Summary Plan Description
Construction Industry Laborers Welfare Fund

To All Participants:

We are pleased to provide you with the Construction Industry Laborers Welfare Fund benefits booklet. This booklet summarizes the benefits available to you under your Welfare Plan.

The contents and provisions of the Plan as of January 1, 2014, include a description of your medical, dental, vision, loss of time, death, and accidental death and dismemberment benefits. This booklet includes eligibility rules, description of the benefits available, as well as limitations and exclusions. Benefit amounts are summarized on the Schedule of Benefits.

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

There is a separate Plan Document which describes in more detail your eligibility to participate and the benefits you will receive under the Plan. Only the Trustees are authorized to interpret the Plan and not any Employer or Union representative. This Plan Document is available at the Fund Office for your review.

You and your Dependents should read this booklet carefully and retain it in a safe place for future reference. If you should have any questions concerning the benefit program, please feel free to write or call the Fund Office at (800) 392-8726.

The Welfare Fund is maintained and administered by an unpaid Board of Trustees on which the Union and Employers are equally represented. The Board of Trustees has the primary responsibility for decisions regarding eligibility rules, time and manner of payment of benefits, administrative policies, management of Fund assets, and interpretation of Plan provisions.

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

Construction Industry Laborers Welfare Fund
6405 Metcalf, Suite 200
Overland Park, KS 66202

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

Telephone: (913) 236-5490
Toll Free: (800) 392-8726

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

Statement Regarding Status as a Grandfathered Health Plan

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

Contact Information

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

FUND OFFICE

TIC International Corporation
6405 Metcalf, Suite 200
Overland Park, KS 66202-9998
(913) 236-5490
(800) 392-8726 (toll-free)

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

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

- Online at www.bluekc.com
- By phone at (800) 340-0109

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

- Toll-Free: (877) 852-5422

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

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

PRESCRIPTION BENEFIT MANAGER (PBM)

LDI Integrated Pharmacy Services
701 Emerson, Suite 301
Creve Coeur, MO 63141
Toll-Free: (866) 516-3121
www.LDIRx.com

DENTAL BENEFIT

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

- Online at www.connectiondental.com
- By phone at (910) 685-6300 or (800) 544-3014

VISION BENEFIT

TIC International Corporation
6405 Metcalf, Suite 200
Overland Park, KS 66202-9998
(913) 236-5490
(800) 392-8726 (toll-free)

NEW DIRECTIONS EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

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

Table of Contents

Section I - Schedule of Benefits

A. COMPREHENSIVE MEDICAL BENEFITS:

Calendar Year Individual Deductible $400

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

Calendar Year Family Deductible
Limited to 2 Individuals
per Family per year $800

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

Coinsurance (Amount the Plan Pays)

• BCBSKC Preferred Care	90%
• Blue Network	90%
• Blue Card PPO Network	85%
• BCBSKC Participating Providers	85%
• Blue Care Traditional Network	60%
• Out-of-Network, Non-Participating Providers	To out-of-pocket maximum after deductible, then 100% for remainder of calendar year

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

Annual Maximum
(All Comprehensive Medical Benefits) Unlimited

Chiropractic Care Benefit
(Covered Employee Only) Subject to deductible, Coinsurance and out-of-pocket limits up to $250
Calendar Year Maximum

Routine Physical Exam (Covered Employee & spouse only)	Subject to Coinsurance and out-of-pocket limits for In Network benefits only
Emergency Room Benefit	Subject to deductible, Coinsurance and out-of-pocket limits after the Emergency Room Co-Payment
Emergency Room Co-Payment	$62
Hospice Care Benefit (Lifetime Maximum)	Subject to deductible, Coinsurance and out-of-pocket limits up to $10,000
Organ and/or Tissue Transplant	Subject to deductible, Coinsurance and out-of-pocket limits for In Network benefits only
Hearing Aid Benefit (Actives Only) Benefit payable for testing and hearing devices once every 5 Consecutive Calendar Years	Subject to Coinsurance and out-of-pocket limits up to $750 for In Network Benefits only. No Out-of-Network Benefits are payable under the Plan
Colonoscopy Limit to 1 every 10 years for Members 50 and older. Screenings earlier than age 50 for family history of colon cancer.	Subject to Coinsurance and out-of-pocket limits for In Network benefits only.
Qualified Alcohol & Drug Treatment	Subject to deductible, Coinsurance, out-of-pocket limits
Inpatient Nervous and Mental Care	Subject to deductible, Coinsurance, out-of-pocket limits
Outpatient Nervous & Mental Care	Subject to deductible, Coinsurance, out-of-pocket limits

B. PRESCRIPTION DRUG BENEFIT:

Retail Pharmacy

Coinsurance	80%

Mail Order

Coinsurance	83%

There are certain classes of prescriptions that are offered at a discounted price; however, you must pay 100% of the coinsurance. *See page 23 for more information.*

