23. Vitamin A when prescribed by a Physician for a Dependent Child under age 19.

24. Services of an assistant surgeon who is a Physician, up to the percentage of the PPO allowance or the Reasonable and Customary Charges for the surgical procedure, as shown in the *Schedule of Benefits*.

25. Services of a certified surgical/Physician assistant, up to the percentage of the PPO allowance or the Reasonable and Customary Charges, as shown in the *Schedule of Benefits*.

26. Services of a certified registered nurse anesthetist (CRNA) if the services are supervised by a licensed Physician. The Plan will cover benefits for anesthesia either for the services of an Anesthesiologist (MD) or a CRNA, but not both. Coverage is limited to 75% of Physician charges when performed by a CRNA.

27. Hospital, anesthesia, and Physician charges for outpatient dental care for Dependent Children younger than 5 years old and disabled Dependent Child under age 19.

28. Claims for the treatment of a dental Injury that is the result of an accidental Injury, after you have exhausted your benefits under the Plan's dental benefit provisions. You will be subject to the calendar year deductible and coinsurance percentages for Medical Benefits, as shown in the *Schedule of Benefits*.

29. Charges for dental treatment in excess of the Plan's annual maximum dental benefit if an individual must undergo radiation therapy for cancer treatment and their treating Physician recommends dental work be performed before beginning radiation treatment.

30. Non-prescription contraceptive methods that are administered, inserted, or removed by a Physician, including Intrauterine Devices (IUDs), diaphragms, and cervical caps. Covered Expenses do not include coverage for Emergency contraceptives or procedures for permanent sterilization, such as vasectomies and tubal ligation.

Women's Health and Cancer Rights Act of 1998

Subject to the Plan's annual deductibles and coinsurance provisions, this Plan complies with the Women's Health and Cancer Rights Act of 1998. That law provides that if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with the mastectomy, coverage is provided in a manner determined in consultation with your attending physician, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Expenses Not Covered Under Medical Benefits

Not all expenses are covered under the Plan's Medical Benefits. Please refer to the *General Plan Exclusions and Limitations* (see page __) for expenses not covered by the Plan.

The Plan pays benefits only for those expenses expressly described as coverage; any omission will be presumed to be an exclusion.

PRESCRIPTION DRUG COVERAGE—FOR ACTIVE AND NON-MEDICARE-ELIGIBLE PLAN PARTICIPANTS

Prescription drug expenses are rising faster than most other health care expenses, and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your Dependents. The Fund has contracted with a Pharmacy Benefit Manager (PBM), currently OptumRx, to provide you with access to a:

- Retail pharmacy program, for your short-term prescription needs; and
- Mail-order program, for your longer-term needs.

You save money for yourself and the Plan when you have your prescriptions filled at a participating pharmacy or through the mail-order program. Amounts you pay for covered prescription drug expenses through the retail pharmacy or mail-order program do not count toward meeting your medical annual deductible or out-of-pocket maximum, which means that prescription drug expenses are never paid at 100%.

When you have a prescription filled at a participating pharmacy:

- Present your ID card.
- Pay your copayment, as shown in the *Schedule of Benefits* on page __.

If you have a prescription filled at a non-participating pharmacy, you must pay the entire cost of the medication when you receive it. You may then submit a claim form to the PBM for reimbursement based on the provider's allowed amount for the prescription less your copayment. Claim forms are available from the Fund Office.

GENERIC EQUIVALENTS AND BRAND NAME MEDICATIONS

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications cost less than their brand name alternatives. This can be a significant source of savings for you and the Plan.

The Plan divides prescription drugs into two categories:

- **Generic medications** are chemically and therapeutically equivalent to the corresponding name brand drug, but are available at a lower price.
- **Brand medications** are available from specific manufacturers and are advertised and sold under a trade name. A generic equivalent may be available.

A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication and costs less.

While the Plan covers generic and brand name medications, you pay more when you receive a brand name medication. When available, generic medications can save you money and should be substituted for brand medications. Therefore, when you or your Dependent needs a prescription, you may want to ask your Physician whether a generic can be substituted for a brand name medication.

The *Schedule of Benefits* shows the coinsurance amounts for each type of medication.

RETAIL PHARMACY PROGRAM

You can use a participating retail pharmacy to fill your prescription for the greater of a 34-day supply or 100-unit dose. If you are taking a prescription on a long-term basis, you should have your prescription filled through the mail-order program. When you use the mail-order program, you can have prescriptions filled for up to a 90-day supply.

You will receive a prescription drug ID card when you are eligible for coverage. When you have a prescription filled at a participating pharmacy and present your ID card, you pay your copayment when you pick it up and the Plan pays the rest.

If you fill a prescription at a non-participating pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled. You will then need to submit a claim form, along with a receipt, to the PBM.

Mail-Order Program

You should use the mail-order program when you need to have prescriptions filled for maintenance medications. Maintenance medications are prescription drugs that are used on an on-going basis. These prescriptions can be used to treat chronic Illnesses such as:

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

When you use the mail order program, you can get a larger quantity of medication at one time–up to a 90-day supply–for less than you would pay at a participating retail pharmacy.

When you need to order medication through the mail-order program:

- Ask your Physician to prescribe a 90-day supply, with refills if applicable.
- Mail the original prescription along with the appropriate form and your copayment to the mail-order drug program.
- Allow about 14 days from the time you mail in your order to receive your prescription(s).

If you need to begin taking the medication right away, you may want to ask your Physician for two prescriptions:

- A short-term supply that you can have filled right away at a participating retail pharmacy; and
- A 90-day, refillable supply that you can have filled through the mail order program.

Covered Prescription Drug Benefit Expenses

Covered Charges include:

- Legend medications that are required under federal law to bear the legend, "Caution: federal law prohibits dispensing without a prescription."
- Compounded medications of which at least one ingredient is a prescription legend drug.
- Any other drug that under applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
- Oral and topical use of Retin A prescribed by a Physician, subject to prior authorization from the PBM. The Plan will not pay for use of Retin A without prior approval from the PBM.
- Birth control medications, supplies, and devices prescribed by a Physician, including oral contraceptives, skin patches, and hormonal vaginal suppositories. Over-the-counter contraceptives are not covered.

Prescription Drug Expenses Not Covered

Not all expenses are covered under the Plan's Prescription Drug Benefits. In addition to any *General Plan Exclusions and Limitations* (see page __), Prescription Drug Benefits are not paid for the following expenses:

- Erectile Dysfunction medications;
- Experimental or investigational drugs;
- Growth hormones;

- Infertility treatments;
- Nutritional supplements;
- Over-the-Counter (OTC) Diabetic supplies;
- Over-the-Counter (OTC) Insulin;
- Over-the-Counter (OTC) Other products;
- Prescription drugs that have an OTC equivalent (covered with prior authorization);
- Smoking cessation products;
- Vitamins—"Single Entity";
- Vitamins—Fluoride products
- Drugs when used for cosmetic purposes;
- Drugs when used to promote hair growth;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Drugs when used for treatment of anorexia, weight loss, or weight gain;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

PRESCRIPTION DRUG COVERAGE—FOR RETIREE BENEFIT PLAN PARTICIPANTS

The Fund provides a prescription drug program for Medicare-eligible Retirees through a self-funded Employer Group Waiver Plan (EGWP) administered by a Pharmacy Benefit Manager (PBM), currently OptumRx.

You are eligible for coverage if:

- You remain eligible through the Mo-Kan Teamsters Health and Welfare Fund;
- You live in the United States and its Territories; and
- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B).

The Fund pays your prescription drug coverage premium. However, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

The *Schedule of Benefits* shows the coinsurance amounts you will need to pay for each type of medication you purchase at a retail pharmacy or through mail order.

GENERIC EQUIVALENTS AND BRAND NAME MEDICATIONS

Generally, a "generic" drug works the same as a brand name drug and usually costs less. When a generic version of a brand name drug is available, network pharmacies will provide you with the generic version.

