KANSAS BUILDING TRADES
OPEN END HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

TO: ALL PLAN PARTICIPANTS - PLEASE READ CAREFULLY

MEDICAL EXPENSES CONTINUE TO RISE - YOU CAN HELP

1) This Plan is not an insurance policy, but a trust fund used to provide health and welfare benefits to you and your family. The money in this trust fund is compensation for your work that your employers pay into the Fund instead of putting on your check. It is your money. The more money the Plan can save by not paying for unnecessary services or services that someone else should pay for, and by you selecting the most cost-effective services and providers, the more money will be available to provide benefits to you and your family and to those who come after you.

2) The main person responsible for helping control health care costs is YOU, the Participant. No one else can do it but you. Your use of Preferred Providers normally saves you and your Plan money. **YOU** must seek out the use of Preferred Providers, particularly in the case of hospitals, because a physician, for his personal convenience, might prefer you to be in a different hospital where the same quality of care costs much more of **YOUR MONEY!**

3) QUALITY medical care for all Plan Participants is the number one goal of the Kansas Building Trades Open End Health & Welfare Trust Fund.

4) Plan Participants need to use all available cost saving ideas in order to save **their** Plan unnecessary expenses, i.e., out-patient testing, out-patient surgery, early hospital dismissal, etc. Please - This means you - not just the other person.

5) Studies indicate that up to 70% of health costs are to treat diseases that are caused by poor health habits. Diet, obesity, tobacco use and lack of exercise have been cited as leading risk factors for the most common and costly diseases that plague Americans: heart disease, cancer, diabetes, emphysema, and others. To encourage healthy habits, the Plan recommends that you complete an annual, no-cost physical examination and biometric screening, the completion of which will provide you with a lower Deductible for the subsequent Plan year.

6) The Trustees and employees of the Health & Welfare Plan never require a specific doctor or hospital but only seek to make Preferred Providers available to Plan Participants and their families. The Trustees cannot be responsible for the results of service provided by any physician, surgeon or hospital - even Preferred Providers.

7) You and your dependents have the right to extend your coverage under this plan in certain circumstances. For more information, see pages 22-30.

8) The Trustees have adopted rules requiring "Pre-certification" for certain inpatient hospitalizations and other specified services. Even admissions which are of an emergency nature should be reported according to the guidelines adopted by the Board of Trustees. These

pre-certification rules may change because the Trustees use a professional pre-certification company to determine if surgery, admission to the hospital, and/or the length of hospital stay is appropriate. The pre-certification number is printed on your medical card.

9) The Board of Trustees frequently adopts lists of Preferred Provider Organizations with whom it has special agreements. Because these agreements do change frequently, and because new doctors, hospitals and other medical facilities are frequently added, these lists are available online or by phone.

10) The medical profession is making great strides in coping with many serious illnesses. Frequently, the Trust Fund Office is not even aware of special types of treatment which may be needed for particular illnesses. Therefore the Trustees have also entered into a contract with an outside company to provide Case Management and medical review in connection with the payment for your medical care. These companies do not have discretionary authority to interpret the Plan, but only provide advice and consultation to the Trustees and Fund Office staff.

11) The medical profession, through its ingenuity, is also creating many **elective medical procedures** which, though perhaps beneficial in the mind of the participant, are not Medically Necessary and, therefore, will not be paid for by this Plan. If you choose to have an elective procedure performed, it will likely not be paid for by the Plan. (Example: fertility treatment). This Plan only pays for services that are Medically Necessary, that is, services that are generally accepted in the medical community as required to diagnose or treat an illness or injury and without which the person seeking the medical care could suffer adverse health consequences.

12) There are appeals procedures for adverse benefit determinations. The Board of Trustees wishes to specifically call to your attention the appeals procedure which is contained on pages 1-8 of this book.

13) Federal and State law establish standards for the privacy of your personal health information. In accordance with these laws, this Plan has established policies and procedures for the protection of the privacy of your medical information. This Plan's standards are described in a document entitled, "Notice of Privacy Practices." You may receive a copy of this document upon request.

14) THIS SUMMARY PLAN DESCRIPTION BOOK IS PUBLISHED AT LEAST EVERY FIVE (5) YEARS AND IS PROVIDED FREE TO EACH ELIGIBLE PLAN PARTICIPANT.

15) ALL CHANGES AND REVISIONS TO THE SUMMARY PLAN DESCRIPTION (SPD) WILL BE PROVIDED TO EACH ELIGIBLE PLAN PARTICIPANT AS THEY ARE PUBLISHED. THESE PAGES SHOULD BE INSERTED INTO THIS BOOK AS SOON AS THEY ARE RECEIVED.

16) **PLEASE KEEP US INFORMED OF YOUR ADDRESS, AND ANY CHANGE OF DEPENDENTS, BY FILING A NEW BENEFICIARY CARD WHICH CAN BE OBTAINED FROM THE FUND OFFICE**.

TO: ALL PARTICIPATING ELIGIBLE PERSONS

This Plan shall be called the:

KANSAS BUILDING TRADES OPEN END HEALTH &WELFARE TRUST FUND.

EFFECTIVE DATE OF THIS DOCUMENT – January 1, 2024

It is most important that you keep the Trust Fund informed of your current address and telephone number. This is URGENT.

SAVE YOUR CHECK STUBS. They serve as proof of the number of hours you worked for purposes of determining your eligibility under this Plan. Any difference between the employer reports and your own personal records can only be corrected if you present your check stubs.

Please read this Plan completely. **This is not just a summary of your Plan, but the actual Plan Document used to administer the Plan. This booklet describes the benefits available to you as of the effective date provided at the bottom left-hand corner of each page.**

If you have any questions, please contact the Fund Office. No Employer, Business Representative or individual Plan Trustee is authorized to interpret the Plan in any way which is binding on the Trust. Only the full Board of Trustees has the authority and discretion to interpret this Plan and to decide all questions and issues that arise under it, including all questions of coverage and eligibility, method of providing or arranging for benefits, and all other related matters including the contribution rate at which the various benefits are provided. Additionally, the Board of Trustees shall have the sole and exclusive power and discretion to interpret and construe any policy, rule, or regulation established by the Board of Trustees. Any interpretation of the Plan or of any policy, rule, or regulation by the Board of Trustees shall be final and binding on all persons, shall be accorded the highest level of judicial deference, and shall be subject to reversal by a court of competent jurisdiction only if such court determines that the decision of the Board of Trustees was arbitrary or capricious.

The Fund Office exists as a service to YOU. The Fund Office maintains a telephone answering device for use by the participants during the hours the Fund Office is closed. This gives you twenty-four hours, seven days a week access to the Fund Office. In order that your call can be processed, please be prepared to leave the following information:

1. Your name
2. Social Security Number
3. Telephone number
4. Current address
5. A brief description of the problem or question

TOPEKA AREA: 785-267-0140

ALL OTHER CALLS: 800-432-3595

CLAIMS AND APPEALS PROCEDURES

You may submit the claim yourself, or your health care provider or another person you designate may submit a claim on your behalf.

Attach all bills pertaining to the claim and forward to the Fund Office, P.O. Box 5168, Topeka, Kansas 66605-0168. If you use a Preferred Provider, they will generally submit the claims for you. Review this SPD carefully to determine whether your service must be pre-authorized. If the service requires pre-authorization under this Plan and you do not obtain such pre-authorization, your claim for benefits will be denied.

Death Benefit and AD&D Claims

You, your beneficiary, or an authorized representative of you or your beneficiary must submit a claim form to the Trust Fund Office with a copy of the death certificate and police or other accident report, if applicable. The Trust Fund Office will decide your claim and send you written notice of this decision within a reasonable period of time, but not later than 90 days after it receives your claim, unless the Plan Manager determines that the Fund Office needs additional time to process your claim. In that case, written notice of the extension will be sent to you within the initial 90 days, and the extension will not be more than an additional 90 days. The extension notice will explain the special circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the claim is granted in full, the Plan may simply send payment rather than a notice explaining the decision.

Disability Claims

A claim for Loss of Time or Long Term Disability benefits must be made on a claim form available from the Trust Fund Office and must be accompanied by the required documentation of the disability. If your claim is denied in any way, the Trust Fund Office will send you a written notice of the decision within a reasonable period of time, but not later than 45 days after receipt of the claim. If the Plan Manager determines that additional time is necessary due to matters beyond the control of the Plan and sends you written notice within the initial 45 day period, the Plan may extend the period for deciding your claim by up to 30 days. The extension notice must explain the circumstances preventing the claim from being decided timely, must inform you of the date by which the Plan expects to render a decision, and must specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If the extension is due to additional information needed from you, you will be given at least 45 days to provide the additional information. The Plan may take a second 30-day extension of time to decide your claim if circumstances beyond the control of the Plan continue to make it impossible to decide your claim within the first extension period and the Fund Office sends you proper written notice of the extension within the first 30 day extension period.

Dental Claims

The Dentist shall file the claim directly with Delta Dental and it shall not be necessary for a participant to execute any other claim form. The Dentist shall use the claim form prescribed by the American Dental Association in submitting all claims. Please see pages 47-49.

CLAIMS AND APPEALS PROCEDURES

Vision Claims

If you use a Vision Service Plan provider, they will submit the claims for you. If you are using a non-preferred provider, you will need to submit the claims. For information on how to submit non-preferred provider vision claims, call 1-800-877-7195.

All Other Health Claims

Some health claims will require pre-certification and others can simply be filed after you obtain the medical care. The descriptions of the various benefits in this booklet will tell you whether you need to obtain pre-certification or not. All pre-certification will need to go through the pre-certification procedures described below. The pre-certification company, the Plan's PPO, and your provider will coordinate the final claim for payment following approval of your pre-certification request. All other health claims will need to be submitted to the Plan's PPO before processing by the Fund Office. The address and other information for submitting health claims is printed on your identification card. If you have questions, you may call the Fund Office or the number printed on your identification card for assistance.

TIME-LIMIT FOR FILING CLAIM FORMS

All claims must be filed within one year from the date of service to the correct claims address. (For example, any claims for service on January 1, 2023 must be submitted by December 31, 2023. If the service was provided to you on December 15, 2023, you must submit your claim to the Fund Office no later than December 14, 2024.) This includes any and all information requested to process your claim.

COMPLIANCE WITH CLAIM RULES

In order to obtain benefits, it is necessary that all claimants comply with the applicable claim rules established by the Trustees and set forth in the Plan. The Trustees shall exercise every right provided under the terms of the Plan to prevent any claimant from receiving benefits who is, in their opinion, attempting to subvert the purposes of the Fund or who does not present a bona fide claim. See "Fraud and Abuse" provisions on page 9.

PRE-CERTIFICATION/PRE-AUTHORIZATION PROCEDURES

The following services must be certified by the Pre-Certification company before the service is provided: all inpatient hospitalizations (except those covered by the Newborns' and Mothers' Health Protection Act of 1996), organ transplants, skilled nursing, genetic testing, admission to an extended care facility, and Psychiatric Care and substance abuse treatment rendered in a residential or physical therapy "Inpatient" setting, as that term is defined on page 12 of this document. Some prescription drugs are also subject to pre-certification requirements in accordance with the medical management policies of the pharmacy benefit manager. See your identification card for appropriate numbers to call for pre-certification. In case of emergency, you must obtain certification within 48 hours or as soon as possible after the emergency preventing you from obtaining pre-certification has been resolved.

If you or your authorized representative fail to follow the Plan's pre-certification procedures, but instead attempt to submit your request for pre-certification to the Trust Fund Office, a Trustee, the Plan Manager, or the incorrect pre-certification company, and your request names a specific patient, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, the Trust Fund Office will notify you of the failure and the correct procedures to follow as soon as possible, but not later than five (5) days (24 hours, if the request indicates a condition that could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested).