C. LOSS OF TIME BENEFIT:

(Active Employee Only)	
Weekly Benefit	$300.00
Maximum Benefit	13 Weeks

D. DENTAL EXPENSE BENEFIT:

Coinsurance	80%
Maximum Amount Per Individual	
Orthodontia-Lifetime Maximum	$1,500
Temporomandibular Joint	
Once every 5 years	$1,000
All Other Charges	
Calendar Year Maximum	$2,000

E. VISION EXPENSE BENEFIT:

Complete Examination *	$50
Lens, Pair *	
Single Vision RX	$60
Contact Lens RX	$100
Bi-Focal RX	$100
Tri-Focal RX	$125
Lenticular RX	$130
Frames*	$90

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

F. DEATH BENEFIT:

	ACTIVE EMPLOYEES	RETIREES NOT ELIGIBLE FOR MEDICARE
Covered Employee	$5,000	$2,500
Spouse	$3,000	$2,500
Dependent Children		
10 days to 6 months	$500	None
6 months to 19 years (or up to 25 if full time student)	$3,000	None

G. ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT:

Actives Only	
Covered Employee	$5,000
Spouse	$3,000
Dependent Children	
10 days to 6 months	$500
6 months to 19 years (or up to 25 if full time student)	$3,000

RETIREES AND/OR DEPENDENTS ELIGIBLE FOR MEDICARE

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

MEDICARE BENEFIT

Medicare Part A	
Deductible per spell of Illness	100%
Daily Co-payment from 61st –90th day of Hospital confinement	100%
Daily Co-payment from 21st-100th day of nursing home confinement for Rehabilitation purposes only	100%
Medicare Part B	
Annual Deductible	100%
The 20% of remaining Covered Expenses	
Prescription Drug Benefit	None

DENTAL EXPENSE BENEFIT:

Coinsurance	80%
Maximum Amount Per Individual	
Orthodontia-Lifetime Maximum	$1,500.00
Temporomandibular Joint-Once every 5 years	$1,000.00
All Other Charges-Calendar Year Maximum	$2,000.00

VISION EXPENSE BENEFIT:

Complete Examination *	$50.00
Lens, Pair *	
Single Vision RX	$60.00
Contact Lens RX	$100.00
Bi-Focal RX	$100.00
Tri-Focal RX	$125.00
Lenticular RX	$130.00
Frames*	$90.00

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

Section II -Employee Eligibility

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

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

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

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

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

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

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

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

Continuing Eligibility during Disability
If you are a Covered Employee who is wholly and continuously disabled because:

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

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

Credit hours will be calculated:

- from the first day of disability due to an accident; or
- from the eighth day of disability due to Illness;

after you are first treated by a legally licensed Physician, or a Qualified Outpatient Alcohol and Drug Treatment Agency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When such service in the uniformed forces is for more than 31 days, the amount of your eligibility that is remaining at the time of activation for service may be frozen or suspended until you return from such service and elect to reinstate coverage under the Plan. You may make self-payments to continue coverage for yourself and your Dependents for up to 24 months (18 months if you enter service before December 10, 2004) under the Uniformed Services Employment and Reemployment Rights Act (USERRA). However, you will not accumulate any additional eligibility during the time you are absent for such service, and an election to make self-payments to continue coverage during the time of such service (for a period of up to 24 months) will not result in the accumulation of any additional eligibility.

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

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into service in the uniformed forces and a retroactive payment to that date may be charged. You have an obligation to notify the Fund Office, as soon as you know you are entering such service **if you wish to take advantage of contribution coverage. Failure to notify the Fund Office may be taken as an**

indication that you do not wish to purchase coverage for you or your Dependents; so your coverage may not be frozen, and therefore your coverage will not be available when you return.

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

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

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

Spouse or Dependent of Active Employee - Right to Waive Coverage

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

Section III - Dependent Eligibility

Dependent

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

If a person who is your Dependent is also a Covered Employee and eligible for benefits under this Plan, the Plan will reimburse reasonable and customary Covered Expenses submitted for both of the Covered Employees of the Plan. Benefits will not exceed a total payment of 100% of the reasonable and customary Covered Expenses.

If a person is a Dependent child where both parents are Covered Employees and are eligible for benefits under this Plan, the Plan will reimburse reasonable and customary Covered Expenses and submitted for that Dependent child for both of the Covered Employee members of the Plan. Benefits will not exceed 100% of the reasonable and customary Covered Expenses.

Section IV - Retiree Eligibility

Initial Eligibility
To be eligible for retiree coverage, the retiree or un-remarried surviving spouse must:

- be receiving monthly benefits under the Construction Industry Laborers Pension Plan; and

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

- have 10 or more pension credits with the Construction Industry Laborers Fund (Reciprocal Pension Credits earned under St. Louis Laborers Pension Fund, the Kansas Open End Pension Fund, or the Kansas City Laborers Pension Fund may be used to satisfy this requirement); and

- have elected coverage at the time of retirement.