Additionally, most state laws require the generic to be dispensed when one is available. The PBM will usually not cover the brand name drug when a generic version is available. However, the PBM will cover the brand name drug if your provider:

- Informs the PBM that there is medical reason that the generic drug will not work for you; or
- Has written "no substitutions" on your prescription for a brand name drug; or
- Has told the PBM that the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you.

RETAIL PHARMACY PROGRAM

In most cases, your prescriptions are covered only if they are filled at a participating network pharmacy. A participating network pharmacy is a pharmacy that has a contract with the PBM to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the Plan's Drug List.

To find a network pharmacy, visit www.optumrx.com.

You may go to any network pharmacy. If you switch from one network pharmacy to another, and you need to refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

When you have a prescription filled at a participating pharmacy:

- Present your ID card.
- Pay your coinsurance amount, as shown on the *Schedule of Benefits* on page __.

If you have a prescription filled at a non-participating pharmacy, you must pay the entire cost of the medication when you receive it. You may then submit a claim form to the PBM for reimbursement based on the provider's allowed amount for the prescription, less your coinsurance. Claim forms are available at www.optumrx.com.

Prescriptions filled at out-of-network pharmacies

Generally, drugs filled at an out-of-network pharmacy are covered only when you are not able to use a participating network pharmacy. For example, prescriptions filled at out-of-network pharmacies are covered in the event you are traveling or need an Emergency prescription. If you use an out of network pharmacy in such an instance, please be sure to retain your receipt. You can submit the receipt to the PBM along with the completed Reimbursement Request Form. Keep in mind, the PBM will reimburse you only for what would have been paid to a participating network pharmacy, which may be less than what you paid out of pocket. You will be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

MAIL-ORDER PROGRAM

You should use the PBM's mail service pharmacy when you need to have prescriptions filled for maintenance medications. Maintenance medications are the medications you take on an ongoing basis to treat conditions such as high blood pressure, diabetes, and high cholesterol. Mail-order prescriptions are typically filled for a 90-day supply at lower coinsurance and are mailed to your home.

To get order forms and information about filling your prescriptions by mail, visit www.optumrx.com. Usually a mail-order pharmacy order will get to you in no more than 14 days. If there is a delay, you will be called and sent a letter addressing the reason for the delay. If you do not have enough medication to last until you receive the shipment, the PBM will authorize a short-term retail supply at a pharmacy of your choice.

Refills on mail order prescriptions. For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Since mail order is less expensive for you and the Fund, it is required that, after the first fill, you fill any maintenance medication through mail order. If you do not use mail order after the first fill, you will be responsible for 100% of the cost of the medication.

COVERED PRESCRIPTION DRUG BENEFIT EXPENSES

The Plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, Dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must have your prescriptions filled at a network pharmacy or through the plan's mail-order service.
- Your drug must be on the PBM's list of covered drugs (formulary). The formulary can be found on www.optumrx.com.

- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books.

PRESCRIPTION DRUG EXPENSES NOT COVERED

The following drugs are not covered under the Plan:

- Part D drugs covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories.
- Off-label use drugs. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors.
- Non-prescription drugs (also called over-the-counter drugs);
- Drugs when used to promote fertility;
- Drugs when used for the relief of cough or cold symptoms;
- Drugs when used for cosmetic purposes;
- Drugs when used to promote hair growth;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject;
- Drugs when used for treatment of anorexia, weight loss, or weight gain; and
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

To find out if a particular drug is not covered, visit www.optumrx.com (the drug list on the website is always the most current).

DENTAL BENEFITS

For Active Plan Participants

Timely, preventive dental care plays an important role in your overall health. To help you meet the cost of routine and unexpected dental care, the Fund provides Dental Benefits to active Employees and their Dependents, along with access to a dental PPO network currently provided by Blue Cross and Blue Shield of Kansas City.

Dental Benefits are not available to Retired Employees or their Dependents.

HOW THE DENTAL PROGRAM WORKS

Calendar Year Deductible

The calendar year Deductible is the amount of Covered Dental Expenses that you and your family pay before the Plan begins to pay Dental Benefits. You and each covered Dependent are responsible for meeting the deductible.

Calendar Year Maximum

Each year, allowable charges for you and each covered eligible Dependent are payable up to the calendar year maximum listed in the *Schedule of Benefits*. The maximum does not apply to your Dependent Children under age 19.

When you or your Dependent needs dental care:

- Choose any Dentist.
- Make an appointment.
- Ask your Dentist to submit the claim form to the address on the back of your ID card.

COVERED DENTAL EXPENSES

Type A – Routine Oral Examinations

Dental Benefits are designed to pay a portion of the cost for routine oral examinations. Covered Charges for preventive and diagnostic procedures and services include:

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

Type B – Restorative and Other Basic Services

Covered Charges for minor restorative procedures and services include:

- Restorations of diseased teeth with amalgam, silicate, acrylic, synthetic porcelain, or composites;

- Endodontic treatment, including root canal therapy. Root canal treatments and/or apicoectomies are only payable once per tooth;
- Treatment of periodontal and other gum and mouth tissue diseases, including gingival tissue or alveolar processes. Gingival curettage is limited to four quadrants in any 12 consecutive-month period;
- Extractions, including local anesthesia and routine post-operative care;
- Oral surgery, including local anesthesia and routine post-operative care;
- General anesthetics, when needed as part of oral or dental surgery;
- Antibiotic injections by the attending Dentist;
- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; and
- Relining or rebasing of present dentures - but only if they were installed more than six months earlier and if they have not been relined or rebased during the past 12 months.

Type C – Major Restorative Services

Covered Charges for major restorative procedures and prosthetic services include:

- Gold restorations when the teeth cannot be restored with another filling material;
- Inlays, onlays, or crowns when the teeth cannot be restored with a filling material;
- First installation of removable dentures. Also included are adjustments of these dentures more than six months after they are installed;
- First installation of fixed bridgework, including inlays and crowns as supports;
- Replacement of crowns, inlays or onlays with new ones - but only if the existing ones are at least five years old and cannot be made serviceable;
- 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:
  - the existing denture or bridgework is at least five years old and cannot be made serviceable; or
  - the existing denture is a temporary denture that cannot be made permanent and is replaced within 12 months by a permanent denture.

Alternative Procedures

The Fund only considers the least costly dental procedure that meets nationally established standards as a 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, Type C, or Type D copayment level, subject to the Calendar Year maximum.

Type D – Orthodontia Services

Covered Charges for orthodontia services include:

- Necessary services related to an active course of orthodontia treatment, including diagnosis, evaluation, and pre-care;
- The initial installation of orthodontic appliances for an active course of orthodontia treatment; and
- Adjustment of active orthodontia appliances; however, repair or replacement of orthodontia appliances will not be covered.

This orthodontia coverage is for non-surgical services provided to correct malocclusion (i.e., improper alignment) of the teeth and/or jaws that significantly interferes with their function.

Expenses related to orthodontia will be covered only when one or more of the conditions noted below have been satisfied:

- The patient must be an eligible Dependent Child under the age of 19; and
- The patient's Dentist must certify that orthodontia is dentally necessary for the patient.

Extension of Benefits

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

- For appliances and their modifications:
  - the Dentist must have taken the master impression while the individual was eligible under the Plan;
  - the appliance must be delivered or installed within 60 days after eligibility ended; and
  - the appliance must not be related to an orthodontic service.
- For crowns, bridges, inlays, onlays, or cast restorations:
  - the teeth must be prepared while the individual was eligible under the Plan; and
  - installation must be within 60 days after eligibility ended.
- For root canal therapy:
  - the pulp chamber must be opened while the individual was eligible under the Plan; and
  - therapy must be completed within 60 days after eligibility ended.