All requests for pre-certification will be decided within a reasonable period of time appropriate to the medical circumstances, but in no case more than 15 days after the request (72 hours if the request involves "urgent care," that is, the risk of serious jeopardy to life or limb, jeopardy to the ability to regain maximum function, or severe pain that cannot be adequately managed without the requested care or treatment). If special circumstances require an extension of time to make the pre-certification decision, this period can be extended once by 15 days, provided the Trust Fund Office sends written notification of the extension, the reason for the extension, and the date by which the Plan expects to make a decision, within the initial 15 days. Urgent care pre-certification request determinations cannot be extended unless the claimant does not provide sufficient information to decide the request.

If the claimant does not provide sufficient information with the initial pre-certification request, the Plan may request the additional needed information as soon as possible. The claimant will then have at least an additional 45 days (48 hours in the case of an urgent care request) to provide the necessary information. The final decision will be made as soon as possible, but not more than 15 days (24 hours, in the case of an urgent care request) after the Plan receives the additional information. The claimant will be sent a written notice of any adverse decision. In the case of an urgent care request, the Fund Office or case management/pre-certification company will notify the claimant as soon as possible by the most expedient means available, such as telephone or fax, with a written notice to follow if the decision is adverse.

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Plan will not require pre-certification for any Hospital length of stay in connection with childbirth for the mother or newborn child.

Pre-certification is simply a process used to assess the appropriateness and/or Medical Necessity of a treatment or service and is not a guarantee of payment.

CLAIMS DECISIONS

Except as specifically described above, all claims for benefits will be decided within a reasonable period of time, not to exceed 30 days from the date the Plan receives your claim. This period may be extended one time by the Plan for up to an additional 15 days, but only if the Plan Manager determines that an extension is necessary due to matters beyond the control of the Plan and if the Fund Office sends you written notice of the extension within the initial 30 day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If the extension

is necessary because the Plan needs additional information from you, you will be given at least 45 days to provide the information, and the deadline for deciding your claim will be "tolled," or suspended, until you provide the information or 45 days have expired, whichever happens first.

Any time the Plan makes a claim decision that is not fully favorable to you, the Trust Fund Office will send you written notice of the adverse benefit determination within the time frames described above. The notice will contain the following information, written in a manner reasonably calculated to be understood by you:

1) the specific reason or reasons for the adverse decision;

2) reference to the specific Plan provisions on which the decision is based;

3) a description of any additional material or information necessary to make your claim complete, as well as an explanation why such material or information is necessary; and

4) a description of the Plan's appeals procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under the Employee's Retirement Income Security Act (ERISA) following any adverse benefit decision on appeal.

In addition, for any claims other than for death benefits or AD&D benefits, the notice will also contain the following, as applicable:

1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the notice will either contain a copy of the specific rule, guideline, protocol, or other criterion, or it will contain a statement that you may get a copy of the specific rule, guideline, protocol, or other criterion free of charge upon request to the Fund Office.

2) If the adverse benefit decision is based on a determination of medical necessity, experimental treatment, or similar type of exclusion or limit (for example, if your claim is denied because the Fund Office determined that the service was not medically necessary), the notice will either contain an explanation of the scientific or clinical judgment on which the decision was based, applying the terms of the Plan to your medical circumstances, or the notice will contain a statement that you have a right to receive such explanation free of charge upon request.

3) If the decision involves urgent care, the notice will also explain the expedited appeal procedures applicable to urgent care claims. In addition, any notice of adverse benefit decision on a claim involving urgent care may be provided orally (such as by telephone), as long as written notice follows no later than 3 days after the oral notice is provided.

APPEALS – PROCEDURE

Any eligible person shall have the right to appeal any adverse benefit decision to the Board of Trustees. The Board of Trustees is the appropriate named fiduciary of the Plan with sole and exclusive jurisdiction to decide all matters under the Plan. All appeals regarding claims for death benefits or AD&D benefits must be submitted within 60 days following the claimant's receipt of written notice of the adverse benefit decision. All other appeals must be submitted within 180 days following the claimant's receipt of the written notice of adverse benefit decision. All appeals must be made in writing and addressed to the Board of Trustees at the Trust Fund Office.

You may submit written comments, documents, records, and other information relating to your claim for benefits with your appeal. Upon your request and free of charge, the Fund Office will provide you with reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information is relevant to your claim for benefits if it (i) was relied on in making the benefit decision; (ii) was submitted, considered, or generated in the course of making the benefit decision, regardless of whether it was actually relied upon in making the decision; (iii) demonstrates compliance with the Plan's administrative processes and safeguards designed to ensure that benefit claim decisions are made in accordance with the governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether the advice or guidance statement was actually followed in making your benefit decision.

The Board of Trustees will conduct a full and fair review of your claim and the benefit decision you received and any additional information you submit in connection with your appeal. The review will take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit decision.

Except in the case of decisions on claims for death benefits and AD&D benefits, the review by the Board of Trustees will afford no deference to the initial decision, but will be considered entirely anew. All appeals will be reviewed by the Trustees, which is the appropriate named fiduciary of the Plan, so the person who made the initial decision will never be the same person who reviews that decision on appeal.

Whenever the benefit decision is based, in whole or in part, on a medical judgment (including determinations whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional providing this consultation and advice will not be the same person who was consulted in connection with the initial benefit decision. If the advice of any medical or vocational expert was obtained in connection with the adjudication of your claim or the consideration of your appeal, you have the right to learn the identity of such experts, regardless of whether the advice was relied upon in making the benefit decision.

The Board of Trustees will review your claim and make a decision on your appeal at the next quarterly meeting following the date on which your appeal is received in the Trust Fund Office, unless it is received within 30 days of the next meeting. If your appeal is received by the Trust Fund Office within 30 days of the next Board of Trustees meeting, your claim will be reviewed and a decision will be made on your appeal at the second Board of Trustees meeting following the date on which your appeal is received in the Trust Fund Office. If special circumstances (such as the need to hold a hearing or to obtain additional information) require an extension of time to rule on your appeal, the Plan Administrator will provide you with written notice of the extension within five days from the date of the meeting at which your appeal was first considered. That notice will inform you of the reasons for the extension and the date of the next Board of Trustees meeting. A decision will be made no later than the date stated in the notice of extension.

The Plan Administrator will send you a written notice of the Board of Trustees' final decision as soon as possible, but not later than five days after the date of the Board of Trustees meeting at which the decision was made. If that decision is fully favorable to you, it will tell you that. If it is not fully favorable to you, the written notice will contain the following information, set forth in a manner reasonably designed to be understood by you:

1) the specific reason or reasons for the decision;

2) reference to the specific Plan provisions on which the decision is based;

3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4) a statement describing this Plan's voluntary appeals procedures and your right to obtain information about such procedures; and

5) a statement of your right to bring a lawsuit under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

In addition, except for appeals of death benefits and AD&D benefits:

6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the notice will either contain a copy of the specific rule, guideline, protocol, or other criterion, or it will contain a statement that you may get a copy of the specific rule, guideline, protocol, or other criterion free of charge upon request to the Fund Office.

7) If the adverse benefit decision is based on a determination of medical necessity, experimental treatment, or similar type of exclusion or limit (for example, if your claim is denied because the Fund Office determined that the service was not medically necessary), the notice will either contain an explanation of the scientific or clinical judgment on which the decision was based, applying the terms of the Plan to your medical circumstances, or the notice will contain a statement that you have a right to receive such explanation free of charge upon request.

Expedited Appeal Procedure

In the case of a request for pre-certification, if your benefits will be reduced if you obtain treatment before the pre-certification is approved, and if you wish to appeal the denial of pre-certification, and if a delay in obtaining the care, treatment, or other item for which pre-certification is requested either could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to pain that cannot be adequately controlled without the treatment or care you request, an expedited appeal process is available.

You may request an expedited appeal orally or in writing. All necessary information, including the Board of Trustees' decision on your appeal, will be transmitted between you and the Trust Fund Office by telephone, fax, or other available similarly expeditious method. You must provide the Trust Fund Office with the telephone or fax number or other means to contact you.

The Board of Trustees will make a decision on your expedited appeal as soon as possible, taking into account your medical situation, but not later than 72 hours after the Trust Fund Office's receipt of your request for expedited appeal (whether it was received by telephone, fax, in person, or in writing). The decision may be communicated to you by telephone, fax, or other similar method, but a written notice will always be sent to you. If the appeal decision is communicated to you other than in writing, it will be followed up by a written notice within three days after you are first told of the decision.

VOLUNTARY ARBITRATION AND LEGAL REMEDIES AVAILABLE

If you are not satisfied with the Board of Trustees' decision on appeal, you have the right to bring a civil action against the Plan under ERISA. You may not bring a lawsuit to obtain benefits until you have requested a review and a final decision has been reached on review. No lawsuit may be brought more than two years after the final decision on review has been reached. Any person claiming entitlement to benefits under the Plan, or any claim brought in connection with the Plan, shall be brought only in the United States District Court for the District of Kansas.

In the alternative, you may request arbitration of your dispute over the denial of your request for benefits. If you choose to request arbitration, the following rules shall apply:

1) You may request arbitration by sending a written request for arbitration to the Board of Trustees within ten (10) days after your receipt of the Board of Trustees' decision on your appeal, or within twelve (12) days of the date on which the decision was mailed to you, whichever is shorter.

2) The Board of Trustees is not bound by your request for arbitration, but has full discretion to agree to arbitrate or to decline your request for arbitration. The Board of Trustees will make this decision and send you written notice of this decision within thirty (30) days following the Trust Fund Office's receipt of your request for arbitration. If the Board of Trustees agrees to arbitrate the decision, the Board of Trustees shall request a provider of alternative dispute resolution services of the Board's own choosing to provide a list of five experienced arbitrators who have worked with employee benefit plans.

3) Upon your receipt of the list of arbitrators, you must strike two names and return the list to the Board of Trustees, who will strike two names. The remaining name will be the neutral arbitrator.

4) Both you and the Board of Trustees will be permitted to present any evidence to the neutral arbitrator.

5) The arbitrator will make a decision within ten (10) days of the arbitration, if possible. The decision of the arbitrator shall be absolute, final and binding. There shall be no appeal from the decision of the arbitrator. All parties to the Plan, and all Participants and their Beneficiaries, accept the finality of the arbitrator's decision.

6) If you choose not to request arbitration, the Plan waives any right to assert that you failed to exhaust your administrative remedies as a result of not seeking arbitration.

7) If you request arbitration and either the Board of Trustees declines your request or you do not obtain a final and binding decision of the arbitrator for any other reason, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled (or suspended) from the time you submit your request for arbitration until you receive written notice that the Board of Trustees declines your request for arbitration or until you receive written notice that no final decision will be issued by the arbitrator.

8) You may request arbitration only after you have requested and received an appeal decision from the Board of Trustees, unless the time for deciding your appeal has expired without a decision having been issued.

9) Upon your request, the Plan Administrator will provide to you sufficient information relating to the arbitration procedure to enable you to make an informed judgment about whether to pursue arbitration, including information about the applicable rules of the arbitration, your right to representation, the process for selecting the arbitrator, and the circumstances, if any, that may affect the impartiality of the arbitrator, such as any financial or personal interests in the result or any past or present relationship with any party.

10) Your decision whether or not to pursue arbitration will have no effect on your rights to any other benefits under the Plan.

11) No fees or costs will be imposed on you as part of the voluntary arbitration process.

12) If you choose not to pursue arbitration, or if you request arbitration but it does not reach a final and binding decision by a neutral arbitrator, you have the right to bring a civil action under section 502 of ERISA.