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

On or after January 1, 2014, you and your Dependents are eligible for Dental and/or Vision Benefits, if you elect that coverage at the time of your retirement. If you subsequently discontinue Dental and/or Vision Benefits, you will not be allowed to re-elect these benefits at a later date.

Retirees Who Return To Work For A Contributing Employer
Effective for hours worked on or after January 1, 2013, there are two rules for establishing initial eligibility when you return to work for a contributing Employer after at least three consecutive months following the date on which your pension benefits began:

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

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

(b) Complete one of the following hours requirements:

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

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

Rule 2

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

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

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

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

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

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

Once you establish eligibility, you maintain your eligibility under the rules listed in Section II of this SPD.

If you return to work in Disqualifying Employment as defined in this booklet, any and all hours worked before the date of Disqualifying Employment will not be used as a basis of eligibility.

If you are a Retiree and are eligible under this Section IV by making the required self-payments, you must continue to make self-payments to maintain coverage until you have worked enough hours as stated above to regain eligibility by hours.

Spouse or Dependent of Retiree - Right to Waive Coverage

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

Section V - Termination of Coverage

Employee Coverage

Your coverage as a Covered Employee will immediately terminate:

1. On the date the Plan is terminated.

2. On the date you commence active duty in any military force of any country or state (see Military Leave beginning on page 8).

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

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

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

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

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

Dependent Coverage

The coverage of your Dependent will immediately terminate:

1. On the date the your coverage is terminated;

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

3. On the date your totally and permanently disabled child or any other child who is not your natural, adopted or stepchild ceases to be a Dependent as defined in Section XXIII;

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

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

6. On the date your surviving spouse ceases to be eligible for a pension benefit under the Construction Industry Laborers Pension Fund;

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

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

However, if your benefits terminate while you are totally and continuously disabled due to a non-occupational Accidental Injury or sickness, comprehensive medical benefits will be payable, for Covered Charges incurred due to that continuing disability for three months following the date of termination of coverage and while this Plan is in force.

Section VI - Right to Continuation of Coverage

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

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

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

    a. Your hours of employment are reduced, or

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

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

    a. Your hours of employment are reduced;

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

    c. You die;

    d. You become enrolled in Medicare; or

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

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

    a. Your hours of employment are reduced;

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

    c. You die;

d. You become enrolled in Medicare;

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

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

How long will COBRA Continuation Coverage last?

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

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

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

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

   b. You become enrolled in Medicare;

   c. You die; or

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

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

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

   b. You become enrolled in Medicare;

c. You die; or

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

Keeping the Fund Office Informed of Changes

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

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

Electing to Continue Coverage

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

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

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

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

Payments

The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees. For the first Benefit Period payments for COBRA Continuation Coverage, you will be given credit for the actual hours contributed on your behalf during the qualifying period. After the first qualifying period, all subsequent payments shall be determined by the Trustees but no deduction for hours shall be credited after the first qualifying period.

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

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

Termination of COBRA Continuation Coverage

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

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

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

3. You or your Dependent becomes entitled to Medicare;

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

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

Section VII - Comprehensive Medical Benefits

Calendar Year Individual Deductible
The individual deductible is the amount of Covered Expenses incurred in a calendar year that must be paid by you before you or your Dependents are eligible to receive Comprehensive Medical Benefits. The comprehensive medical deductible amount is shown in the Schedule of Benefits. Any amount that an individual pays towards the Calendar Year Individual Deductible from October 1 through December 31 each year will be credited towards both the current calendar year and the next calendar year.

Calendar Year Family Deductible
If the Covered Expenses applied to the individual deductibles for all eligible family members reach the Family deductible as shown in the Schedule of Benefits, then no additional deductible will be required for the remainder of the calendar year. No single member of the family can satisfy more than the individual deductible amount as shown in the Schedule of Benefits. Any amount that an individual pays towards the Calendar Year Family Deductible from October 1 through December 31 each year will be credited towards both the current calendar year and the next calendar year.

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

Co-Payment
Co-Payment is the portion of Covered Charges that you are required to pay after the calendar year deductible has been satisfied. There are different Co-Payment levels that apply to the various networks and to out-of-network providers.

Out-of-Pocket Maximum
The maximum dollar amount you are required to pay for Covered Expenses incurred in any calendar year. When this amount is reached for an individual in any calendar year, certain Covered Expenses are payable at 100% for the remainder of the calendar year. The out-of-pocket maximum is shown in the Schedule of Benefits.

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

- Ineligible Charges;
- Prescription drug Charges or Co-payment; or
- Charges in excess of plan maximums.

Participating Provider Network
You are covered by the BlueCross BlueShield Kansas City Network. For the most up-to-date provider information for BlueCross BlueShield Kansas City (BCBSKC), you can visit BKBSKC's website at www.bluekc.com or contact the Provider Finder at (800) 810-BLUE (2583). You may also call the Fund Office at (913) 236-5490 or toll-free at (800) 392-8726.