DENTAL EXPENSES NOT COVERED

Not all expenses are covered under the Plan's Dental Benefits. In addition to any *General Plan Exclusions and Limitations* (see page __), Dental Benefits are not paid for the following expenses:

- 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;
- Dental services for which you or your eligible Dependent incur no charge;
- Dental services for you or your Dependent either provided or paid for by any governmental agency or under any governmental program or law, except charges for 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;
- Dental care for a congenital or developmental malformation;
- Cosmetic services, including:
  - veneers, facings or similar properties of crowns or pontics placed on or replacing teeth in back or the second bicuspid; and
  - personalization or characterization of dentures;
- Loss or theft of a denture;
- Services covered under the Medical Benefits;
- Realignment of teeth (orthodontics);

Pre-Estimation of Benefits

If your or your Dependent's dental treatment or service is expected to exceed $150, you may submit a claim form showing the recommended treatment plan and fees to the Fund Office.

The Fund Office will then notify you and your Dentist of the amount payable for each approved service.

- Expenses for root canal treatment and/or apicoectornies when previously paid under another benefit; and
- Examinations and/or prophylaxis performed within six (6) months of the last examination.

VISION BENEFITS

For Active Plan Participants Only

Vision Benefits are not available to Retired Employees or their Dependents.

The Plan provides Vision Benefits for you and each of your enrolled Dependents. If you or your eligible Dependents require an eye examination, the Plan will pay the Covered Charges during a two consecutive year period up to the amount shown in the *Schedule of Benefits*. The maximum does not apply to your Dependent Children under age 19.

COVERED VISION EXPENSES

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

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

VISION EXPENSES NOT COVERED

Not all expenses are covered under the Plan's Vision Benefits. In addition to any *General Plan Exclusions and Limitations* (see page __), Vision Benefits are not paid for the following expenses:

- Any vision care services or supplies received from a mutual benefit association, labor union, trustee, or other similar group;
- Any eye examination required by an Employer as a condition of employment;
- Any vision care services or supplies that are payable or furnished by any group policy or prepayment plan;
- Any medical or surgical treatment of the eye;
- Sunglasses, plain or prescription;
- Safety lenses or goggles;
- Orthoptic, vision training, or aniseikonia;
- Repairs of any kind; or
- Loss or theft.

HOSPICE BENEFIT

For Active and Retired Plan Participants

If you or your eligible Dependent have covered expenses for Hospice Care, the Plan will cover Reasonable and Customary expenses up to the maximum shown in the *Schedule of Benefits*. Hospice Care must be received as part of a Hospice Care Program through a licensed Hospice Care Agency. You or your Dependent must be assessed by a Physician to have a life expectancy of six months or less.

COVERED HOSPICE EXPENSES

Covered expenses include the Reasonable and Customary Charges for the following:

Home Care

- Physician services;
- Physical, respiratory, and occupational therapies;
- Drugs, medications, and medical supplies when provided under the Hospice Care Program through a Hospice Care Agency;
- Private duty nursing services by a Registered Nurse or Licensed Practical Nurse, if certified by a Physician;
- Rental of Durable Medical Equipment (DME); and
- Oxygen and rental of related equipment.

Inpatient Care

- Care received while you are an admitted patient in a Hospice facility;
- Room and board, which may include overnight visits by family;
- Nursing services;
- All other related Hospital expenses;
- Physician services; and
- Ambulance service or alternative types of transportation.

Other Services

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

HOSPICE BENEFITS NOT COVERED

Not all expenses are covered under the Plan's Hospice Benefit. This Benefit is subject to the *General Plan Exclusions and Limitations* (see page __).

HEARING AID BENEFIT

For Active and Retired Plan Participants

If you or your eligible Dependent requires a hearing aid, the Plan will pay the Covered Charges up to the amount shown in the *Schedule of Benefits*.

COVERED HEARING AID EXPENSES

Covered hearing aid expenses are the charges that you or your eligible Dependents are required to pay for the following:

- Hearing exam performed by a Physician or a licensed audiologist; and
- Hearing aid device furnished or dispensed by a Physician or a licensed audiologist.

HEARING AID EXPENSES NOT COVERED

Not all expenses are covered under the Plan's Hearing Aid Benefit. In addition to any *General Plan Exclusions and Limitations* (see page __), the Hearing Aid Benefit does not pay for:

- Amplifiers;
- Hygienic cleaning of the aid;
- Lip reading; and
- Speech therapy.

IN THE EVENT OF DISABILITY OR DEATH

For Active Plan Participants Only

To help provide financial protection for you and your family, the Plan provides benefits to you in the event of your disability or your Dependent's death and to your Beneficiary in the event of your death. This section describes these benefits.

LOSS OF TIME BENEFIT

For Active Employees Only

The Plan provides a Loss of Time Benefit, which is available to you if you are unable to perform the duties of your job due to disability and are not engaged in any other occupation for wage or profit.

Contact the Fund Office if you become disabled. To be eligible for benefits, you must provide written proof of your disability.

The amount of the benefit is shown in the *Schedule of Benefits*. Loss of Time Benefits begin on the:

- First day of disability due to Injury or Hospital Confinement (including outpatient surgery); or
- Eighth day of disability due to Illness.

During a partial week of disability, payment will be made at the daily rate of one-fifth of the weekly benefit. Benefits continue for up to a maximum of 13 weeks during any one period of disability, but will end earlier upon retirement or death. Two or more periods of disability are considered as one unless, between periods of disability, you returned to active full-time work for at least one week.

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 Trustees.

Loss of Time Exclusions and Limitations

Spouses, Dependent Children, and Retirees are not eligible for Loss of Time Benefits.

No benefits will be payable for a disability that is work-related or for which you are not under the care of a licensed Physician. A written statement from your Physician confirming your disability is required.

DEATH BENEFITS

For Active Employees and their Spouses Only

In the event that you or your designated Beneficiary are eligible to receive a Death Benefit, proof of the death must be provided to the Fund Office before the benefit will be paid.

Death Benefits are not available to Retired Employees or their Dependents.

For Active Employees

In the event of your death, your designated Beneficiary will receive a lump-sum benefit. The amount of the benefit is listed in the *Schedule of Benefits*.

For Spouses of Active Employees

The Plan provides a Death Benefit to you in the event of the death of your spouse. The amount of the Spouse Death Benefit is listed in the *Schedule of Benefits*.

Generally, benefits are paid to you. However, in the event you are not living, this Death Benefit is paid in equal shares to your spouse's Children.

Accidental Death and Dismemberment (AD&D) Benefits

For Active Employees Only

The Plan provides an Accidental Death and Dismemberment (AD&D) Benefit for active Employees. The benefit is payable for the loss of life, limb(s), or the entire and irrecoverable loss of sight of one or both eyes. The loss must be due to an accidental Injury and, as the direct result of that accident and independent of all other causes, the loss occurs within 100 days of the accident.

In the event of your death, benefits are paid to your designated Beneficiary. For all other losses, benefits are paid to you. The full amount of the AD&D benefit is listed in the *Schedule of Benefits* (see page _) and is paid as follows:

For Loss of:	Benefit
▪ Life ▪ Two hands ▪ Two feet ▪ Sight of two eyes ▪ One hand and one foot; or ▪ One hand or foot and sight of one eye	100% of full amount
▪ One hand ▪ One foot ▪ Sight of one eye	50% of full amount

If more than one loss is sustained as the result of the same accident, benefits will be paid only for the loss with the greatest benefit amount.

Loss of:

- Hand(s) means severance at or above the wrist joint;
- Foot or feet means severance at or above the ankle joint; and
- Eye(s) means the total and irrecoverable loss of sight.

AD&D Benefits Exclusions and Limitations

Benefits are not paid for any loss (death or Injury) that:

- Is caused by suicide or attempted suicide while sane;
- Results from declared or undeclared war or act of war;
- Is a bodily or mental Illness or disease of any kind;
- Results from medical or surgical treatment of an Injury or Illness;
- Results from Ptomaine or bacterial infections (except for pyogenic infections occurring simultaneously with and as a consequence of a visible accidental cut or wound);
- Due to service in the armed forces of any country; or
- Due to participation in a riot or in the commission of a crime that may be punishable as a felony.

DESIGNATING YOUR BENEFICIARY

You may designate any person or persons as your Beneficiary by completing and submitting a written form to the Fund Office. If you want to designate more than one Beneficiary, be sure to allocate the percentage to be paid to each Beneficiary; otherwise, Beneficiaries will share equally. The Beneficiary(ies) you designate for your Death Benefit will be the same for your AD&D Benefit (if applicable).