FRAUD AND ABUSE

The Trustees reserve the right to not pay any item believed to be abuse of the Plan. This includes any type of fraudulent claim or other attempt to seek benefits improperly, such as submitting a claim containing false information about the service provided or the medical necessity of the service or attempting to enroll a person not eligible as a dependent under the terms of this Plan. In the event the Trustees determine that any eligible person (either an employee, retiree, former employee, dependent, or COBRA-qualified beneficiary) has willfully submitted a false or fraudulent claim or has willfully abused the Plan in another way, that person and his or her entire family shall be suspended from the Plan for a period of six (6) months, and the Trustees shall obtain recovery of any monies paid which have been determined to have been paid improperly.

The Trustees will have the right to recover any amounts improperly paid from any of the following sources: the Participant on whose account the amount was paid, the person who received the medical care (if not the employee, retiree, or former employee), or the person to whom the amount was paid.

You must notify the Fund Office if you become divorced. A divorced spouse will be covered through the end of the month that the divorce is final. After that time he/she will be offered COBRA coverage. If you are required to provide medical coverage for a divorced spouse, you can continue his/her coverage through KBT for up to 36 months by paying his/her COBRA contributions. If you do not notify the Fund Office of your divorce, you will be personally responsible for any claims incurred by your divorced spouse.

GRANDFATHERED STATUS

It is the interpretation of this group health plan that the 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 the law was enacted. This means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement to provide preventive services without cost sharing. However, grandfathered health plans must still comply with certain other consumer protections of the Affordable Care Act; for example, the elimination of lifetime and annual dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered can be directed to the Fund Office at (785) 267-0140 or (800) 432-3595. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or visit the website at www.dol.gov/ebsa/healthreform for a table summarizing which protections do and do not apply to grandfathered health plans.

DEFINITIONS

COBRA – the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and in particular, Sections 601 through 608 of the Employee Retirement Income Security Act of 1974 and Section 4980B of the Internal Revenue Code.

COINSURANCE – As used herein, "Coinsurance" means the percentage of allowed charges that you must pay after the Deductible is met. After the Deductible is met, the Plan will pay a percentage of the allowed expenses, and the Eligible Participant or Eligible Dependent will be responsible for the remaining amount up to the Coinsurance limit.

COSMETIC ITEMS (including Cosmetic Surgery) – Cosmetic items or procedures including any care, treatment, service, supply, or procedure which is directed at improving or changing the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. The fact that there may be an incidental medical benefit as a result of the procedure does not prevent a determination that the care, treatment, service, supply, or procedure is cosmetic.

A procedure which is medically necessary, as defined below, is not treated as a cosmetic procedure for purposes of this Plan. The term "cosmetic surgery" is distinguished from reconstructive surgery, which is a type of surgery or other procedure that is not done solely or primarily for appearance purposes, but is required to correct a physical disfigurement caused by birth defects, illness, or injury.

Cosmetic surgery is not covered under this Plan, but reconstructive surgery is covered if it meets the other requirements to be a covered medical procedure.

DEDUCTIBLE – As used herein, "Deductible" means the amount that must be paid by an Eligible Participant or Eligible Dependent before the Plan will pay allowed expenses.

ELIGIBLE PARTICIPANT – As used herein, "Eligible Participant" means any person who is eligible for benefits for himself and his dependents according to the provisions set forth under "Eligibility Rules," beginning on page 14.

ELIGIBLE DEPENDENT – As used herein, "Eligible Dependent" means any of the following persons not employed by any contributing employer.

1. The Eligible Participant's spouse. In cases where the name of the spouse differs from the Eligible Participant's name or separate residence is indicated, proof of marital status will be required. Common law spouses must be verified prior to coverage. Contact the Fund office for paperwork to verify common law spouses.

2. Each natural or adopted child (including a child placed for adoption) under 26 years of age.

3. Step-children may also be covered as dependent children under this Plan. A copy of the divorce decree or other legal documents will be requested in order to determine which of the natural parents are required to provide coverage.

4. Nieces, nephews, grandchildren, and any other person, even though wholly dependent on the Eligible Participant for care and support, will not be eligible for benefits unless you have been awarded legal custody.

5. Any child or other dependent of the Eligible Participant for whom the Eligible Participant has a legal obligation to provide health care coverage pursuant to a Qualified Medical Child Support Order. See pages 19-21 for more information about procedures and requirements for Qualified Medical Child Support Orders.

ELIGIBLE PERSON – As used herein, "Eligible Person" (also called a PARTICIPANT) means either the Eligible Participant or Eligible Dependent.

HOSPICE – The term "Hospice" means a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings, for Eligible Persons suffering from a condition that has a terminal prognosis. A hospice must have an inter-disciplinary group of personnel which include at least one physician and one registered graduate nurse, and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD – The term "Hospice Benefit Period" means a specified amount of time during which the Eligible Person undergoes treatment of a hospice. Such time period begins on the date the attending physician of an Eligible Person certifies a diagnosis of terminally ill, and the Eligible Person is accepted into a hospice program. The period shall end the earliest of six months from this date or at the death of the Eligible Person. A new benefit period may begin if the attending physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new benefit period can begin.

HOSPITAL – The term "Hospital" means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the patient's expense; and

2. It is constituted, licensed, and operated in accordance with the laws of the jurisdiction in which it is located which pertain to hospitals; and

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an illness or an injury; and

4. Such treatment is provided for compensation by or under the supervision of physicians with continuous twenty-four (24) hour nursing services by registered graduate nurses (R.N.'s); and

5. It qualifies as a general, children's, long term acute, psychiatric, or rehabilitation hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and

6. It is a provider of services under Medicare; and

7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES – The term "Hospital Miscellaneous Expenses" means the actual charges made by a hospital on its own behalf for services and supplies rendered to the Eligible Person which are medically necessary for the treatment of such Eligible Person. Hospital miscellaneous expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the hospital or otherwise.

ILLNESS – The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of an Eligible Person. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

INCURRED EXPENSES – The term "Incurred Expenses" means the charges for those services and supplies rendered to an Eligible Person. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

INJURY – The term "Injury" means a condition which results in damage to the Eligible Person's body from an external force. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from injury.

INPATIENT – The term "Inpatient" refers to the classification of an Eligible Person when that person is admitted to a hospital, hospice, or other institution for treatment, and charges are made for room and board to the Eligible Person as a result of such treatment.

MEDICAL NECESSITY, MEDICALLY NECESSARY – A service is medically necessary if it is proper and needed to prevent, identify, care for, or treat an illness or injury; is generally accepted by health care providers in the local geographic area where the service is provided who specialize in the field of medicine related to that illness or injury as appropriate, effective, and not experimental or investigational; is not solely for the convenience of you, your family, your health care provider, or a hospital or other facility; and does not duplicate other care or services being provided to you. Services or other items will only be paid for by this plan if they are medically necessary and not experimental or investigational.

PHYSICIAN – As used in this booklet, the term "Physician" means any doctor or dentist licensed under the Kansas Healing Arts Act or properly licensed by the state in which the doctor or dentist is providing services to you.

PLAN – As used herein, "Plan" means this formal written plan established by the Trustees of the Kansas Building Trades Open End Health and Welfare Trust Fund.

DEFINITIONS

PREVENTIVE MAINTENANCE DRUGS – The term "Preventive Maintenance Drugs," as used in this booklet, includes prescription medications that help prevent, treat, and manage various health concerns which, if not prevented or managed, can lead to more serious illness and complications. Effective January 1, 2015, generic preventive maintenance drugs are covered through the prescription drug program at no cost and with no copayment amounts applied. Before visiting your health care provider to obtain a prescription, please ask the Plan's pharmacy benefit manager for an updated list of commonly-prescribed preventive maintenance drugs. Coverage may be denied for preventive maintenance drugs not listed on the Plan's formulary. Preferred brand name and non-preferred brand name preventive maintenance drugs shall be covered with the usual co-payment amounts applied.

PSYCHIATRIC CARE – The term "Psychiatric Care," as used in this booklet, also includes psychological or psychoanalytic care and means appropriate and generally accepted treatment for a mental illness or disorder, a functional nervous disorder, alcoholism, or drug addiction.

PSYCHOLOGIST – The term "Psychologist" means an individual holding the degree of Ph.D., properly licensed by a state agency as a clinical psychologist, professional counselor, or similar occupation with another name under the applicable regulatory scheme, and acting within the scope of his license.

REASONABLE – The term "Reasonable" refers to the charge, or portion of the total charge, made by any provider that is determined to be reasonable in the discretion of the Trustees, after giving due consideration to the nature and severity of the condition being treated, any medical complications or unusual circumstances which require additional time, skill or expertise, and the usual and customary charges made for similar services or other items by other providers in the same field of medicine and local geographic area.

REGISTERED NURSE – The term "Registered Nurse" means an individual who has received specialized nurse's training and is authorized to use the designation of "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

ROOM AND BOARD – The term "Room and Board" refers to all charges by whatever name called which are made by a hospital, hospice, or other inpatient facility as a condition of occupancy. Such charges do not include the professional services of physicians nor intensive nursing care by whatever name called.

SEMI-PRIVATE – The term "Semi-Private" refers to a class of accommodations in a hospital or convalescent nursing facility in which at least two patients' beds are available per room.

TRUSTEES – As used herein, "Trustees" means the Board of Trustees of the Kansas Building Trades Open End Health and Welfare Trust Fund, sited in Topeka, Kansas.

YEAR – As used herein, "Year" or "Plan Year" means the 12-month period commencing January 1 and ending December 31 of each calendar year.

ELIGIBILITY RULES

NEWLY-ACQUIRED DEPENDENTS

NO DEPENDENT SHALL BE ELIGIBLE FOR ANY BENEFITS UNTIL THE FIRST DAY OF THE MONTH FOLLOWING THE MONTH IN WHICH A VALID INFORMATION/BENEFICIARY DESIGNATION CARD IS FILED WITH THE FUND OFFICE **AND THE REQUIRED HOURS ARE IN THE HOUR BANK.**

Newborn children will be eligible from date of birth, provided that a new beneficiary card is received within (6) six months of their birth. Notification received after (6) months will begin eligibility the first of the following month.

THE FIRST FIVE (5) ELIGIBILITY RULES BELOW APPLY ONLY TO BARGAINING UNIT EMPLOYEES AND NOT TO NON-BARGAINING CONTRACTS.

I. INITIAL ELIGIBILITY (Bargaining Unit Only)

A bargaining unit employee shall become eligible on the first day of the month following the month during which the employee is credited with his 600th hour of employer contributions, provided such hours are accumulated during a period not exceeding twelve (12) consecutive calendar months.

II. CONTINUED ELIGIBILITY (Bargaining Unit Only)

Once having become eligible, an employee will remain eligible for benefits for the balance of that benefit quarter and thereafter, subject to the following schedule:

To be eligible for benefits in this BENEFIT QUARTER:	You must have hours worked credited to your HOUR BANK for one of these periods:	
January, February, and March	330 Hours in August, September, and October, OR	1,320 Hours in November through October
April, May, and June	330 Hours in November, December, and January, OR	1,320 Hours in February through January
July, August, and September	330 Hours in February, March, and April, OR	1,320 Hours in May through April
October, November, and December	330 Hours in May, June, and July, OR	1,320 Hours in August through July

If the employee fails to maintain his eligibility, his eligibility for benefits will cease at 12:00 midnight, the last calendar day of the Benefit Quarter.

Employer contributions must be received by the Fund Office for hours to be credited to the employee's Hour Bank.

III. ELIGIBLITY UNDER SPECIAL BENEFIT PLANS (Bargaining Unit Only)

The Board of Trustees, acting through its officers, is hereby empowered to establish a benefit program different from that published in the book. This benefit program may be applied to special groups who make application to participate in this Trust. This special benefit may also be imposed by the Officers on groups of employees or bargaining units represented by labor unions who for any reason do not negotiate the contribution amounts required by the Trustees. No labor organization shall have a right to bargain for the special benefit program without the advance approval of the Officers or the full Board of Trustees.