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

Without prior authorization, your claim might not be approved.

Covered Medical Expenses
If you or your Dependent receives Medically Necessary treatment as a result of a non-occupational accidental bodily injury or illness, the Fund will pay the reasonable and customary charges or PPO negotiated rate for Covered Expenses for any such treatment or service. Payment is subject to the deductible amount, Coinsurance and maximum amounts shown in the Schedule of Benefits.

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

Comprehensive Medical Benefit Limitations and Exclusions
Please read this section carefully.

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

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

2. Any treatment or service by a dentist or dental surgeon except as specifically provided for in these comprehensive medical benefits;

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

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

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

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

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

8. Any services or treatment in connection with an admission to a Hospital on a Friday or a Saturday, unless:

    - admission is due to an emergency
    - admission is due to maternity
    - admission occurs within 48 hours of and is the result of an accident
    - surgery is performed the next day
    - the attending Physician certifies in writing the admission is Medically Necessary;

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

10. Any donor Expense in connection with an organ and/or tissue transplant;

11. The following minor surgical procedures are **not covered unless:**

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

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

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

12. Any item listed under "General Limitations."

Group health plans and health insurance issuers offering group health insurance coverage generally may NOT, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your Physician, nurse midwife or physician's assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour, as applicable) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer many not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan administrator.

Section VIII - Prescription Drug Benefit

Prescription Drug Charges are payable only under this benefit and not under any other provision of the Plan. Prescription Drug Charges **do not apply** to the annual deductible or out-of-pocket maximum under the Comprehensive Medical Benefit. Prescription drug means a drug which by law must say "Caution: Federal Law Prohibits Dispensing Without Prescription", and is prescribed for an FDA approved use on well documented standard of medical treatment. The Plan will pay for prescription drugs, subject to the applicable Coinsurance, exclusions and limitations. The prescription benefit allows for a 90 day supply or 300 units, whichever is greater.

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

Retail Pharmacy

To purchase a prescription at a participating retail pharmacy, present your prescription drug card, not your Welfare eligibility card, and prescription to the pharmacist. Your Co-payment will be 20% per covered prescription purchased at a participating pharmacy.

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

Mail Order

If you are taking a maintenance prescription (a prescription that you can expect to take for an extended period of time, i.e., for treatment of high blood pressure or high cholesterol), you can save money by purchasing your maintenance prescription through mail order. If you purchase your prescription through mail order, your Co-payment will be 17% of the cost of each covered prescription. To purchase a prescription through mail order, you must contact the Plan's prescription benefit manager identified on the back of your insurance card.

Limitations

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

- Weight Control
- Cosmetic Drugs: (example skin pigmentation)
- Sexual Dysfunction
- Smoking Deterrents
- Diaphragms

Exclusions

No benefit will be payable for the following:

- Fertility drugs; infertility drugs
- Items lawfully obtainable without a prescription-excluding insulin
- Devices and Appliances
- Prescriptions covered without Charge under Federal, State or Local programs, to include Worker's Compensation
- Drugs used for cosmetic purposes [e.g. Rogaine (monoxidil) for hair restoration]
- Any Charge for the administration of a drug or Insulin
- Experimental, Investigative or Inappropriate Drugs
- Unauthorized refills such as attempting to refill a prescription prior to using 75% of the prescribed dosage
- Genetically Engineered drugs [e.g. Growth Hormones]
- Drugs used for the treatment of addiction to tobacco products, i.e., nicotine gum, Nicoderm patches
- Drugs used for weight control (appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamin supplements containing fluoride)

Contact Information

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

Call: 24-hour Customer Care Call Center: (866) 516-3121

Website: www.LDIRx.com

Section IX - Dental Expense Benefits

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

Routine Oral Examination Benefit

The following procedures are included in this Routine Oral Examination Benefit for "check-up" purposes. These services must be separated by at least six months (182 days) from the last date of service.

(a) Cleaning (prophylaxis)
(b) Oral examination
(c) X-rays
(d) Diagnosis
(e) Preparation of a complete treatment plan

Basic Dental Benefit

These benefits may be part of a treatment plan or in connection with dental disease, a defect or injury, and include:

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

Denture Replacement Benefit

This denture replacement benefit (full or partial) applies to covered dental Charges arising from the replacement of dentures which is not the result of theft, breakage or loss of the previous dentures.

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

Orthodontic Benefit

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

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

If eligibility terminates after a course of orthodontic treatment has begun and appliances were inserted while eligibility was in force, payments will continue until either:

- treatment is completed; or
- the maximum benefit allowable under the Plan has been paid.

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

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

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

If eligibility terminates after a course of Temporomandibular Pain-Dysfunction Syndrome therapy has begun and appliances were inserted while eligibility was in force, payments will continue until either:

- Treatment is completed; or
- The maximum benefit allowable under the Plan has been paid.