You can change your Beneficiary(ies) at any time, without the consent of the previously named Beneficiary. The initial designation or change of designation will take effect on the date the Fund Office receives the signed form.

It is important that you designate a Beneficiary(ies). If you do not, or your designated Beneficiary(ies) does not outlive you, your benefit will be paid to your:

- Surviving spouse; or if none,
- Surviving Children in equal shares; or if none,
- Surviving parent(s) in equal shares; or if none,
- Surviving brothers and sisters in equal shares; or if none,
- Your estate.

If you designate your spouse as your Beneficiary and you subsequently get divorced, the designation will no longer be valid. You may then designate anyone as your Beneficiary, including your former spouse. If you do not name a new Beneficiary after your divorce, the portion of your Death Benefits that your former spouse was eligible for will be paid to your estate.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan provides coverage for many healthcare expenses; however, not all expenses are covered. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits will not be paid or payable for any item listed in this section.

The Plan pays benefits only for those expenses expressly described as coverage; any omission will be presumed to be an exclusion.

1. Any Illness 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 institution 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 an Illness 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 Illness or Injury resulting from the participation in a public disturbance or terrorist act, or riot or resulting from the commission of a felony. This exclusion will not apply to Injury resulting from an act of domestic violence or a medical condition (physical or mental).
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 by or available from the local, state or federal government, whether or not that payment is received.
9. Services or supplies that are Experimental or Investigative or do not meet accepted standards of medical practice.
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, that 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 inpatient stay when the stay is primarily for behavioral problems, social maladjustment, or other antisocial actions that are not specifically the result of a Mental and 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, 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 that are not 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 tuba1 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.
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 steroids;
    - prescription contraceptives, non-prescription contraceptives;
    - hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa);
    - tobacco/smoking cessation; and
    - Vitamin A derivatives.

38. Genetic testing and 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 aids, auditory aids, speech aids, programs to assist with auditory perception and/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.
41. Immunizations or vaccines for foreign travel.

CLAIM AND APPEAL 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 US. 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

A claim 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 641 11
Attn: Mark E. Myhrman
816-756-3313
Fax: 816-756-3659

Providers should file claims directly with the PPO.

Authorized Representatives

An Authorized Representative 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.

An Authorized Representative is a person with authority to act on your behalf to file a claim in accordance with the Fund's procedures. In the case of a claimant under the age of 18, the parent or stepparent of the claimant will automatically be deemed an Authorized Representative, unless the Fund receives a written, signed notice from the claimant requesting otherwise. The following individuals may be recognized as your (or a claimant's) Authorized Representative:

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

An assignment of payment to a health care provider is not a designation of the provider as an Authorized Representative. In addition, you are not permitted to assign payment of any claim directly to an out-of-network health care provider.

The Fund may request additional information to verify that this person is authorized to act on the claimant’s behalf.

A duly Authorized Representative will be able to make any decision or take any action or inaction that is available to the claimant regarding the claim. 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.

The written decision of the Board of Trustees or the Claims Appeal Committee will be final, binding, and conclusive upon a claimant. All review procedures described above must be followed and exhausted before a claimant may institute any legal action, including an action or proceeding before any court, administrative agency, or arbitrator.

Claims for Medical Services

The following procedure applies to claims for Medical Services (Non-Disability claims):

- 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).
- 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.

Generally, all health care benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered your notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision on your claim.

The deadlines differ for the different types of claims as shown in the following information.

Urgent Care Claims. An initial determination will be made within 72 hours from receipt of your claim, unless additional information is needed. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to provide the additional information. The initial 72-hour deadline is suspended for up to 48 hours or, if sooner, until the information is received. Notice of the decision will be provided no later than 48 hours after the Fund Office receives the additional information or, if sooner, the end of the period given for you to provide this information.

Pre-Service Claims. An initial determination will be made within 15 days from receipt of your claim. If the Fund Office determines that additional time is necessary to make a determination, due to matters beyond the control of the Plan or the provider, the initial period may be extended for up to 15 additional days. Within the initial 15-day deadline, you will be informed of the extension, including the circumstances requiring the extension and the date the Plan expects to make a determination. If additional information

is needed to process your claim, the Fund Office will notify you of the information needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 15 days.

Post-Service Claims. An initial determination will be made within 30 days from receipt of your claim. If the Fund Office determines that additional time is necessary to make a determination due to matters beyond the control of the Plan or the provider, the initial period may be extended for up to 15 days. Within the initial 30-day deadline, you will be informed of the extension, including the circumstances requiring the extension and the date the Plan expects to make a determination. If additional information is needed to process your claim, the Fund Office will notify you of the information needed. You then have up to 45 days from receipt of the notice to provide the requested information. After 45 days or, if sooner, after the information is received, a determination will be made within 30 days.

Concurrent Care Claims. While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment (i.e., longer than the prescribed period of time or number of treatments), the Plan or provider will act on your request as soon as possible, and you will be notified within 24 hours after the Plan or provider receives your request, provided your claim is received at least 24 hours before the expiration of the approved treatment (i.e., prescribed period of time or number of treatments).

Disability Claims

A **Disability claim** is a claim for Loss of Time benefits. You must complete a Disability claim for a Loss of Time benefit and submit it, along with written proof of your disability, to the Fund Office. The Fund makes a decision on your claim and will notify you of the initial decision within 45 days of the date your claim is received.

The 45-day timeframe may be extended. If the Fund requires an extension of time due to matters beyond its control (for example, there's a delay in receiving medical information from your Physician or other provider), it may extend its decision period by 30 days. The Fund will notify you of the extension in writing before the end of the first 45-day period. The notification will include the reason for the delay and when the Fund expects to make a decision. The decision period may be delayed an additional 30 days, provided the Fund Office notifies you (before the expiration of the initial 30-day extension period) of the circumstances that require the extension and the date on which the Fund expects to make its decision regarding your claim.

If an extension is needed because the Fund needs additional information from you, your extension notice will include the additional information needed and the time period in which you must provide the additional information. You will have 45 days from the date you receive the notice to provide the additional information. If you do not provide the requested information within this time period, the Fund will make a decision on your claim based on the information it has, and as a result may deny your claim. During the period in which you are allowed to provide the additional information, the Fund's normal period for making its decision is suspended. The deadline is suspended to either 45 days from the date of the extension notice, or 45 days from 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 your claim and notify you of its determination. If the Fund has applied either of the 30-day extensions, it has the additional time to determine the claim.

The Fund reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while your claim for a Loss of Time benefit is pending.

Death Benefit and AD&D Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 90 days of receipt of your claim. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Plan or provider), you will be notified within this 90-day deadline. This 90-day period may be extended up to an additional 90 days maximum.

Denial (Adverse Benefit Determination)

For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination is defined as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit;
- A determination after service occurred, of an individual's eligibility to participate in this Fund;
- A benefit denial resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate;
- Payment in accordance with the plan of benefits, but less than the total amount of expenses submitted with regard to a claim; for example, application of deductible, or copayment requirements; or
- Any cancellation or discontinuance of coverage that has retroactive effect, except to the extent that it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

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

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 adverse determination;
- Reference to the specific benefit provision(s) on which the denial is based;
- A description of any additional material or information necessary to complete the claim, and an explanation of why the material or information is necessary;
- A description of the Plan's review 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;

- The specific internal rule, guideline, protocol, standard, or other similar criteria that the Plan relied upon in making the adverse determination on your claim (at no charge); or a statement that such rule, guideline, protocol, standard, or other similar criteria of the Plan does not exist.
- If the adverse benefit determination is based on a medical judgment (Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit)—either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your claim); or a statement that such an explanation will be provided free of charge upon request.
- For a disability claim filed on or after April 1, 2018, a discussion of the adverse benefit determination, including an explanation of the basis for disagreeing with or not following:
    - the views you presented to the Plan of the health care and vocational professionals who treated and evaluated you;
    - the views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, regardless of whether that advice was relied upon in making the benefit determination; and
    - a disability determination made by the Social Security Administration that you presented to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to your claim for benefits.