IV. REINSTATEMENT OF ELIGIBILITY (Bargaining Unit Only)

A. A participant who fails to remain eligible in accordance with Rule II shall become eligible again on the first day of the second month after he is credited with employer contributions in the amount of 330 hours during three or less consecutive months.

B. In the event a participant remains ineligible for twelve (12) consecutive months, he must comply with the requirements of Rule I to re-establish eligibility, except as provided in paragraph C below.

C. A participant who has worked out of the Plan's jurisdiction, but has maintained continuous eligibility in another similar Plan, may be reinstated on the first day of the following month if:

   1. 330 hours have been reported into this Plan within a three month period; and

   2. The member has been ineligible under this Plan for a period not exceeding twenty-four months.

D. Any participant working out of the Plan's jurisdiction should inquire about reciprocal agreements to see if contributions can be transferred back to this Fund so that he can maintain eligibility.

V. EMPLOYMENT OUTSIDE OF JURISDICTION (Bargaining Unit Only)

A contributing employer may continue to contribute for his employees even though they are doing work outside of the geographic jurisdiction of the Union, provided the employer continues to be recognized as a contributing employer by the Trustees and is working in an area that does not have fringe benefits available through a Collective Bargaining agreement

covering that jurisdiction.

VI. SELF CONTRIBUTIONS

A. Self-contributions will be allowed from participants who are in danger of losing eligibility due to unemployment in the jurisdiction of this Plan, as determined by the Board of Trustees. Self-contributions can be made for a maximum of 18 months. These contributions shall be made in the amount of the difference between employer hourly contributions received and 330 hours per quarter as established in Rule II. Participant hours thus contributed will be credited to the participant's account the same as employer hours. Self-contributions must be received or post-marked no later than the "Date Due" shown on the self-contribution statement. If a self-contribution is not made, and the participant becomes ineligible, eligibility can only be re-established as outlined in Rule IV.

B. In the event that the participant receives a self-contribution statement because of hours not yet reported by the employer (late hours), the participant must pay the self-contribution to avoid becoming ineligible. The Fund Office will refund the self-contribution to the participant as soon as the contributions are received from the employer.

C. Partial payments of self-contributions will be allowed only if the total self-contribution is $200.00 or more. One-half of the self-contribution amount will be due on the "Date Due" shown on the statement with the other half being due thirty (30) days later. Notice explaining this procedure will be sent with the self-contribution statement.

D. Extended Self-Contributions (**Retiree Contributions**): In order to be allowed to make extended self-contributions upon retirement, a participant must meet one of the following requirements:

1. Participants who have been continuously eligible in the Plan for five (5) consecutive years or more at the time of retirement and/or becoming totally disabled will be eligible to make extended self-contributions to maintain their eligibility in the Plan, subject to periodic review of the Trustees, OR

2. Participants who are currently eligible at the time of retirement and/or becoming totally disabled and who were continuously eligible for the preceding ten (10) years with no more than twenty-four (24) months of no coverage under the Plan during that ten year period are also eligible for extended self-contributions during retirement. For purpose of the twenty-four months, periods during which the participant is receiving Workers' Compensation benefits will not be counted against him.

3. Retirees must be age 55 or older unless they have retired on a 30-year pension.

E. In order to qualify for a total disability, the participant must qualify for Social Security Disability. The Trustees may require annual proof to continue disability.

1. The participant must submit to the Trustees each year copies of tax returns showing that the Eligible Participant has income of $15,000 or less.

2. Failure to provide the required proof of continued disability will terminate the participant's eligibility.

F. Non-Bargaining unit participants who meet the five (5) Year Continuous Service Rule (D. 1. above) shall be permitted to make extended self-contributions provided they are legitimately retired and age 55 or older and/or they are permanently disabled.

G. If a participant who has qualified under this provision is deceased, then his or her spouse may continue self-contributions until death or re-marriage, however the surviving spouse shall not be eligible for any death benefits or short or long term disability benefits and will not be allowed to add new dependents.

H. Any retired participant who is eligible for Medicare is required to carry both Part A and Part B in order to make extended self-contributions. Participants affected by this rule are required to submit proof of coverage to the Fund Office. This Plan will be governed by Medicare rulings. If a retired participant fails to carry Part B, claims will be processed as if Medicare had made the normal Part B reimbursement. The participant will still be required to apply for Part B coverage at the next eligible date set by Medicare.

I. Employers, self-employed persons, and persons working for employers in the construction industry not properly reporting all hours worked, are not eligible to make self-contributions under this rule.

J. Participants who knowingly work for employers who do not properly report all hours to the Trust Fund, shall not be eligible for any benefits for such period of time as shall be determined by the Trustees.

K. THE TRUSTEES MAINTAIN THE RIGHT TO REQUEST COPIES OF TAX RETURNS OR OTHER DOCUMENTATION TO VERIFY WORK HISTORY OF ANY PARTICIPANT.

VII. NON-BARGAINING EMPLOYEE ELIGIBILITY

Non-bargaining unit employees, including partners of partnerships who are contributing employers, shareholders of corporations who are contributing employers, and proprietors of sole proprietorships who are contributing employers, who are permitted to make contributions to the Fund shall be governed by all rules applying to bargaining unit employees, provided that no employer or employee shall be entitled to receive any benefit under any plan for injury or disability arising out of his occupation.

VIII. CHANGE OF ELIGIBILITY RULES

The Trustees, at their discretion, are empowered to change or amend the foregoing Eligibility Rules at any time.

IX. TERMINATION OF ELIGIBILITY

A. If you perform any bargaining unit work in the jurisdiction of the Fund for an employer that is not signatory to a collective bargaining agreement with a labor organization, your eligibility for benefits terminates immediately the day you work for the non-signatory employer.

For example, if you are working for a contributing employer on March 1, 2023, and you perform any bargaining unit work on May 5, 2023 for an employer that is not signatory to a collective bargaining agreement with a labor organization, your eligibility for benefits terminates May 5, 2023. **You will lose all hour bank privileges and coverage will terminate immediately.**

If you wish to become eligible again, you must meet the Initial Eligibility requirements for bargaining unit work in order to reinstate your coverage under the Plan.

This applies to actives and retirees. If you are a retiree working for a non-signatory contractor, you could be jeopardizing your health and welfare coverage. If a retiree loses coverage, they not only have to meet the Initial Eligibility rules to reinstate coverage eligibility, but would also have to meet the 5 year requirement to be eligible to make retiree self-contributions.

B. The benefits of any Eligible Person shall terminate prospectively on the earliest of the following:

1. the date the Plan is terminated or otherwise ceases providing benefits to any person;

2. the date the Eligible Participant ceases to be eligible for benefits according to the Eligibility Rules established by the Trustees;

3. the date the Eligible Person, if a Dependent, ceases to be a Dependent as defined in the Plan;

4. the date any Participant fails to make a self-contribution as required by the rules of the Board of Trustees;

5. the date the Eligible Participant's employer ceases to be a contributing employer for one of the reasons described in paragraph C. below; or

6. the date determined under paragraph D. below following an Eligible Participant's death.

C. Coverage of all employees of a contributing employer shall terminate prospectively when the employer ceases to be a contributing employer:

1. for nonpayment of contributions;

2. for fraud or other intentional misrepresentation by the employer;

3. for noncompliance with material plan provisions;

4. because the plan is ceasing to offer coverage in a geographic area;

5. when there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan (this provision only applies if the Plan does not provide out of network benefits and then only so long as the plan applies this paragraph uniformly without regard to the claims experience of employers or any health-related factor in relation to such individuals or dependents); or

6. for failure to meet the terms of the applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the Plan, to renew a collective bargaining or other agreement, or to employ employees covered by such agreement.

D. Following the death of an Eligible Participant, the eligibility of his dependents shall terminate on the last day of the quarter in which he would have normally lost his eligibility. Such dependents shall have the right to continue coverage under the Plan as required under federal law (COBRA). The currently effective rules will be provided on request to any eligible person. It is the intention of this Plan to comply with all federal laws pertaining to the rights of terminated employees, widows, divorced spouses, and children to make self-contributions in order to maintain eligibility. COBRA guidelines are available at the Fund office. For a more detailed explanation of your COBRA rights, please see the section titled "Continuation Coverage Rules" which can be found on page 22.

X. QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

A. The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), requires the Plan to establish procedures for handling medical child support orders, and requires the Plan to determine whether an order is "qualified."

B. A medical child support order is a judgment, decree, or order (including an approval of a property settlement) that:

1. Is made pursuant to State domestic relations law (including a community property law) or certain other State laws relating to medical child support; and

2. Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

C. A medical child support order that is qualified under ERISA is referred to as a Qualified Medical Child Support Order, or "QMCSO." A QMCSO is a medical child support order that:

1. Creates or recognizes the right of an "alternate recipient" to receive benefits for which a participant or beneficiary is eligible under a group health plan or assigns to an alternate recipient the right of a participant or beneficiary to receive benefits under a group health plan; and

2. Is recognized by the Plan as "qualified" because it includes information and meets other requirements of the QMCSO provisions found in Section 609 of ERISA, including the name of the participant and alternate recipient, the type of coverage to be provided to the alternate recipient, and the period to which the order applies.

3. In addition, a properly completed National Medical Support Notice will be treated as a QMCSO.

D. An "alternate recipient" is any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant. The child can be the participant's natural child, adopted child, or child placed for adoption, whether or not the adoption has become final.

E. Upon receipt of a judgment, decree, or other order issued by a court of competent jurisdiction, the Plan administrator will notify the participant and each alternate recipient of the order. The administrator will then determine whether the order is qualified within a reasonable period of time, pursuant to reasonable written procedures that have been adopted by the Plan. If you are a participant or alternative recipient subject to any such order, you may obtain a copy of the Plan's written procedures for determining the qualified status of medical child support orders by contacting the Trust Office at 785-267-0140 or 800-432-3595. The Plan administrator will provide the participant and all alternate recipients with prompt notification of its determination as to whether or not the order is qualified.

F. If the order is determined to be a QMCSO, the Plan Administrator shall notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage for the dependent child(ren). However, no coverage will be provided for any dependent child under a QMCSO unless the employee is eligible for benefits under this Plan and contributions for sufficient hours are received by the Fund Office. Notwithstanding the Plan's requirements for coverage of a dependent child, the Plan must comply with any direction contained in a QMCSO requiring the Plan:

1. to enroll a child under his or her parent's health insurance even if the child was born out of wedlock, does not reside with the insured parent or in the insurer's service area, or is not claimed as a dependent on the parent's Federal income tax return;

2. to enroll a child pursuant to court or administrative order without regard to the Plan's open season restrictions or other time limits on enrollment;

3. to comply with court or administrative orders requiring the parent to provide health coverage for a child; and

4. to permit a custodial parent to file claims on behalf of his or her child under the non-custodial parent's health coverage and to make benefit payments to the custodial parent or health care provider.

G. If the Plan Administrator determines that the order is not a QMCSO, the parties shall be notified. If such order is amended or modified and subsequently re-filed with the Plan, the

order as amended or modified shall be treated as a new order, with the above procedures being applicable to such new order.

H. A QMCSO cannot require the Plan to provide any type or form of benefit that is not already offered. Coverage under a QMCSO is required until the earliest of the following dates: (a) when the requirement for coverage under the QMCSO ends; (b) when the Employer eliminates family (or dependent) coverage for all employees; or (c) when the participant or child is no longer eligible for coverage (for example, when the participant terminates employment or when the child attains age 26).