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

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

5. For oral hygiene instruction or supplies;

6. For behavioral management or supplies;

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

Extension of Dental Benefits after Termination of Coverage
Dental Expense Benefits payable under the Plan will be paid if you or your Dependent incurs covered dental expenses after the termination date, and if all of the following conditions are met:

1. The dental treatment was started during a period of eligibility;

2. A treatment plan, signed by the licensed dentist, was received and placed on file with the Fund Office prior to termination of coverage; and

3. Expenses shown on the filed treatment plan are incurred within 90 days after the termination of eligibility.

The above provisions apply to all covered dental expenses with the exception of Orthodontic and Temporomandibular Joint Benefits.

If eligibility terminates after a course of Orthodontic or Temporomandibular Pain-Dysfunction Syndrome therapy has begun and appliances were inserted while eligibility was in force, payments will continue until either:

1. Treatment is completed; or

2. The maximum benefit allowable under the Plan has been paid.

Section X - Vision Expense Benefits

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

(a) Examinations performed by a licensed optometrist or ophthalmologist;

(b) Lenses or contact lenses prescribed by such person; and

(c) Frames.

Vision care services can be obtained from any vision provider.

Vision Expense Benefit Limitations
No Vision Expense Benefits will be payable for the following:

1. Examinations in excess of one in any calendar year;

2. Lenses in excess of one pair in any calendar year;

3. Frames in excess of one set in any two calendar years;

4. Sunglasses, unless they are prescribed to be worn generally at all times;

5. Cosmetic materials or options having no corrective value, such as tinted or coated lenses, etc.;

6. Routine yearly examinations, lenses or frames required by an Employer in connection with the occupation of the Covered Person;

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

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

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

Section XI - Situations That Affect Benefit Payments

Coordination of Benefits with Other Plans
This provision refers to coordination of all comprehensive medical, dental and vision benefits under this Summary Plan Description with other plan benefits, including group plans (insured or self-insured) such as benefits available from your spouse's employer and Medicare.

Effect on Benefits
If this Plan, as well as another plan, covers you, or your Dependent during any claim determination period, benefits will be coordinated between the two plans. This provision limits benefits payable under this Plan and other plans during the same claim determination period to 100% of allowable expenses.

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

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

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

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

3. Under uninsured or underinsured motorist insurance;

4. Under motor vehicle medical payment insurance and;

5. Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverages or insurance.

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

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

The Plan reserves the right to initiate an action in the name of the Subrogation Covered Person or his or her guardian, conservator or next friend to recover its subrogation interest, and the Subrogation 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 Subrogation Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Plan, or (2) to take any other action requested by the Plan 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 Subrogation Covered Person.

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

The Plan shall not pay or be held responsible for any portion of the Subrogation 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 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 Subrogation Covered Person shall provide all of the above referenced individuals with notice of the Fund's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Subrogation Covered Person or his/her guardian, conservator or next friend, provided any such agreement is established in writing.

If the Subrogation Covered Person, or his/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 shall be entitled to institute legal action against the responsible party or parties in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to or on behalf of the Subrogation Covered Person.

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

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

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

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

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

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

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

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

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

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

Section XII - Loss of Time Benefit

(Covered Employees only)

Eligibility

Only the Covered Employee (including non-bargained Employees) is eligible for the loss of time benefit. Dependents, retirees and persons eligible under COBRA are not eligible for this benefit.

Benefit

If you become completely and continuously disabled by a non-occupational, accidental bodily injury or illness and are prevented from performing each and every duty of your occupation, a weekly benefit is payable to you in the amount shown in the Schedule of Benefits.

Benefits will be paid up to a maximum of 13 weeks for any one period of disability, regardless of the number of illnesses or injuries during that period.

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

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

2. Undergoes surgery; because of this illness.

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

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

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

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

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

Successive periods of disability separated by less than one day of active work on a full time basis or availability for full time work will be considered one period of disability.

Limitations
Please read this section carefully.

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

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

2. Any period of disability during which the Covered Employee is not under treatment by a legally licensed Physician;

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

4. Any claim where you commit or attempt to commit a felony and thereby suffer injury or disability as a result of that commission or attempt;

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

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

7. Any period of disability during which you are eligible as a qualified beneficiary under the Consolidated Omnibus Budget Reconciliation Act (COBRA);

8. Retirees; or

9. Dependents of the Covered Employee.

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

Section XIII - Death Benefit

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

Benefit

The amount of your Death Benefit and your Dependent's Death Benefit stated in the Schedule of Benefits will be paid to the Beneficiary as defined herein.