In addition, the Plan must provide notices and requests in a culturally and linguistically appropriate manner.

Request For Appeal Of Denied Claim

If your claim is denied—in whole or in part—or you disagree with the decision made on your claim, you have up to 180 days after you receive an initial adverse benefit determination to file a written appeal with the Fund Office. The Fund will not accept appeals filed after this 180-day period.

If you file a timely written appeal, you may:

- Submit additional materials, including reasons you disagree with the decision on your claim, and any written comments, documents, records, statements, or other supporting information relating to your claim.
- Request to review and obtain copies of all information and 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; or
    - was submitted, considered, or generated (regardless of whether it was relied upon); or
    - demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making.
- Be provided, upon request, with the identity of any medical or vocational experts (if any) whose advice was obtained on behalf of the Fund in connection with your

adverse benefit determination, regardless of whether their advice was relied upon in making the adverse benefit determination.

The Board of Trustees is the Plan Administrator and the fiduciary responsible for all benefit determinations on appeal. The Board of Trustees may delegate all fiduciary responsibility for claims determination on appeal to the Claims Appeal Committee. Once your appeal is received, the Claims Appeal Committee reviews your appeal at their next regularly scheduled quarterly meeting. The Committee provides a full and fair review, taking into account all comments, documents, records, and other information submitted (without regard to whether such information was submitted or considered in the initial benefit determination). If you file your appeal within 30 days of the date of the meeting, a determination on your appeal is made at the second regularly scheduled quarterly meeting following the receipt of your appeal. If special circumstances require a further extension, a decision is made at the third quarterly meeting following the receipt of your appeal. You are notified if any extension is necessary.

The Committee does not give deference to the initial adverse benefit determination, and decision is not made by the same people (or subordinates of those people) who made the initial adverse benefit determination. The decision is made on the basis of the record, including such additional documents and comments you may submit on your appeal.

If your initial adverse benefit determination was based on medical judgment (such as a determination that the treatment, service, drug, or other item was not medically necessary, not appropriate, 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 adverse benefit determination, or the subordinate of that person.

In the case of a Disability claim, the Fund will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated when making the benefit determination in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of a date on which the notice of adverse benefit determination on review is required and provided to give you a reasonable opportunity to respond prior to that date. In addition, the Fund will provide you, free of charge, with any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination or review is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

You receive notice of the decision in writing within five days of the meeting at which the decision on your appeal is made.

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;
- Was submitted, considered, or generated in the course of making the decision (regardless of whether it was relied upon);
- Demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or

- Constitutes a statement of plan policy regarding the denied treatment or service.

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

The Board of Trustees or 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 subordinates 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

A determination on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

Health Care Claims:

- **Urgent Care Claims**. A determination will be made within 72 hours from receipt of your appeal.
- **Pre-Service Claims**. A determination will be made within 30 days from receipt of your appeal.
- **Post-Service Claims**. A determination will be made at the Trustees' next regularly scheduled meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a decision will be made at the third meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. You will be notified of the decision in writing within five days of the meeting at which the decision is made.
- **Concurrent Care Claims**. A determination will be made before reduction or termination of your benefit.

Loss of Time, Death Benefit, and AD&D Benefit

A determination will be made at the Trustees' next quarterly meeting following receipt of your appeal. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second quarterly meeting following receipt of your appeal. If special circumstances require a further extension, a decision will be made at the third quarterly meeting following receipt of your appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. You will be notified of the decision in writing within five days of the meeting at which the decision is made.

Hearing Procedures

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

Notice of Decision on Review

If your appeal is denied—in whole or in part—you will receive the written decision that includes the following:

- The specific reason(s) for the adverse appeal review decision.
- Reference to the specific Plan provision(s) on which the denial is based.
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- A description of the Plan's review procedures and applicable time limits, including the right to bring civil action under ERISA Section 502(a) within two years following the appeal.
- The specific internal rule, guideline, protocol, standard, or other similar criteria that the Plan relied upon in making the adverse determination on your appeal (at no charge); or a statement that such rule, guideline, protocol, standard, or other similar criteria of the Plan does not exist.
- If the denial is based on a medical judgment (Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit)—either an explanation of the scientific or clinical judgment for the denial (applying the terms of the Plan to your appeal), or a statement that such an explanation will be provided free of charge upon request.
- The statement that: You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your U.S. Department of Labor Office and your State insurance regulatory agency.
- For disability claims filed after April 1, 2018, a discussion of the adverse benefit determination on appeal, including an explanation of the basis for disagreeing with or not following:
  - the views you presented to the Plan of the health care and vocational professionals who treated and evaluated you;
  - the views of medical or vocational experts whose advice was obtained by the Plan in connection with your adverse benefit determination, regardless of whether that advice was relied upon in making the benefit determination; and
  - a disability determination made by the Social Security Administration that you presented to the Plan.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records, and other information relevant to your appeal.

In addition, the Plan must provide notices and requests in a culturally and linguistically appropriate manner.

For disability claims filed after April 1, 2018, before the Plan can issue a denial on an appeal, the Fund Office provides you—free of charge—with any new or additional rationale and evidence considered, relied upon, or generated by the Plan, insurer, or by

any other person making the benefit determination in connection with the claim. This information is provided as soon as possible and sufficiently in advance of the date on which the notice of your appeal denial is required to be provided to you. This is to give you a reasonable opportunity to respond to this evidence prior to the notification date.

Limitation on When a Lawsuit May Be Started

You may not file suit against the Plan until you exhaust all of the Plan's claims and appeals procedures.

If the Plan does not comply with all the regulations stated in these procedures, you are deemed to have exhausted the administrative remedies available under the Plan and are entitled to pursue any available remedies under ERISA Section 502(a). However, the administrative remedies will not be deemed exhausted, if the Plan demonstrates a violation was for good cause or due to matters outside the Plan's control, and the violation does not cause harm to you.

SOLE AUTHORITY ON BENEFITS

You may not file suit against the Plan until you have exhausted all of the Plan's Claim and Appeal Procedures, as described in this section. However, if the Plan does not issue a decision on a claim within the periods stated in these procedures, you have the right to file an appeal. In addition, if a decision on an appeal is not provided within the time limits stated in these procedures, the requirement to exhaust Plan remedies does not apply.

Under the documents creating the Plan, the Trustees have sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the Participant or Beneficiary is entitled to benefits under the Plan's terms. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a Plan benefit. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

You may have, at your own expense, legal representation at any stage of the review process. If a provision of the Trust Agreement or the Plan, or any amendment to the Trust Agreement or the Plan, is determined to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

BENEFIT PAYMENTS

Benefit payments under the Fund may become payable to a person who is judged to be incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which they are paid, if they are paid:

- Directly to such person;
- To the legally appointed guardian or conservator of such person;

- To any spouse, Child, parent, brother, or sister of such person for the welfare, support, and maintenance of that person; or
- By the Trustees directly for the support, maintenance, and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

COORDINATION OF BENEFITS

The Plan has been designed to help you meet the cost of Illness or Injury. It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of Medical, Dental, and/or Vision Benefits payable under this Plan will take into account any medical, dental, or vision coverage you or a Dependent has 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 that, when added to the benefits payable to you by the other plan or plans, will equal the total Allowable Expenses. However, no more than the maximum benefits payable under this Plan will be paid.

Allowable Expenses

Any necessary, reasonable, and customary item of expense that at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

If you or your Dependents are covered under another plan, you must report such duplicate group health coverage to the Fund Office to secure reimbursement of Allowable Expenses incurred.

Another plan means any plan providing benefits or services for medical, dental, or vision care that are provided by:

- Group insurance coverage;
- Any group Hospital service prepayment plan, group medical service prepayment plan, or other prepayment coverage;
- Any coverage under a labor-management trusteed plan or employee benefit organization plans; and
- Any coverage under governmental programs or required or provided by any state, including Medicaid.