XI. SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after that other coverage ends.

If coverage is lost under Medicaid or a state Children's Health Insurance Program ("CHIP"), you and/or your dependents may request enrollment no later than 60 days after the date that Medicaid or state CHIP coverage terminated, if you provide proof of the loss of coverage. CHIP is a partnership between the federal and state governments that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage, and works closely with its state Medicaid program. CHIP benefits are different in each state.

You and/or your dependents may request enrollment no later than 60 days after the date you and/or your dependents are determined to be eligible for assistance from Medicaid or state CHIP, if you provide proof of the eligibility determination.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

XII. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act allows you to take up to 12 weeks of unpaid leave during any 12-month period for your own illness, or to care for a seriously ill child, spouse, or parent; the birth or placement of a child for adoption; or an urgent need for leave before your spouse, son, daughter, or parent is on active duty in the armed services in support of a military operation. In addition, FMLA provides that an eligible employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12-month period of care for the covered service member with a serious illness or injury incurred in the line of duty. **Your eligibility for FMLA leave will be determined by your contributing Employer.**

CONTINUATION COVERAGE RULES

If you are eligible for FMLA leave, the Fund will maintain your prior eligibility status until the end of the leave, provided your contributing Employer properly grants the leave under federal law and makes the required notification and payment to the Fund. Your Employer must pay the cost of coverage in an amount determined by the Fund for each week you are on FMLA leave.

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

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage due to certain life events. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, please contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator will determine the date of the qualifying event.

This Plan does not discriminate among active employees based on age or Medicare eligibility status. Accordingly, a qualifying event will not occur based on an active employee becoming entitled to Medicare benefits.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 12 months after the qualifying event occurs. Your failure to provide notice of a qualifying event waives your right to receive COBRA continuation coverage. You must provide this notice to: Gary Muckenthaler, Plan Administrator, Kansas Building Trades Health and Welfare Plan, 4101 SW Southgate Drive, Topeka, Kansas 66609-1276. This notice must be provided in writing and mailed or delivered to the Fund Office within 12 months following the date of the qualifying event. If mailed, the notice must be postmarked within 12 months following the qualifying event. If the qualifying event is divorce or legal separation, you must submit a copy of the court order or decree granting the divorce or legal separation (also sometimes called separate maintenance).

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred (or makes a determination that a qualifying event has occurred), COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to extend coverage due to a disability, you must send a copy of the Social Security Administration's disability determination letter to Gary Muckenthaler, Plan Administrator, Kansas Building Trades Health and Welfare Plan, 4101 SW Southgate Drive, Topeka, Kansas 66609-1276 within 60 days of the date of the disability determination letter or within 60 days after commencement of COBRA continuation coverage, if later.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former

employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Special extension for dependents of former employees who become entitled to Medicare

If an employee receiving COBRA coverage becomes entitled to Medicare during the 18-month period, the employee's spouse and dependent children may request an extension of their COBRA coverage to a total of 36 months, even if the employee's entitlement to Medicare would not have caused the spouse and children to lose coverage under the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Gary Muckenthaler, Plan Administrator
Kansas Building Trades Health and Welfare Plan
4101 SW Southgate Drive
Topeka, Kansas 66609-1276
785-267-0140 (Topeka area)
800-432-3595 (toll free)

COBRA Continuation Coverage Procedures

General

All participants and beneficiaries will receive a general notice of the fact that coverage under the Plan may be continued on a self-pay basis following a "Qualifying Event" that would result in a loss of coverage under the Plan. The general notice has been included in this document and is also available in a separate document. It will be provided to all participants and spouses no later than 90 days after the participant or spouse first becomes covered under the Plan. Regardless of whether the notice is provided as part of this document or as a separate document, the Plan will ensure

delivery to both the participant and the spouse either by mailing the notice to the home address of the participant and spouse, addressed to both of them, or, if the Plan knows that the spouse lives at a different address from the participant, by mailing a separate notice to each person.

The Plan will maintain reasonable written procedures for ensuring the COBRA rights of all participants and beneficiaries.

A participant or beneficiary with respect to whom a qualifying event has occurred shall be a qualified beneficiary entitled to elect COBRA continuation coverage. Any person who has properly elected continuation coverage shall remain a qualified beneficiary until continuation coverage is terminated.

There may be other coverage options available for you and your family in the event coverage is lost, aside from COBRA continuation coverage. You may be able to purchase coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away if you do not currently have coverage that meets government standards for affordability and minimum value. In the Marketplace, you can see what your premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Notice of Qualifying Events

Participating employers are not required to provide notice of qualifying events to the Plan Administrator. The Plan Administrator shall determine whether a qualifying event has occurred due to the employee's termination of employment or reduction in hours of employment, the employee's death, or the employee's becoming entitled to Medicare.

In order to make a determination whether a qualifying event has occurred as a result of termination of employment or reduction of hours of employment, the Plan Administrator shall review the monthly employer contribution reports to determine the number of hours to be credited to the employee based on the number of hours worked and whether full contributions are received for all hours worked. If employer contributions reports are submitted timely, the Plan Administrator will generally have sufficient information to determine whether an employee will lose coverage as a result of a termination of employment or reduction of hours of employment within 45 days after the last day of the qualification period in which the employee does not have sufficient hours or contributions credited to maintain coverage.

The Plan Administrator shall determine whether an employee has become entitled to Medicare and whether such entitlement constitutes a qualifying event. If the Plan Administrator so determines, he shall send a COBRA election notice to all qualified beneficiaries within 30 days following the date of the qualifying event.

The Plan Administrator shall send notice of the qualifying event and all qualified beneficiaries' rights to elect COBRA continuation coverage as soon as possible after determining that an employee has died. Unless the Plan Administrator has no reason to know of the employee's death, the COBRA election notice shall be sent to all qualified beneficiaries within 14 days after such qualified beneficiaries would lose coverage as a result of the qualifying event.

The Plan Administrator shall send notice of the qualifying event and the qualified beneficiaries' rights to elect COBRA continuation coverage within 14 days after having determined that a qualified event has occurred as described above.

An employee must give written notice to the Plan Administrator within 12 months after the occurrence of a qualifying event that is a divorce or legal separation of the employee (or retiree) and spouse or a dependent child's ceasing to meet the Plan requirements for an eligible dependent. The notice shall be provided in writing, mailed or delivered to the Fund Office. The Plan will provide forms to participants and beneficiaries which may be used to provide this notice. Use of the Plan's form is not required as long as the written notice of qualifying event contains all of the necessary information and is accompanied by documentation of the qualifying event, if applicable. The Plan Administrator will then send notice of the qualified beneficiaries' rights to elect COBRA continuation coverage, or the unavailability of COBRA continuation coverage, within 14 days after receiving such notice.

Second Qualifying Event and Disability

If a qualified beneficiary experiences a second qualifying event while on COBRA continuation coverage that is subject to a maximum period of 18 or 29 months, the qualified beneficiary must provide written notice to the Plan Administrator within 60 days of the second qualifying event in order to extend the maximum COBRA continuation coverage period to 36 months.

If a qualified beneficiary or any member of the qualified beneficiary's family is disabled, as determined by the Social Security Administration, at any time within the first 60 days of COBRA continuation coverage, the qualified beneficiary must provide written notice of such disability to the Plan Administrator within the first 60 days of COBRA continuation coverage or, if later, within 60 days from the Social Security Administration's determination that the qualified beneficiary or family member is disabled. The notice must be accompanied by a copy of the Social Security Administration's determination letter. A qualified beneficiary may, but is not required to, use a form provided by the Fund Office to provide this notice. If the Social Security Administration determines that the person's disability has ended while the person is on COBRA continuation coverage, the qualified beneficiary must provide a copy of the Social Security Administration's letter stating that the person is no longer disabled, to the Plan Administrator within 30 days after the Social Security Administration's determination.

The Plan Administrator shall send notice of right to elect an extended period of continuation coverage, or notice of the unavailability of an extension of continuation coverage, within 14 days after receiving notice from the qualified beneficiary.

CONTINUATION COVERAGE RULES

Unavailability of COBRA Continuation Coverage

When the Plan Administrator receives a notice from an employee or beneficiary relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary, or other individual, and the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage or an extension of COBRA continuation coverage, the Plan Administrator shall provide a notice to the person sending the notice explaining why the individual is not entitled to COBRA continuation coverage. The unavailability notice shall be sent within 14 days from receipt of the notice from the employee or other individual.

Early Termination of COBRA Continuation Coverage

Whenever COBRA continuation coverage is terminated prior to the latest date shown on the Election Notice (that is, prior to the end of the 18, 29, or 36 month maximum period), notice must be sent to all affected qualified beneficiaries explaining the reason for the termination, the date of termination, and any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. The termination notice will be provided as soon as practicable following the Administrator's determination that continuation coverage shall terminate.

COBRA continuation coverage will terminate on the earliest of the following dates:

- The first day of the month for which the required applicable self-contribution is not paid within the required time period;

- The date the individual first becomes **covered,** after the date the Qualified Beneficiary elects COBRA continuation coverage under this Plan, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such qualified beneficiary;

- The date the individual becomes entitled to Medicare if that date is after his continuation coverage election date;

- The date the Plan terminates;

- The last day of the maximum period of continuation coverage;

- With respect to a disabled qualified beneficiary and his eligible family members who are extending coverage for the additional 11 months, COBRA coverage will terminate 30 days after the month in which Social Security determines that the qualified beneficiary's disability no longer exists;

- The qualified beneficiary's continuation coverage is terminated for cause (for example, because of the submission of fraudulent claims).

Change of Premium Rate

In the event COBRA premiums change, the Plan Administrator shall send notice of such change to all qualified beneficiaries at least one month prior to the effective date of the change. Such changes shall not occur more than once in a twelve month period.

Deficient Premium Payment

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is less than the full premium amount due, and the deficiency is not more than $50.00 (or the deficiency is not more than 10% of the applicable premium amount, if 10% of the premium is less than $50.00), the Plan Administrator shall provide notice of deficiency to the qualified beneficiary, demanding payment of the deficiency in full within 30 days from the date of the notice of deficiency. The deficient premium will be considered full payment until the end of the 30 day period. If the Plan Administrator fails to provide notice of the deficiency to the qualified beneficiary within 30 days after receipt of the payment, the amount paid will be deemed to constitute full payment of the applicable premium.

In the event a qualified beneficiary submits a payment for COBRA continuation coverage that is significantly less than the full amount due (that is, the deficiency exceeds the lesser of $50.00 or 10% of the applicable premium), no additional time will be granted to make up the deficiency. If the deficiency is not paid within the initial 30 day grace period, coverage will be retroactively terminated as of the first day of the month for which full payment was not made.

CONTINUATION COVERAGE DURING A PERIOD OF UNIFORMED SERVICE (Uniformed Services Employment and Re-employment Rights Act, "USERRA")

YOUR RIGHTS AND BENEFITS WHEN CALLED TO ACTIVE DUTY UNIFORMED SERVICE

If you are on active duty for more than 30 days, you and your dependents may be eligible for military health care. Contact your military unit for information on these programs.

You shall be entitled to benefits for you and your covered spouse and dependents during your military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Such continuation coverage shall be made available to you for qualifying service in the uniformed services within the meaning of USERRA. USERRA continuation coverage shall run concurrently with COBRA continuation coverage.

If your military service is for 30 or fewer days, you and your dependents may continue coverage as if you were still working in covered employment. If your military service lasts for more than 30 days, you may continue your health and welfare benefits by paying the cost of coverage for up to 24 months.