Death Benefit in the Event of Permanent and Total Disability (Covered Employee Only)

The Death Benefit stated in the Schedule of Benefits will be in force on the disabled covered Employee from the last day on which he is actively employed at work until age 62. Upon reaching age 62, the disabled Covered Employee becomes eligible for the Retirees' Death Benefit and the amount of coverage will be the amount stated in the Schedule of Benefits. Upon your death, the Plan will pay the amount of coverage to the Beneficiary if:

(a) You ceased active work because of permanent and total disability resulting from bodily injuries or disease which prevented you from engaging in business or occupation and from performing any work for compensation or profit;

(b) You ceased active work because of the disability before attaining age 60;

(c) The disability is continuous until your death;

(d) You furnish the Fund Office with written proof on the Plan's prescribed forms that you are permanently and totally disabled as defined in (a) of this provision and have been so disabled continuously since the date you ceased active work. This written proof must be provided after nine months following the date the Covered Employee ceased active work but within 12 months following the date of termination of employment. At the time you furnish proof of disability, the Plan will acknowledge receipt of proof and the date upon which it was approved.

(e) You furnish the Plan annually, upon request and on the Plan's prescribed forms, written proof of continued permanent and total disability during your life. The Fund will notify you of continued permanent and total disability coverage;

(f) Written proof of your death must be furnished to the Fund Office on the Fund's prescribed forms within one year of the death of the Covered Employee. In the event of your death, within one year of the date of termination and before proof of disability has been submitted, proof that you were continuously disabled from the date of termination to the date of death must be furnished within one year after your death. This proof must be in writing and on the Plan's prescribed forms.

The Plan has the right to have you submit proof of disability in accordance with this provision examined at any time by Physicians designated by the Plan; provided that after the disability has continued for two full years, an examination will not be required more often than once in each subsequent year.

All of your rights under this provision will cease on the earliest of the following dates:

1. The date your permanent and total disability ends;

2. The date you engage in any business or occupation or perform and work for compensation or profit, whether or not you continue to be permanently or totally disabled;

3. The last day of any 12-month period of continued coverage if proof of disability is not furnished within a three-month period after it is requested by the Plan;

4. The date on which you refuse to submit to examination by Physicians designated by the Plan, upon its request.

You may not bring judicial proceedings against the Plan to enforce approval of your coverage under this provision unless it is brought within two years after the Plan refuses to approve coverage. This two year limitation will be extended to the minimum period permitted by the law of the state in which you reside at the time this Plan is issued, if the time limitation in that state is longer than two years.

Limitations

- The Death Benefit will not be paid for any claim where you or your Dependent commits or attempts to commit a felony causing death as a result of that commission or attempt.

- In the event of your death or the death of your Dependent who is eligible for this Death Benefit both as a Covered Employee and as a Dependent of a Covered Employee, only the Covered Employee's Death Benefit will be payable for that person.

- Benefits provided to qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) do not include Death Benefits.

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

Section XIV - Accidental Death and Dismemberment Benefit (AD&D)

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

Benefit

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

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

Benefits will be paid to you, in the case of your dismemberment or the dismemberment of your Dependent, or to the Beneficiary as explained in Section XV of this Summary Plan Description.

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

Limitations

- If you or your Dependent suffers more than one of the above losses as the result of one accident, no more than the full benefit amount will be paid.
- Certain losses, such as those caused by war, while on active duty in any military force of any country or state, suicide, disease or ptomaines are not covered.
- Losses as a result of an Occupational Injury or Disease arising out of and in the course of the your employment or your Dependent's employment, whether or not payment in whole or in part is received under any Workers' Compensation laws or similar federal or state laws. No claim will be considered or paid based on a denial by the Worker's Compensation Insurance Company or so long as a Worker's Compensation or similar law claims is pending, or has not been finally adjudicated as to coverage under the Act.
- Any claim where the you or your Dependent commits or attempts to commit a felony and thereby suffers injury, causing death, as a result of that commission or attempt will not be paid.
- In the event of a claim for you or your Dependent if you or your Dependent are eligible both as a Covered Employee and as a Dependent of a Covered Employee, only the Covered Employee benefits will be payable for that person.
- Benefits provided to qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) do not include Accidental Death and Dismemberment Benefits.

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

Section XV - Beneficiary

Employee or Retiree

The Covered Employee or Retiree has the right to name any Beneficiary to whom the Death Benefit will be paid, except the Covered Employee's local Union, Employer or Union business agent. The named Beneficiary must be on file with the Fund Office. The Covered Employee or Retiree may change Beneficiaries at any time by completing the proper form and forwarding it to:

Construction Industry Laborers Welfare Fund
6405 Metcalf, Suite 200
Overland Park, KS 66202

The amount of the Covered Employee's or Retiree's Death Benefit stated in the Schedule of Benefits will be paid to his named Beneficiary. If the Covered Employee or Retiree did not state a Beneficiary designation, or if the designated Beneficiary dies before receiving the Death Benefit, the Death Benefit will be paid to the Covered Employee's estate.