Coordination of Benefits with Medicare

The Medicare Coordination of Benefits (COB) rules take precedence before any other Plan COB rules. Medicare is a multi-part program:

- **Medicare Part A:** Officially called *Hospital Insurance Benefits for the Aged and Disabled,* it primarily covers Hospital benefits, although it also provides other benefits.
- **Medicare Part B:** Officially called *Supplementary Medical Insurance Benefits for the Aged and Disabled*, it primarily covers Physician's services, although it, too, covers a number of other items and services.
- **Medicare Part C:** Called *MedicareAdvantage,* it is a Medicare managed care offering. If you are covered by an HMO, the Plan will presume that you have

complied with the HMO rules necessary for your expenses to be covered by the HMO.

- **Medicare Part D:** Called *Medicare Prescription Drug Coverage,* it is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

Coordination with Medicare Coverage for Active Members

Generally, anyone age 65 or older is eligible for Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also generally eligible for Medicare coverage after a waiting period.

- **Medical Participants Who Retain Or Cancel Coverage Under This Plan**

  If you, your covered spouse, or Dependent Child becomes covered by Medicare, you may either retain or cancel your coverage under this Plan. If you choose to retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits and your contributions for coverage will remain the same. The Plan will pay first and Medicare will pay second.

  If you choose to cancel your coverage under this Plan, coverage for your spouse and/or Dependent Child(ren) will terminate.

- **Coverage Under This Plan and Medicare When You Are Totally Disabled**

  If you become totally disabled and you are entitled to Medicare because of your disability, you will no longer be considered "actively employed." As a result, once you become entitled to Medicare because of your disability, Medicare will become your Primary Plan and will pay first, with this Plan paying second.

- **Coverage Under This Plan and Medicare When You Have End-Stage Renal Disease**

  If, while you're 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.

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

Coordination with Medicare Coverage for Retired Members

If you are retired and covered by Medicare Parts A, B, or C, as well as this Plan, Medicare pays first and this Plan pays second. Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. If a Retiree under this Plan is covered by Medicare and cancels coverage under this Plan, coverage for his/her Dependents will terminate.

When a retired member or Dependent of a retired member is covered by Medicare Part A and B, this Plan will be secondary to Medicare. In such cases, this Plan pays the Part A deductible and coinsurance and the Part B deductible and coinsurance amounts not

payable by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Reasonable and Customary Charges of the health care provider.

If you are a Medicare-eligible Retiree or Medicare-eligible Dependent of a Retiree and enroll for Medicare Prescription Drug Coverage (Medicare Part D), you will no longer receive prescription drug benefits under this Plan. You will continue to be eligible to receive medical benefits under this Plan. However, your monthly premium for coverage under this Plan will not be reduced.

If you or your Dependent enroll for Medicare Part D, lose Health and Welfare Fund prescription drug benefits, and later decide to drop Medicare Part D, you will be given the opportunity to re-enroll in this Plan's prescription drug benefits. Contact the Fund Office for more information.

This Plan will pay benefits as if you are enrolled in all Medicare Parts A and B benefits that you would be eligible for regardless of whether you enrolled in Medicare. So, even if you do not enroll in Medicare Parts A and B when you are eligible, the Plan will pay Retiree benefits as if Medicare were also making payments on your behalf.

Coordination with Medicaid

The Plan honors any Medicaid assignment of rights made on your behalf. The Plan also honors any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for expenses covered by the Plan. In addition, the Plan will not consider Medicaid eligibility or medical assistance provided by Medicaid in determining Plan benefits or eligibility.

PRIVACY RULES

These rules describe how medical information about you may be used and disclosed and how you can have access to this information. Please review them carefully.

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

The Health and Welfare Fund exists for one purpose—to provide health and welfare benefits to Participants in the Fund. In the course of providing benefits, the Fund receives and maintains information that constitutes "protected health information," as defined in federal privacy rules. Please contact the Fund Office for a copy of the HIPAA Privacy Notice describing the Fund's policies that protect you from the unnecessary disclosure of your health information and give you certain rights regarding your health information.

Contact Person

The Fund has a designated Privacy Coordinator. The Privacy Coordinator is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Coordinator at 3100 Broadway, Suite 805, Kansas City, Missouri 64111, 816-756-3313.

PROTECTION AND SECURITY OF PROTECTED HEALTH INFORMATION (PHI)

- The Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) only to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund will not disclose protected health information to the Plan Sponsor, the Board of Trustees of the *Plan*, or permit a health insurance issuer or HMO to disclose protected health information unless this disclosure complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

- The Fund may disclose to the Board of Trustees "summary health information" (information which summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Trustees provide coverage under the Fund and from which aspects permitting identification, other than a five digit zip code, have been eliminated) and this information may be used by the Board of Trustees to obtain premium bids from health plans for providing health insurance coverage under the Fund or for the Board of Trustees to modify, amend or terminate this Plan.

- The Fund may disclose to the Board of Trustees protected health information concerning whether a person participates in the Fund or have enrolled or disenrolled from a health insurance issuer, or in the event the Fund were ever to have such options, an HMO.

- The Fund may disclose protected health information to the Board of Trustees pursuant to a written authorization supplied by the Participant or Beneficiary, which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

- Except for the disclosures set forth above, in order for the Fund to disclose protected health information to the Board of Trustees or to permit the disclosure of such information to the Board of Trustees by a health insurance issuer or HMO with respect to the Fund, for any purposes including the administration of the Fund, the Fund must ensure that the plan documents restrict uses and disclosure of protected health information consistent with the requirements of the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. These restrictions are set forth in this Section.

- In order for the Fund to disclose protected health information to the Board of Trustees other than as set forth above, the Board of Trustees must certify that the Plan has been amended to incorporate the provisions set forth as follows and that the Board of Trustees agrees to each of these items. Specifically, the Board of Trustees agrees that it will:

  - not use or further disclose protected health information other than as permitted or required by the plan documents or as required by law;
  - ensure that any agents, including a subcontractor, to whom the Board of Trustees provides protected health information received from the Fund agree to the same

restrictions and conditions that apply to the Board of Trustees with respect to the protected health information;

- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;
- report to the Fund any use or disclosure of the protected health information that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- make available protected health information as required by the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;
- make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;
- make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information; and
- if feasible, return or destroy all protected health information received from the Fund that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible and provide for the separation of the Fund and Board of Trustees and protections set forth below.

■ The Board of Trustees shall ensure that adequate separation exists between the Fund and the Board of Trustees. In order to ensure this separation:

- access to protected health information provided from the Fund to the Board of Trustees shall be restricted to the members of the Board of Trustees who are involved in matters relating to payment, health care operations or other matters pertaining to the Fund in the ordinary course of business:
- Access by the Trustees to protected health information provided from the Fund to the Board of Trustees shall be restricted to the plan administration functions that the Board of Trustees provide for the Fund; and
- The Board of Trustees shall provide an effective mechanism for resolving any issues of noncompliance by Trustees with the provisions of this Section.

■ The Fund may not disclose protected health information to the Board of Trustees nor permit a health insurance issuer or HMO to disclose protected health information to the Board of Trustees as otherwise permitted under the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information unless a statement required by Section 164.520(b)(1)(iii)(C) of these Regulations is included in the Notice of Privacy Practices promulgated under Section 164.520.

■ The Fund may not disclose protected health information to the Board of Trustees for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

SUBROGATION

In the event the Plan provides benefits for an Injury, sickness, or other loss (hereinafter the "Injury") to any Covered Person, the Plan will be automatically 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," for this section only) may have arising out of said Injury, sickness or other loss. Said recovery will not be limited by characterization of loss and will include recovery for personal Injury, lost wages, loss of service, disability, and claims for wrongful death, survivor, or other claims under any state or federal law. The Plan is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Plan will automatically have a first priority lien and will be entitled to first dollar reimbursement from any recovery regardless of whether the Covered Person is made whole by said recovery. These rights of reimbursement and subrogation are reserved whether the admitted, determined, and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights will attach to any lawsuit, full or partial judgment, settlement, or other recovery. The Plan will be entitled to assert a lien against third parties, insurers, attorneys, and any other appropriate person or entities admitted, determined, and/or alleged to be liable to the Covered Person in order to protect its right of subrogation.