Your coverage will continue until the earlier of the end of the period during which you are eligible to apply for reemployment in accordance with USERRA or 24 consecutive months after your coverage would have otherwise ended. Your coverage will end on the earliest of when:

- Your coverage would otherwise end;

- Your former Employer no longer provides any health plan coverage to any Employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

You must provide notice to the Fund Office prior to leaving for your service on active duty, unless providing such notice is unreasonable, impossible, or prohibited due to military necessity (that is, if DOD regulations, your orders, or your commanding officer prohibit giving notice in your particular case). Contact the Fund Office as soon as you receive your orders to protect your right to continue coverage. The Fund Office can also provide you with the Plan's written procedures and rules governing USERRA continuation coverage.

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

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

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

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

MEDICAL BENEFITS

Quality Preferred Provider Organizations have agreed to discount services provided to Plan Participants by participating Preferred Providers, reducing benefit costs for both the Plan and the participant. The higher coinsurance for care provided by non-Preferred Providers does not begin to cover the increased costs to the Plan when using a non-Preferred Provider. Exceptions apply in the case of certain surprise medical bills as explained on page 42.

COMPREHENSIVE MEDICAL BENEFITS: (The annual deductible applies to this page.)

	Preferred Providers	Non-Preferred Providers
Deductible	$350.00 per individual/ $700.00 per family Deductible increased to $425.00 per individual (up to $850.00 per family) if the Eligible Participant and/or the Eligible Participant's spouse fail to complete no-charge physical examination and biometric screening in prior or current Plan Year	$350.00 per individual/ $700.00 per family Deductible increased to $425.00 per individual (up to $850.00 per family) if the Eligible Participant and/or the Eligible Participant's spouse fail to complete no-charge physical examination and biometric screening in prior or current Plan Year
Coinsurance	The Plan will pay 80% of allowed charges after the deductible has been met, up to $37,500.00 out-of-pocket per calendar year, per family and 100% in excess of $37,500.00.	The Plan will pay 50% of allowed charges after the deductible has been met, up to $37,500.00 out-of-pocket per calendar year, per family and 100% in excess of $37,500.00.
	Any billed charge that exceeds the allowable charge will be the participant's sole responsibility and will not count toward the deductible or the participant's coinsurance responsibility.	
Organ and/or tissue transplants	Limited to kidneys, liver, lung, bone marrow, and heart transplant.	
CHIROPRACTIC: Limited to twelve (12) visits per calendar year.		
NERVOUS & MENTAL CARE:		
	Preferred Provider	Non-Preferred Provider
Coinsurance	The Plan will pay 80% of allowed charges.	The Plan will pay 50% of allowed charges.
QUALIFIED ALCOHOL & DRUG TREATMENT:		
	Preferred Provider	Non-Preferred Provider
Coinsurance	The Plan will pay 80% of allowed charges. <u>All benefits for residential or Inpatient treatment must be pre-certified.</u>	The Plan will pay 50% of allowed charges. <u>All benefits for residential or Inpatient treatment must be pre-certified.</u>
Emergency Room Co-Pay	$150.00 per visit. This amount is in addition to the deductible and the participant's coinsurance responsibility.	

Dietician	1 visit per month
Centers of Excellence	No deductible, coinsurance, or copayment shall apply for surgeries or musculoskeletal care provided through a Centers of Excellence program approved by the Board of Trustees. For more information about Centers of Excellence, contact the Fund Office.

DENTAL: DELTA DENTAL 800-234-3375

	Delta PPO	Delta Premier
Deductible	$25.00 per person/per year	$25.00 per person/per year
Coinsurance – General	The Plan will pay 90% of negotiated charges.	The Plan will pay 50% of PPO fee schedule.
Examination and Cleaning	The Plan will pay 100% of the contracted rate. 2 per year	The Plan will pay 50% of PPO fee schedule. 2 per year
Orthodontic Lifetime Maximum	$1,600.00 per individual; Lifetime maximum does not apply to Medically Necessary orthodontia coverage for Eligible Persons under the age of 19.	
Annual Maximum for Dental Benefits (including Orthodontic benefits)	$2,000.00 per individual / $4,000.00 per family. The annual maximum does not apply to Eligible Persons under the age of 19.	

OPTICAL: **V**ision **S**ervice **P**lan (1-800-877-7195) – Routine Vision Only

Eye exam every 12 months, spectacle lenses or contact lenses every 12 months, and frames every 24 months. Eye exam co-payment $10.00, lenses and frame co-payment $25.00. $120 allowable for Frames anything over allowance is patient responsibility. Safety glasses – member only - $25 co-pay $65 allowance- lenses every 12 months frames every 24 months. Anything over the $65 allowance is patient responsibility. Anything over $120 there is a 20% savings. The Plan has signed an agreement with a preferred provider network for vision correction procedures. The Plan will pay up to $2,000.00 per person per lifetime for vision correction surgery.

PRESCRIPTION DRUGS:

	30 day	90 day
Generic Diabetic Drugs	No co-pay	
Generic Preventive Maintenance Drugs	No co-pay	
Co-Pay – Generic Drugs	20% or $5.00, whichever is greater (not to exceed the full price of the drug)	$7.50
Co-Pay – Preferred (Formulary) Drugs	20% or $15.00, whichever is greater (not to exceed the full price of the drug)	$22.50
Co-Pay – Non-Preferred Brand Name Drugs	20% or $30.00, whichever is greater (not to exceed the full price of the drug)	$45.00

DEATH BENEFITS

Participant – Accidental Death and Dismemberment Principal Amount	$10,000.00
Participant Death Benefits	$10,000.00
Dependent Death Benefits	$5,000.00

MEDICAL BENEFITS

DISABILITY BENEFITS (eligible participants only)

Loss of Time Rate	$300.00 gross amount per week, up to a maximum of 13 weeks
Long Term Disability Rate	$100.00 gross amount per month, up to a maximum of 60 months
Loss of Time and Long Term Disability benefits are subject to tax withholding.	

MASSAGE & ACUPUNCTURE BENEFITS

Massage and/or acupuncture benefits will be covered up to $500.00 per year subject to the co-pays.

This Plan provides comprehensive medical benefits, assisting you with the costs associated with necessary treatment and diagnostic services for sickness or injury, as well as certain routine and preventive care benefits.

COVERED MEDICALLY NECESSARY EXPENSES

Covered Medically Necessary expenses **GENERALLY** include all reasonable and necessary charges performed or prescribed by a duly-licensed physician as set forth hereafter for the following types of services.

1. Services of physicians, including limited specialists and limited consultations and in-hospital medical visits, but specifically excluding fees in excess of the usual and customary charge;

2. Hospital charges for room and board, including special diets, intensive care, and general nursing care;

3. Operating or treatment rooms;

4. Anesthetics and their administration;

5. X-rays and other diagnostic laboratory procedures;

6. Oxygen and its administration;

7. All acute drugs, medicines, and dressings used in the hospital;

8. Services of a qualified physiotherapist;

9. Home health care and/or Hospice care services by a registered nurse or a licensed practical nurse not related to the patient. Home health care and/or Hospice care services by a non-skilled person, such as limited custodial care, are allowed, but only if the patient meets the criteria for Hospice care and is terminally ill.

10. Hospice care facility benefits, including room and board, services, and supplies necessary for the management of a terminal illness or injury.

11. Rental of durable medical equipment and other Home Health Care equipment required for temporary use for restorative purposes; the Board of Trustees reserves the right to purchase durable medical equipment required for temporary use for restorative purposes if purchasing said equipment is more cost effective;

12. Professional ambulance service during any one illness; (Facility to Facility transfers will require medical records for approval)

13. Splints, braces and crutches, and artificial limbs or eyes, when prescribed by a physician. Only the original issue will be covered. Replacement items are NOT covered.

14. Extended care facilities or similar facilities will be covered as an alternative to in-patient hospitalization when medically appropriate and cost-effective if the Eligible Participant would otherwise need to be in the hospital. Pre-certification is required.

15. Breast pumps.

COMPLETE PHYSICAL BENEFITS

Each Eligible Participant and his/her Dependent spouse will be offered a complete, no-cost physical examination on a yearly basis. The following items will be covered without any cost-sharing and are not affected by deductibles. The examination should include the following:

- Complete Physical Exam – Height and Weight, Blood pressure and heart rate measurements, Physician consult and goal setting. (required)
- Laboratory series, including Metabolic profile, Lipid profile and CBC/with differential (required)
- TSH (females), PSA (males), a colorectal cancer screen Hemoccult test and Urinalysis (for possible diabetes or urinary tract/kidney disease), A1C (estimated average glucose) (optional)
- Resting EKG (optional)
- Exercise stress EKG (if indicated)
- Mammogram/3D Mammogram (optional)
- PAP exam and HPV test(optional)

Flu shots are not covered as part of your physical. If Flu shots are done in the doctors' office, they are subject to the deductible or co-insurance. Flu shots are covered through the prescription drug program at no cost to you, with no co-payment requirement.
All services included as part of the complete physical examination must be completed within 1-2 months.

HEALTH AND WELLNESS BENEFITS

The Plan will provide coverage of up to one (1) visit per month for individualized nutritional evaluation and/or counseling as part of an overall health and wellness regimen, when services are provided by a licensed health care professional (e.g., a registered dietician or nutritionist). Allowed benefits are exclusive of any food, supplements, fitness club/gym dues, or surgical procedures, which will not be covered under any circumstances. Prior authorization is required for prescription medications used in the management and treatment of obesity. Coverage is available to all individuals covered by the Plan, regardless of the presence of an underlying medical condition or other health status-related factor.

HOSPITAL IN-PATIENT BENEFITS

When accidental bodily injury or sickness requires the Eligible Person to be confined in a hospital for Medically Necessary treatment, this Plan will pay the reasonable expenses actually incurred while the individual is covered under this Plan for:

- Reasonable charges for ROOM AND BOARD, not in excess of the usual and customary rates for a semi-private room, if semi-private rooms are available at the facility. If a private room or specialized unit room, such as an intensive care unit room, is Medically Necessary, or if a semi-private room is not available at the facility, reasonable charges for room and board, not in excess of the usual and customary rates for the least intensive Medically Necessary room will be covered.

- HOSPITAL MISCELLANEOUS charges for Medically Necessary services and supplies furnished by the hospital which are not included in the room charge. This includes charges for anesthesia when billed by the hospital, drugs and medicines administered in the hospital, x-ray and laboratory examinations in the hospital, physiotherapy treatment by a physiotherapist while in the hospital, and other Medically Necessary treatments administered in the hospital.

- Physicians' charges for Medically Necessary care and treatment, subject to the rules for Physician Benefits below.

- Expenses for personal comfort or convenience items will NOT be covered.

The Plan will pay approved benefits directly to the provider when the Eligible Participant assigns benefits to the provider.

When an Eligible Participant is admitted to the hospital for Medically Necessary care and treatment that could safely and effectively be provided outside of the hospital, such as through outpatient surgery, NO benefits are payable for physician charges in the hospital, NO benefits are payable for room and board charges, and benefits will be reduced to 50% of the reasonable, usual, and customary charge for Medically Necessary diagnostic and hospital miscellaneous costs.

PHYSICIAN BENEFITS

Surgical Benefits are payable for reasonable surgical fees charged by a legally qualified physician or surgeon for operations performed while the Eligible Person is covered under this Plan. The Plan will pay its share of reasonable charges for one primary surgeon, as limited in this section.

Reasonable charges for Assistant Surgeons will be covered only up to a total of 25% of the primary surgeon's fee. Charges for the service of assistant surgeons that, taken together, are more than 25% of the primary surgeon's total allowed charge will not be covered by this Plan. Hospital rules are not binding on the Plan.

If two or more significant surgical procedures are performed through the same incision, the Plan will pay its share of the allowable charge for the procedure with the highest total charge. The allowable charge for any other procedures will be limited to one-half of the amount that would be allowed if the other procedures were performed alone. The Plan will not pay for secondary procedures performed through the same incision which would not require significant time or complexity.