Dependent

The amount of the Covered Dependent's Death Benefit stated in the Schedule of Benefits will be paid to the Covered Employee in the event of the Dependent's death. If the Covered Employee dies before receiving the Death Benefit, the Death Benefit will be paid to the Covered Employee's estate.

Section XVI - General Limitations

The following General Limitations apply to all portions of this plan. No benefits will be paid under any section of the plan, whether the coverage is for you or your Dependent, for charges related to:

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

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

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

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

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

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

7. Custodial Care as defined in Section XXIII;

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

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

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

11. Surrogate pregnancy;

12. Transsexual surgery;

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

14. Routine physical examinations, well child examinations, immunizations or school physicals for Dependent children;

15. Preventative services, including but not limited to, influenza virus or pneumococcal vaccines;

16. Chiropractic services to legal spouse and Dependent children;

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

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

19. Orthoptics or Vision Training;

20. Hearing aid batteries;

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

22. Drugs except as provided through the prescription drug program;

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

24. Completion of a claim form, a telephone conversation with a provider in place of an office visit, writing a prescription and for medical summaries;

25. Lodging or travel, even though prescribed by a Physician for the purpose of obtaining medical treatment;

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

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

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

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

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

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

32. Services for developmental, educational, self-management training or therapy;

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

34. Private Duty Nursing;

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

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

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

38. Any services rendered after termination of coverage (except as provided for under Extended Benefits after Termination under the Dental Expense Benefit);

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

40. Employment or school physicals;

41. Court ordered alcohol or drug treatment.

Section XVII - Claims Filing Procedure

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

Construction Industry Laborers Welfare Fund
6405 Metcalf, Suite 200
Overland Park, KS 66202

The following procedures should be followed to file a claim:

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

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

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

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

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

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

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

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

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

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

   (a) Your name and social security number;

   (b) The patient's name and address;

   (c) The diagnosis;

   (d) Date of service;

   (e) Type of service and amount charged;

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

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

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

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

Prescriptions

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

Section XVIII - CLAIMS AND APPEALS PROCEDURES

A. FILING A CLAIM:

1. A Medical or a Disability Claim is filed by a Claimant when received by the Fund Office.

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

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

B. INITIAL BENEFIT DETERMINATION:

1. Medical Claims:

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

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

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

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

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

   a) The specific reason(s) for the adverse determination;

   b) Reference to the specific Plan provisions on which the determination is based;

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

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

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

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

5. Medical Claim for Benefits:

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

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

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

6. Disability Claim: A disability Claim is a Claim for benefits under the Loss of Time Benefit described in Section XII, or Accidental Death and Dismemberment Benefit described at Section XIV.

D. APPEAL OF DENIAL OF ALL CLAIMS:

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

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

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

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

3. Decision on Review:

a) The Appeals Committee shall hold quarterly meetings to make benefit appeals decisions. If an appeal is filed more than 30 days before a quarterly meeting, then a decision will be rendered by the next quarterly meeting after the Fund's receipt of the Claim. If the appeal is filed less than or equal to 30 days before the next quarterly meeting, then a decision will be rendered by the second meeting after the Fund's receipt of Claim. If special circumstances beyond the control of the Fund exist, such as the need for a hearing, an extension of time for benefit determination will be made. In the event of an extension due to the Claimant's request for a hearing, the hearing will be held by the second meeting after the Fund's receipt of notice of appeal, with a final decision rendered no later than the third meeting following the Fund's receipt of notice of appeal.

b) If an extension is required because more information is needed from the Claimant, the Claimant will be notified before the initial decision deadline. The Claimant will be provided 45 days from receipt of notice to provide the requested information. The Fund's timeline for benefit determination on an appeal will be tolled until the earlier of: 1) the Fund's receipt of the requested information; or 2) the end of the period afforded the Claimant to provide the requested information.

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

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

a) The specific reason(s) for the adverse determination;

b) Reference to the specific Plan provisions on which the determination is based;

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

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

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

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

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

5. Claimant's Rights Regarding Information on Appeal:

a) A Claimant or his duly Authorized Representative may, in writing:

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

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

iii) Submit written comments, documents, records, and other information relating to the Claim for benefits.

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

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

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

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

Section XIX - Change or Discontinuance of the Plan

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

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

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

Section XX - Plan Information

Type of Plan
The Construction Industry Laborers Welfare Fund is a welfare plan that provides comprehensive medical, dental, vision, loss of time, death, and accidental death and dismemberment benefits. Details regarding each of the benefits that the Plan provides are presented in this Summary Plan Description.

Establishment and Administration of the Fund
The Construction Industry Laborers Welfare Fund was established and is maintained pursuant to collective bargaining agreements between:

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

Pursuant to contract stipulations, other Employers who are non-members of the Associated General Contractors of Missouri and other Employer associations also make contributions to the Fund on behalf of Covered Employees represented by various Local Unions.