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

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

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

The Covered Person, or if a minor, the Covered Person's parent or legal guardian, conservator or next friend will execute and deliver such documents and papers (including, but not limited to a benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund Office as the Plan may

require to protect its rights of reimbursement and subrogation. The Covered Person will do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan or the joinder of the Trustees or Plan in any claim or action against the admitted, determined, and/or alleged to be liable party or parties.

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

The Plan 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 Plan in such instances.

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

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

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

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

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

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

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

ADMINISTRATIVE INFORMATION

Plan Name

Mo-Kan Teamsters Health and Welfare Fund

Plan Numbers

The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 43-6124888. The Plan number assigned to this Plan by the Board of Trustees per Internal Revenue Service instructions is 501.

Plan Year

The accounting records of the Plan are kept on a Plan Year basis, beginning each January 1 and ending the following December 31.

Plan Sponsor and Plan Administrator

A Board of Trustees is responsible for the operation of this Plan. Although the Trustees are legally designated as the Plan Sponsor and Plan Administrator, they have delegated daily administrative responsibilities to a contract administrator, currently Wilson-McShane Corporation. The Fund Office, under the direction of the Administrative Manager, is responsible for maintaining eligibility records, accounting for Employer contributions, answering Participant inquiries, processing certain claims, and handling other routine administrative functions.

The Board of Trustees consists of Employer and Local Union representatives selected by the Employers and the Local Union that have entered into collective bargaining agreements that relate to this Plan. If you want to contact the Board of Trustees, you may use the address and phone numbers below:

Mo-Kan Teamsters Health and Welfare Fund
c/o Wilson-McShane Corporation
3100 Broadway, Suite 805
Kansas City, MO 64111
Phone: 816-756-3313
Fax: 816-756-3659
www.wilson-mcshane.com

If you want to inspect or receive copies of additional documents relating to this Plan, contact the Board of Trustees. You may be charged a reasonable fee to cover the cost of any document you request.

The Trustees of this Plan are:

Union Trustees	**Employer Trustees**
Mr. Mark Bruemmer Teamsters Local Union No. 833 230 West Dunklin Street Jefferson City, MO 65101	Mr. Greg Davey The Builders' Association 720 Oak Street Kansas City, MO 64106
Mr. Dan Gercone Teamsters Local Union No. 541 4501 Emanuel Cleaver II Boulevard Kansas City, MO 64130	Mr. Patrick Leis [Address Needed]
Mr. Mike Keeran Teamsters Local Union No. 541 4501 Emanuel Cleaver II Boulevard Kansas City, MO 64130	Ms. Mary E. McNamara Cornell Roofing & Sheet Metal Co. 901 S. Northern Boulevard Independence, MO 64053
Mr. Jeff Stiffler [Address Needed]	Mr. Mike Morris Mullelman & Hall 4992 E. Blue Banks Avenue P. O. Box 300858 Kansas City, MO 64130

Administrative Manager

Mark Myhrman
Wilson-McShane Corporation
3100 Broadway, Suite 805
Kansas City, MO 64111
Phone: 816-756-3313
Fax: 816-756-3659

Fund Counsel

Arnold, Newbold, Winter & Jackson P.C.

Fund Auditor

Summers, Spencer & Company, P.A. SS&C

Fund Consultant

Segal Consulting

Collective Bargaining

This Plan is maintained pursuant to collective bargaining agreements between Employers and the Local Union. Upon written request, the Fund Office will provide you with a copy of the collective bargaining agreement under which you are covered. The Fund Office will also provide, upon written request, information as to whether a particular Employer is participating and, if so, the name and address of the Employer. The collective

bargaining agreements specify the amount of contributions, due date of Employer contributions, and type of work for which contributions are payable.

Plan Funding

Benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. Employer contributions finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions of their collective bargaining agreements with Teamsters 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 Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Plan and a portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

Plan Type

This Plan is a welfare plan maintained to provide medical, prescription drug, dental, vision, loss of time, and death benefits for Participants who meet the eligibility requirements described in this booklet.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are described in this SPD. Circumstances that may cause a Participant to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described in this booklet.

Legal Process

Michael G. Newbold, 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. Newbold of Arnold, Newbold, Winter & Jackson, P.C. at 1100 Main Street, Suite 2001, Kansas City, Missouri 64105 or upon any Trustee at the Fund Office, 3100 Broadway, Suite 805, Kansas City, Missouri 64111.

Plan Amendment and Termination

The Board of Trustees expects that the Fund will be permanent. However, the Trustees have the right to change, modify, or terminate all or any part of the Plan at any time, in accordance with the Trust Agreement and the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Board of Trustees will notify you in writing if the Plan is amended or terminated. If all or a part of the Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plan, and distribute the balance of the assets in a manner consistent with the purpose of the Fund.

Board of Trustees' Discretion and Authority

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan, and decisions of the Trustees or their delegates are final and binding. **Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan.** In the

event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder and will be accorded judicial deference, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. You may, at your own expense, have legal representation at any stage of the review process.

If a provision of the Trust Agreement or the Plan, or any amendment made to the Trust Agreement or the Plan, is determined or judged unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

YOUR ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to continue healthcare 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. The Fund Office will provide you with the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

Nearest Regional Office
Employee Benefits Security Administration
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
816-285-1800

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visitingwww.dol.gov/ebsa.

DEFINITIONS

Terms defined in this section are used throughout this Summary Plan Description booklet. For your convenience, these defined terms are capitalized in the text of this booklet.

Allowable Expense

Any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.

Child

A Child includes your:

- Legitimate child born of a valid marriage;
- Natural child who is not a legitimate child born of a valid marriage;
- Legally adopted child, including a child placed with you pending legal adoption;
- Stepchild, which is a child of your current spouse who, before your marriage, was born to your spouse or was legally adopted by your spouse (including a child placed with your spouse pending adoption);
- Foster child, which is a child who has been placed in your home by an authorized placement agency or by a court judgment, decree, or other court order, provided that no state or private social service agency pays any support or compensation to you or any member of your household for the support or maintenance of the child; and
- A child for whom you have responsibility under a Qualified Medical Child Support Order (QMCSO).

"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. The child's placement with the Participant ends upon the termination of this legal obligation.

Covered Charge

The Reasonable and Customary Charge for services or supplies listed as covered under the Plan that are provided on the recommendation and approval of a Physician (for medical benefits) or Dentist (for dental benefits). A charge is considered incurred on the date the service or supply is received. Covered Charge does not include any charge:

- For a service or supply which is not Medically Necessary; or
- Which is in excess of the Reasonable and Customary Charge for such service or supply.

Covered Employment

Employment for which your Employer is required to contribute to the Fund on your behalf under a collective bargaining agreement with the Local Union.

Custodial Care

Care intended primarily to help a disabled person meet basic personal needs when:

- There is no plan of active medical treatment to reduce the disability; or
- The plan of active medical treatment cannot be reasonably expected to reduce the disability.

Dentist

A person licensed to practice Dentistry by the governmental authority having jurisdiction over the license and practice of Dentistry.

Dependent

An eligible Dependent is any one of the following persons:

- Your legal spouse; or
- Any Child, whether married or unmarried, until the last day of the month in which they turn age 26; or
- An unmarried Child who is incapable of self-sustaining employment because of a permanent physical or mental condition that is expected to result in death or last for a continuous period of 12 months or more, provided:
  - such incapacity began before the Child reached age 19;
  - the Child receives more than one-half of his or her financial support and maintenance from you;
  - the Child maintains a permanent residence with you during more than one-half of the calendar year; and
  - proof of such incapacity is submitted to the Trustees within 31 days of the date the child's eligibility would otherwise terminate.