The Plan will cover charges for surgery performed in the hospital, the doctor's office, or elsewhere.

The Plan will pay reasonable anesthesiologist charges based upon the physician's actual time and the Medical Necessity and appropriateness of the physician's services.

All surgical benefits are limited to a reasonable amount that does not exceed usual and customary charges.

All other Medically Necessary physician services will be covered according to general Plan rules.

ORGAN TRANSPLANTS

This benefit must be pre-authorized by the Trust Fund Office and is limited to coverage for kidney, liver, lung, bone marrow, and heart transplants at medical centers with a long established record of success in the particular surgery required. Benefits will not be provided unless there is both a primary and two secondary medical opinions that there is a reasonable probability of success and no other serious organic problem which would significantly affect the probability of success. All transplants will be coordinated by a Case Manager.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits, under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductible and coinsurance apply: annual deductible of $350.00 per individual (unless the family deductible of $700.00 per family per year has been met). NOTE: Deductible is increased to $425.00 per individual (up to $850 per family) if the Eligible Participant and/or the Eligible Participant's spouse fail to complete no-charge physical examination and biometric screening in prior Plan Year. After the deductible has been met, the Plan will pay 80% of allowable charges made by Preferred Providers or 50% of Non-Preferred Providers' reasonable and customary charges up to $37,500.00. The Plan pays 100% of allowable, reasonable, and customary charges in excess of $37,500.00 per year.

If you would like more information on WHCRA benefits, call your Plan Administrator at 785-267-0140 in the Topeka area or 800-432-3595 outside of the Topeka calling area.

MATERNITY BENEFITS

Maternity Benefits apply only to:

1. a female Eligible Participant, or

2. an Eligible Dependent who is the lawful wife of an Eligible Participant.

Other Dependents are not covered for maternity benefits.

Elective abortion is excluded. Therapeutic abortion will be covered only when Medically Necessary as certified by the attending physician.

Under the Newborns and Mothers' Health Protection Act of 1996, group health plans generally may not 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 Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a group health plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OUT-PATIENT X-RAY, LAB, AND DIAGNOSTIC TESTS

When accidental bodily injury or sickness causes the Eligible Person to incur these expenses, the Plan will pay x-ray, laboratory, and other diagnostic testing out of hospital. For those who go into the hospital for testing, treatment, or therapy which could safely be done out of the hospital and for which hospitalization is not Medically Necessary, the Plan will not pay in-hospital physician charges.

Benefits are not payable for dental X-rays under the medical benefit.

OUT-PATIENT PHYSICAL THERAPY

This coverage is specifically limited to therapy administered by a licensed Physical Therapist under the direction of a licensed physician. This coverage includes medically necessary water physical therapy and hydrotherapy. Virtual physical therapy is also available at no cost to you through a third-party vendor approved by the Board of Trustees.

SLEEP THERAPY

Sleeping disorders, and the diagnosis thereof, will be covered on an out-patient basis only, with the exception of self-administered at-home sleep studies, and where appropriate medical guidelines are met. The Plan will pay a maximum of two sleep studies, including self-administered at-home sleep studies. Bed wetting therapy requires prior approval by the Board of Trustees.

CPAP and BIPAP machines are purchased one every six years. Tubing, masks, headgear and non-disposable filters are replaced twice a year. Disposable filters and Mandibular advancement devices (MAD) are not covered by the Plan.

ALCOHOL AND DRUG ABUSE

Outpatient therapy will be paid at 80% for Preferred Providers, and at 50% when care is provided by a Non-Preferred Provider. Inpatient therapy will be paid at 80% when provided by a Preferred Provider, and at 50% when care is provided by a Non-Preferred Provider. Treatment provided in a residential or inpatient setting is subject to pre-authorization. Plan will pay reasonable and customary fees for drug testing. The Plan will not pay for excessive drug testing.

NERVOUS AND MENTAL LIMITATION

Benefits for treatment of mental health care conditions ("nervous and mental benefits") will be paid on an 80/20 basis when care is provided by a Preferred Provider, and on a 50/50 basis when care is provided by a Non-Preferred Provider. Treatment provided in a residential or inpatient setting is subject to pre-authorization.

OUTPATIENT ACUTE CARE DRUGS

Acute care and specialty drugs are generally available under the terms of this Plan through a unique pharmacy benefit manager at the customary rates applied to prescription drugs, as found on page 32 of this Summary Plan Description, and certain prescription drugs will be paid for as therapy when administered by a physician, in a physician's office, and not otherwise available.

Contact information for the Plan's pharmacy benefit manager utilized for specialty drugs is available by calling 1-800-432-3595.

MEDICAL EMERGENCY BENEFITS

When medical emergencies require the Eligible Person to incur expenses for emergency hospital room services and supplies, and/or emergency treatment by a legally qualified physician, the Plan will pay the expenses.

A medical emergency is the sudden onset of a condition requiring immediate treatment. The Trustees maintain the right to deny payment on any emergency room visit which they determine not to be a medical emergency. This will include treatment that could have been administered in a physician's office. Medical emergency benefits shall be provided in a manner consistent with the No Surprises Act.

All medical emergency benefits will be paid at the preferred provider co-pays.

Emergency Room Co-Pay	$150.00 per visit. This amount does not count toward the deductible or the participant's coinsurance responsibility.

OUT-PATIENT ACCIDENT BENEFITS

Accident benefits are provided in connection with accidental bodily injury (such as a slip, trip, or fall) and not for self-induced injury or injury resulting from an eligible person's own acts (such as fights, drugs, alcohol, etc.) regardless of whether the effects are direct or indirect. Any accidental injury that results from a physical or mental health condition or an act of domestic violence will be covered under the accident benefit.

When accidental bodily injury requires the Eligible Person to incur out-patient expense or supplies ordered by a legally qualified physician, the Plan will pay the expenses actually incurred within one year from the date of the accident.

Because of the significantly higher rates charged for hospital emergency room treatment, you are requested to seek other forms of treatment when available. It will save you money.

CHIROPRACTIC COVERAGE

Payments will be made to licensed chiropractors as set forth in the Schedule of Benefits. Treatments are limited to twelve (12) visits per person, per year. Vertebral decompression is not covered under the terms of the Plan. Medically Necessary diagnostic x-rays are covered and are not included in the annual twelve visit limitation. Chiropractic visits are subject to your deductible.

ALTERNATIVE TREATMENTS – ACUPUNCTURE AND MASSAGE

The Plan will cover certain alternative pain treatments, limited to acupuncture and massage. Coverage is limited to an aggregate dollar limit of $500 per year, per person. Charges for alternative treatments shall not accumulate towards the Plan's deductible, nor shall Eligible Persons be required to reach the applicable yearly deductible before the Plan will pay covered expenses for alternative treatments.

Charges for treatments which are otherwise Medically Necessary and submitted to the Plan as part of a rehabilitative course of treatment or therapy shall not be subject to this provision or the $500 limitation, and instead shall be processed under the applicable Medically Necessary expense.

PROTECTIONS FROM SURPRISE MEDICAL BILLS

Under a federal law called the No Surprises Act, you have protections against surprise medical bills from Out-of-Network providers and facilities. This law applies to Out-of-Network Emergency Services, Out-of-Network Air Ambulance Services (but NOT ground ambulance services), and services provided by Out-of-Network providers at In-Network Health Care Facilities (unless you consent to receiving services from the Out-of-Network provider). If you receive such covered services, they will be treated as In-Network for determining cost-sharing requirements, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. The Plan will count any cost-sharing payments incurred for these services toward the deductible and/or the out-of-pocket maximum in the same manner it would count cost-sharing payments made for In-Network services. If you receive such services, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

The amount of your cost-sharing for such services will be based on the Recognized Amount. The Recognized Amount is the amount determined in the following order:

1. An amount determined by an All-Payer Model Agreement, if applicable;
2. An amount determined by a specified state law, if applicable;
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount. The Qualifying Payment Amount generally means the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) certain non-ancillary services from an Out-of-Network Provider at a Network Health Care Facility or (2) services from an Out-of-Network Emergency Facility or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in an In-Network facility. Ancillary services include items and services related to

emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services, and items and services provided by an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

CONTINUING CARE

Under the No Surprises Act, if you are receiving care from an in-network provider that becomes an out-of-network provider, you may have certain rights to continue your course of treatment if you are a Continuing Care Patient. A Continuing Care Patient means a patient that:

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

If you are a Continuing Care Patient and the Plan terminates its contract with your In-Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an In-Network provider for up to 90 days after the notice is provided or until you no longer qualify as a Continuing Care Patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

GENERAL PLAN EXCLUSIONS

This Plan does NOT cover any:

1. Loss caused by accidental bodily injury, or sickness, which arises out of, or occurs in the course of, any occupation or employment for wage or profit for which the Eligible Employee or Dependent is entitled to benefits under any workers' compensation or occupational disease law unless specifically provided for in the Schedule of Benefits by inclusion of the words "24 hour coverage" with the amount of the benefit.

2. Care rendered within any facility of, or care provided by, any public institution; expenses incurred during confinement in a hospital owned and operated by a state, province or political subdivision unless there is an unconditional requirement on the part of the Eligible Person to pay such expenses without regard to any liability against others, contractual or otherwise.

3. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country.

4. Injury or loss to any Eligible Person covered by any of the following four (4) situations:

   a. Alcohol and Drug Use (Including Driving Under the Influence)

   Injury or loss to any Eligible Person which the Trustees determine in their sole discretion was sustained as the result of the use of alcohol or drug, regardless of whether the effects are direct or indirect. This clause includes injury or loss to an Eligible Person which the Trustees determine in their sole discretion was sustained as a result of the operation of a motor vehicle while under the influence of alcohol or drugs. For purposes of this paragraph, an Eligible Person's refusal to submit to a test to determine the use of alcohol or drugs may be considered by the Trustees as sufficient evidence of being under the influence of alcohol or drugs. This clause does not include injury or loss resulting from the use of prescription drugs taken as directed by a physician or from the use of "over the counter" drugs taken as directed. This clause does not include any injury or loss resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions) even if such medical condition is not diagnosed before the injury or loss.

   b. Fighting, Assault, and Criminal Activity (Excluding Domestic Violence)

   Injury or loss to any Eligible Person sustained in the course of any illegal act that the Trustees determine in their sole discretion could be reasonably expected to result in harm to the individual. This clause includes injury or loss to any Eligible Person which was the result of an assault, attack, or violent act. This clause does not include injury or loss to any Eligible Person caused as a result of an act of domestic violence or a medical condition (including both physical and mental health conditions) even if such medical condition is not diagnosed before the injury or loss.

   c. Dangerous Activities

   Injury or loss to any Eligible Person which resulted from participation in an activity which the Trustees determine in their sole discretion could reasonably be expected to result in harm to the Eligible Person. This clause does not include injury or loss to any Eligible Person caused as a result of an act of domestic violence or a medical condition (including

both physical and mental health conditions) even if such medical condition is not diagnosed before the injury or loss.

d. Intentional Self-Inflicted Injury, Suicide Attempts and Suicide

Injury or loss to any Eligible Person which the Trustees determine in their sole discretion was the result of suicide, attempted suicide or intentionally self-inflicted injury. This clause does not include injury or loss to any Eligible Person resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions) even if such medical condition is not diagnosed before the injury or loss.