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

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

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

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

- eligibility for benefits;
- entitlement to benefits; and/or
- nature of, amount and duration of benefits; subject to the applicable provisions of the Trust Agreement and the applicable collective bargaining agreements.

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

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

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

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

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

TIC International Corporation
Construction Industry Laborers
Welfare Fund
6405 Metcalf, Suite 200
Overland Park, KS 66202

or

Ms. Linda N. Winter
Arnold, Newbold, Winter & Jackson, P.C.
1125 Grand Boulevard, Suite 1600
Kansas City, MO 64106-2503

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

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

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

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

1. Enrollment card completed by the Covered Employee;

2. Marriage license;

3. Birth certificate issued by the State that lists the name of the mother and father for all children;

4. Complete copy of a Divorce Decree, Property Settlement and Qualified Medical Child Support Order (QMCSO), if applicable;

5. Any other documents as defined in Section III (Dependent Eligibility).

Important
It is your responsibility to notify the Construction Industry Laborers Welfare Fund, 6405 Metcalf, Suite 200, Overland Park, KS 66202, of any change in your status whenever you:

1. Change your home address;

2. Change your marital status;

3. Change your Dependents;

4. Change your Beneficiary; or

5. Change your Local Union affiliation.

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

Union Trustees

Mr. Perri Prior, Chairperson
Eastern Missouri Laborers District Council
2450 Hollenberg Drive
Bridgeton, MO 6304

Mr. Steven Whalen
Eastern Missouri Laborers District Council
2450 Hollenberg Drive
Bridgeton, MO 6304

Mr. Gabriel Jones
Laborers Local 663
7820 Prospect
Kansas City, MO 64132

Mr. Jason Mendenhall
Laborers Local 663
7820 Prospect
Kansas City, MO 64132

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

Mr. James Sparks
Laborers Local 840
PO Box 461
Rolla, MO 65401

Employer Trustees

Mr. Steven Glenn
Luhr Brothers Inc
801 Progress Street
Cape, Girardeau, MO 63702

Mr. Joe Garrison
Irvinbilt Construction Company
PO Box 80
Chillicothe, MO 64601

Mr. George Hornung
Comanche Construction
PO Box 14158
Shawnee Mission, KS 66285

Mr. David Kaestner
Millstone Bangert Inc
601 Fountain Lakes Boulevard
St. Charles, MO 63301

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

Section XXI - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use Protected Health Information (PHI) only in accordance with the *Health Insurance Portability and Accountability Act of 1996* and the Regulations issued thereunder, which regulations are commonly referred to as the HIPAA Privacy and Security Rules. You may request a copy of the Fund's Privacy Notice by contacting the Fund Office.

Section XXII - Statement of ERISA Rights

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

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

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

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $200 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

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

Although every effort has been made to ensure that the information contained in this booklet is accurate and to avoid any conflict between the actual terms of the Plan and this booklet, it should be understood that in the event of any conflict the terms of the Plan shall prevail.

Section XXIII – Important Terms

Covered Charge or Covered Expense
Covered Charge or Covered Expense is only the expense incurred, or portion of such expense determined to be allowable after application of the appropriate discount by the Network, for medical care, services or supplies that are Medically Necessary for the treatment of an illness or injury and not specifically excluded under the limitations of the Plan.

Covered Employee
Covered Employee means:

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

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

- Any full-time Employee of the Association;

- Any full-time Employee of the Trustees; or

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

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

Covered Person
Covered Person means either the Covered Employee or the Dependent.

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

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

Dependent
Dependent means:

1. Your legal spouse, who is not legally divorced. A legal spouse includes a same-sex spouse where the Covered Employee and spouse were legally married in a state (or any foreign jurisdiction having the legal authority to sanction marriages) that recognizes same-sex marriages.

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

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

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

Disqualifying Employment
Disqualifying Employment is employment that is:

- within the geographic jurisdiction of the Fund;

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

- with an employer that is not a Contributing Employer.

Section 8.20 – Employer or Contributing Employer
Employer or Contributing Employer means:

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

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

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

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

Experimental, Investigative or Inappropriate Drug, Device, Treatment or Procedure
Drugs, devices, medical treatments/procedures, and/or supplies are considered Experimental or Investigational if:

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

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

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

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

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

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

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

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

Medically Necessary or Medical Necessity
The Plan pays benefits only for services or supplies that are Medically Necessary. In general, Medically Necessary means:

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

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

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

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

- Consistent with attaining reasonably achievable outcomes; and

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

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

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

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

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

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

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

With regard to Medical Doctors and Nurses, the Fund will recognize the licensure of:

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

Plan
Plan is the Construction Industry Laborers Welfare Fund

PPO Provider
PPO Provider is a Hospital, Physicians and other clinical facilities who have a written PPO agreement with a Network to provide health care services and supplies to Plan participants for a negotiated Charge at the time the service or supply is provided. A list of providers is available to participants and Dependents upon request.

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

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