  In the case of a divorce or separation, if the disabled Child does not have the same principal place of residence as you for over one-half of the calendar year, or if you do not provide over one-half of the disabled Child's support, the Child will be an eligible Dependent provided that:
  - you and the disabled Child's other parent are:
    - divorced or legally separated under a decree of divorce or separate maintenance;
    - separated under a written separation agreement; or
    - living apart at all times during the last six months of the calendar year;
  - you and the disabled Child's other parent provide over one-half of the Child's support during the calendar year;
  - the disabled Child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
  - the disabled Child meets all other required eligibility criteria**.**

Durable Medical Equipment

Equipment that:

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

Emergency

- A medical condition that, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part, or other serious medical consequences. These conditions must be severe, sudden in onset, and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal, or urinary system. In no event will a condition be considered an Emergency if the first treatment by a Physician is provided more than 24 hours after the onset of symptoms.
- If symptoms exist that reasonably may have been interpreted as an Emergency under the above definition, that condition will be considered an Emergency even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made.
- Conditions that result from accidents that appear to be serious and so threatening to a body part that emergency room treatment is indicated. These conditions will be considered Emergencies, even though they do not otherwise meet the definition of Emergency.
- Transportation to the nearest Hospital or trauma center by police, fire department, or ambulance, when the transportation is made under circumstances over which the person has no control, except in cases of transportation to a Hospital for reasons related to the use of alcohol or non-legal use of controlled substances.
  [**NOTE to Fund Counsel:** This may possibly be prohibited by HIPAA (discrimination on the basis of a health factor - i.e., an addiction).]

Employee

An individual who is working for an Employer within the jurisdiction of the Fund which is covered by a collective bargaining agreement or any written agreement requiring Employer contributions on the Employee's behalf to be made to this Health and Welfare Fund.

Employer

An association, individual, partnership, or corporation that has a collective bargaining agreement or other written agreement with the Local Union, if that Agreement requires the employer to pay contributions to the Fund.

Enrollment Date

For:

- An Employee, the date the Employee begins the waiting period for initial eligibility;
- A Retiree, the date the Retiree meets the Plan's eligibility requirements for the Retiree Benefit Plan; and
- Dependents, the date the person is added as a Dependent.

Experimental/Investigative

Services, supplies, or procedures that the consensus of expert medical opinion, based on reliable evidence (i.e., published reports or articles) indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment. Experimental or Investigative also means services or treatments not recognized as having proven beneficial outcomes, those still primarily confined to a research setting and those that are not appropriate based on medical circumstances or given the advanced stage of an individual's Illness or the likelihood that the service or treatment will measurably improve the individual's Illness or medical condition. The Trustees will have the sole authority to determine whether a treatment, service or supply is Experimental or Investigative.

Fund

Mo-Kan Teamsters Health and Welfare Fund, as established under the Amended Agreement and Declaration of Trust.

Home Health Agency

- A Hospital possessing a valid operating certificate authorizing the Hospital to provide home health services; or
- A public or private health service or agency licensed as a Home Health Agency by the state in which it operates to provide coordinated home care.

Each visit from a Home Health Agency of four hours or less is considered a single visit.

Home Health Aide

A health worker other than a Physician, nurse, or professional therapist, who is on the staff of a Home Health Agency and performs personal health care services, such as helping the patient bathe, helping the patient in and out of bed to exercise, helping the patient with medications that are ordinarily self-administered, and other services that are intimately related to the health care of the patient and have been specifically ordered by a Physician.

A Home Health Aide does not include a person who ordinarily resides in your home or is your spouse, Child, son-in-law, daughter-in-law, brother, brother-in-law, sister, sister-in-law, parent, father-in-law, or mother-in-law.

Home Health Care Plan

A program for care and treatment established and approved, in writing, by a Physician, together with the Physician's certification that the proper treatment of the Injury or Illness would require confinement as an inpatient in a Hospital or other institution in the absence of the services provided as part of the Home Health Care Plan.

Hospice

A manner of providing care for terminally ill patients, either in their home or in a special care facility. Hospice care allows terminally ill individuals to live their final days in as natural and comfortable a setting as possible.

Hospital

A facility that:

- Has received Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation;
- Operates lawfully in the jurisdiction where it is located;
- Maintains permanent and full-time facilities for bed care of five or more resident patients;
- Has a Physician in regular attendance;
- Continuously provides 24-hour a day nursing service by Registered Nurses; and
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care (either on the premises or by formal arrangement with an acceptable institution) of Injured and Ill persons on a basis other than as a rest home, convalescent home, place for the aged, or place for drug addicts.

Hospital Confinement

A confinement in a Hospital for which you are charged for room and board by the Hospital. Successive periods of Hospital Confinement are considered one confinement, unless:

- They are due to entirely different causes;
- With respect to an Employee's eligibility, the later confinement begins after the Employee has returned to active work on a full-time basis for two weeks; or
- With respect to a Retiree's or Dependent's eligibility, the later confinement is separated from the previous confinement by a period of at least three months.

Illness

A disease (including pregnancy) or bodily Injury.

Infertility

The inability, as certified by the covered individual's Physician, to:

- Conceive after one year of unprotected sexual intercourse; or
- Sustain a successful pregnancy.

Injury

Any damage to a body part resulting from trauma from an external source.

Intensive Care Accommodation

A section, ward, or wing in a Hospital that:

- Is operated exclusively for critically ill patients; and
- Provides special supplies, equipment, and constant supervision and care by a Registered Nurse (RN).

This does not include any Hospital facility maintained for the purpose of providing normal post-operative recovery, treatment, or service.

Licensed Nurse

A professional nurse legally entitled to use the title of Registered Nurse (RN) or Licensed Practical Nurse (LPN).

Local Union

Local Union No. 541 of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers.

Medically Necessary or Medical Necessity

Services, supplies, treatments, and/or confinements must meet the following standards:

- Be effective and essential for the treatment of the patient's condition, disease, ailment or Injury;
- Be at the appropriate level of care or the appropriate setting based on the diagnosis and the generally recognized and accepted standards of medical practice in the United States;
- Be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of care; and
- Not be solely for the comfort, convenience or administrative ease of the provider, 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 this 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.

Mental and Nervous Disorder

All forms of Illness in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature as manifested in maladaptive behavior or impaired functioning, whether caused by genetic, physical, chemical, biological, environmental, psychological, social, or cultural factors, meeting the criteria further described in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition – Revised) and any subsequent revisions thereto, of the American Psychiatric Association.

Morbid Obesity

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 that 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 that is aggravated by obesity.

Outpatient Surgical Facility

A health care facility where the primary function is performing surgery on an outpatient basis and patients are typically admitted and discharged within 24 hours. A Hospital is not considered an Outpatient Surgical Facility, nor is an office maintained by a Physician or a Dentist for the practice of medicine or Dentistry. Also, a facility whose primary function is performing eye surgery or terminating pregnancies is not an Outpatient Surgical Facility.

Participant

Any one of the following individuals:

- An Employee of an Employer or Retiree who is or may become eligible to receive Plan benefits upon meeting the applicable eligibility requirements; or
- A Dependent of an Employee or Retiree who is or may become eligible to receive Plan benefits by meeting the Plan's definition of Dependent.

Physician

A doctor of medicine, osteopathy and Dentistry operating within the scope of their licenses.

Plan

The health and welfare benefits provided under the Mo-Kan Teamsters Health and Welfare Fund, as described in this Summary Plan Description or subsequently provided.

Qualified Medical Child Support Order

A court order that requires the Fund to cover a Child under the Plan. To be qualified, the QMCSO must contain specific information, must be submitted to the Plan Administrator and must be approved by the Trustees. The Plan has written QMCSO qualification procedures, which are available upon request from the Fund Office.

Reasonable and Customary Charge

The charge made for Medically Necessary services or supplies. These services or supplies cost the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where they are received. In determining whether charges are reasonable and customary, consideration will be given to the nature

and severity of the Injury or Illness being treated and any medical complications or unusual circumstances that require additional time, skill, or experience.

Retiree or Retired Employee

An Employee who formerly worked in Covered Employment and is who is eligible for Retiree benefits under the Plan, as described on page __, and who elects Retiree coverage.

Trust Agreement

The Agreement and Declaration of Trust establishing the Mo-Kan Teamsters Health and Welfare Fund, as amended from time to time.

5754287v5/00868.026