5. Loss occasioned while in service in the Armed Forces of any country.
6. Cosmetic surgery, which includes any procedures whose primary or sole purpose is to change the Eligible Person's appearance and involves reshaping normal structures of the body. This exclusion does not apply to reconstructive surgery that is Medically Necessary to restore or improve function of a body part, such as after a traumatic injury or as a result of congenital or developmental abnormalities, disease, infection, or tumors. This exclusion does not apply to procedures covered under the Women's Health and Cancer Rights Act of 1998.
7. Dental treatment, except that covered under the Dental Plan.
8. Eye refractions or the fitting of glasses, except as may expressly be authorized elsewhere in the Plan. Contacts provided by the surgeon as a completion of treatment following cataract surgery are covered. Vision correction procedures are subject to the limitations described on page 49.
9. That portion of any expense paid or payable under Title 18 of the Social Security Amendments of 1965 (Public Law 89-97) as currently constituted and as it later may be amended, commonly known as "Medicare," subject to this Plan's coordination of benefits rules and Medicare Secondary Payer laws and regulations.
10. Difference between the average semi-private room rate and private room rate, unless confinement in a private room or other specialized room is Medically Necessary or the facility does not provide semi-private rooms.
11. Apart from those services specified in the section titled "Health and Wellness Benefits" on page 35 of this Summary Plan Description, the Plan will not cover programs, fitness club or gym dues, or surgical procedures designed for weight reduction (Bariatric Surgery).
12. Hearing Aids.
13. Speech therapy, unless for rehabilitative purposes.
14. Fertility Treatment
15. Gene therapy, including any services, supplies and/or drugs. Gene therapy includes treatment, procedures or drug that uses genes to treat or prevent disease.
16. Aqua Therapy
17. Dependent Pregnancy

PRESCRIPTION DRUG PROGRAM

Covered prescription drugs are those drugs which are never sold over the counter and are available only by prescription from a physician. In addition, special life sustaining medication such as insulin will be covered under this prescription drug benefit program. You must present your prescription card to the pharmacy so they can submit your claim.

In order to obtain benefits for prescription drugs, you must have a prescription drug card and go to a participating pharmacy. The Plan's pharmacy benefit manager maintains a list of participating pharmacies. Because the list is subject to change, it is not included in this SPD. For a list of participating pharmacies, contact the Plan's pharmacy benefit manager, Save RX 1-800-228-3108.

The participant pays a co-payment, based on name brand or generic usage, for each prescription. The Fund pays the participating pharmacy direct for the balance of the charge. No claims are filed by you. PRESCRIPTION DRUGS NOT PURCHASED AT THE REQUIRED PHARMACY OR IF THE PARTICIPANT DOES NOT GIVE THE PHARMACY THEIR PRESCRIPTION CARD AT THE TIME OF SERVICE, THESE CLAIMS WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

The maximum prescription filled is a 90 day supply (participating pharmacies only).

The only cost to the Eligible Participant will be the individual co-payments. This cost will not be refunded or cannot be applied towards any deductible. Your co-payment amount is the **greater** of the minimum co-payment or 20% of the cost of the drug. Minimum co-payment amounts are:

30 day fills:

- $5.00 for generic drugs
- $15.00 for preferred brand name (formulary) drugs
- $30.00 for non-preferred brand name drugs (brand name drugs that are not listed on the Plan's formulary or preferred drug listing)

90 day fills:

- $7.50 for generic drugs
- $22.50 for preferred brand name (formulary) drugs
- $45.00 for non-preferred brand name drugs (brand name drugs that are not listed on the Plan's formulary or preferred drug listing)

Some diabetic supplies are covered through the prescription drug program; however, diabetic education will be covered under the Medical plan. There are no co-payments for generic diabetes drugs. There is a co-payment requirement for test strips, which are limited to 100 per month, per person. Certain glucose monitoring systems are covered by the prescription plan. Some non-stick glucose monitoring systems are covered under your medical benefit.

PRESCRIPTION DRUG BENEFITS

Generic preventive maintenance drugs are covered through the prescription drug program at no cost to you, with no co-payment requirement. In general terms, a "preventive maintenance" drug is one that can help prevent, treat, and manage various health concerns which, if not prevented or managed, can lead to more serious illness and complications. Before visiting your health care provider to obtain a prescription, please ask the Plan's pharmacy benefit manager for an updated list of commonly-prescribed preventive maintenance drugs. Coverage may be denied for preventive maintenance drugs that are not listed on the Plan's formulary. Preferred brand name and non-preferred brand name preventive maintenance drugs shall be covered subject to the usual co-payment amounts described above (Hypertension, heart failure, high cholesterol and Asthma).

Flu shots and Covid vaccines are covered through the prescription drug program at no cost to you, with no co-payment requirement.

FDA-approved contraceptive drugs, devices, and injections provided to an Eligible Participant or an Eligible Dependent are covered subject to the usual co-payment amounts described above.

You may obtain a copy of the Plan's formulary listing from the Plan's pharmacy benefit manager. Please share this list with your health care provider whenever you need to get a prescription. Using generic drugs whenever available, and preferred brand name drugs when generics are not available or not appropriate, will save you money.

If possible, your doctor or his or her nurse should call the pharmacy before you leave the doctor's office. This will reduce the length of time before you receive your prescription.

Encourage your doctor to indicate refill information. You will need a new prescription each time you order drugs, if the doctor fails to indicate refill information.

Any prescription drug which is not generally available to all licensed pharmacies will not be provided under this plan.

All prescription drugs must be Medically Necessary for benefits to be available. Drugs prescribed for weight reduction purposes are covered, prior authorization required.

Participating pharmacies have been directed by the Trustees to avoid filling prescriptions without specific consultation with the prescribing physician where there is the possibility of overuse or abuse of the drug.

The Plan has also contracted with a mail order pharmacy to provide prescription drugs to Eligible Participants. Mail order may be more convenient for your maintenance medications (those that you take regularly for a long time), but it will not always be the most appropriate source of your prescriptions. For example, you may need an "acute care" (short-term) medicine very quickly, such as an anti-biotic to treat an infection. You should go to a participating retail pharmacy to obtain prescriptions that you need right away.

There are some legal limitations on sending prescription drugs through the mail. For example, the law may limit the quantity of medicines that may be sent through the mail or may entirely prohibit certain drugs from being sent by mail order. Laws and regulations may also require additional

information on the written prescription for some prescription drugs to be filled through a mail order pharmacy. Your doctor or the pharmacy will advise you on these drugs as required.

Pharmacies are required by state law to consult with Plan participants regarding the proper use of their prescriptions when needed and they encourage you to call the pharmacy if you have any questions regarding the use of your prescriptions.

The pharmacy benefit manager also has a Toll-Free Phone Service for use by your doctor or his or her nurses, in ordering your initial prescriptions for you and your dependents. In an emergency or an unusual situation, you may reorder a prescription refill by calling 1-800-228-3108. This number is also printed on your prescription drug plan identification card from SavRX.

If a physician prescribes a medication that requires prior authorization, the Plan will not cover the prescription until the prior authorization process has been completed and the medication has been approved. Drugs that are subject to prior authorization are listed on schedules maintained by the pharmacy benefit manager. These schedules are subject to change. For more information and to obtain a list of drugs subject to prior authorization requirements, contact the pharmacy benefit manager listed on your prescription drug card.

Medications subject to the High Impact Advocacy program require you to use the designated specialty pharmacy to obtain these medications and enroll in the appropriate manufacturer assistance programs. The pharmacy benefit manager will facilitate your enrollment in these programs. Drug classes include brand HIV drugs, CGRP inhibitors, PCSK9 inhibitors, and GLP agonists. Drugs included in the High Impact Advocacy program are subject to change. For more information and to obtain a list of program drugs, contact the pharmacy benefit manager listed on your prescription drug card.

The Plan will cover 90-day fills for carefully selected generic specialty medications that are well tolerated with minimal specialty storage requirements. Such drugs include generic HIV and generic transplant medications. The list of generic specialty medications available for 90-day fills is subject to change. For more information and to obtain a list of generic specialty medications, contact the pharmacy benefit manager listed on your prescription drug card.

DENTAL BENEFITS

DENTAL BENEFITS ARE PROVIDED BY DELTA DENTAL OF KANSAS.

If you have any questions regarding your Delta Dental coverage, you can contact Delta Dental of Kansas by calling (316) 264-4511 or toll free (800) 234-3375. You may also access the Delta Dental network through its website at www.deltadentalks.com

CERTAIN BENEFITS MUST BE PRE-AUTHORIZED IN ORDER TO BE PAID

BENEFITS PROVIDED

A. The Dental Plan will pay up to $2,000.00 per calendar year per person, up to a maximum of $4,000.00 per family. The annual maximum does not apply to Eligible Persons under the age of 19. After you have met a $25.00 per person deductible, the Plan will pay ninety (90) percent of the charges if you use a Delta Dental preferred provider. However, after the $25.00 deductible is met, dental checkups are covered at 100%. (A "dental checkup" includes an examination, cleaning, 2 bitewing x-rays, prophylaxis, and fluoride treatment.) The Plan Participant is responsible for the balance of any fee not paid by the Plan regardless of how large the balance is. That is, you are responsible for 10% or 50% of the reasonable charge, plus any additional amount charged by your dentist that the Trustees determine exceeds a reasonable charge.

B. The Plan will pay no more than $1,600.00 per person per lifetime for orthodontic treatment, except in the case of Medically Necessary orthodontia rendered to Eligible Persons under the age of 19, in which case the lifetime dollar limitation shall not apply.

C. Equilibration and any treatment related to the temporomandibular joint (TMJ) are expressly excluded from coverage.

D. Your Dentist's office can verify your eligibility for benefits by contacting the Trust Fund Office directly. Once the Dentist has determined a person's eligibility, the Dentist shall file the claim directly with Delta Dental and it shall not be necessary for a participant to execute any claim form. The participant remains personally liable for all bills incurred personally, or by his dependents, which are not paid for by the Trust Fund Office.

E. Dental charges are not covered under any other part of the Plan.

USE PREFERRED PROVIDERS - THEY SAVE YOU MONEY

COVERED DENTAL SERVICES

1. Prophylaxes (scaling and polishing), oral examination, bitewing X-rays and limited instruction in dental hygiene.

2. Periodontal services and gingivectomies.

3. Oral X-rays.

4. Oral Surgery, including but not limited to:

    a) Excision of exostosis of the jaw and hard palate.
    b) Extractions.

5. Endodontic services, including but not limited to extirpation of pulp treatment, filling of root canal.

6. Amalgam, silicate cement or resin fillings.

7. Dentures:

    a) The original set of upper and/or lower dentures.
    b) The original partial denture.
    c) Replacement of upper and/or lower dentures, but only after five (5) years of use.

8. General anesthesia in connection with covered services when performed by a Physician or Dentist other than the operating Dentist. If procedures require general anesthesia in a hospital setting, dental and anesthesia are covered under dental, hospital is covered under medical.

9. Precious metal restorations (fillings or inlays) and all crowns.

10. Topical fluoride treatment.

11. Orthodontic services (braces, spacers, straightening, and replacements, etc.)

12. Dental implants.

13. Nightguards.

RULES FOR ORTHODONTIC BENEFITS

Orthodontic care is limited to $1,600.00 per **lifetime** per person, except in the case of Medically Necessary orthodontia rendered to Eligible Persons under the age of 19, in which case the lifetime dollar limitation shall not apply. In addition, benefits for orthodontic treatment will be combined with all other dental services for purposes of the annual maximum for dental benefits. Orthodontic claims are paid in monthly installments over the treatment period.

APPROVAL OF ORTHODONTIC TREATMENT WILL NOT BE MADE UNLESS THE PATIENT HAS CONSULTED WITH A QUALIFIED ORTHODONTIST OR THE SERVICE IS BEING DONE BY A SPECIAL AGREEMENT WITH A PREFERRED PROVIDER DENTIST. NO PAYMENT WILL BE MADE ON TREATMENT STARTED BEFORE THE PARTICIPANT WAS ELIGIBLE WITH THE PLAN.

A second opinion, by a qualified orthodontist, will be required if a dentist other than a qualified orthodontist is performing the work.

DENTAL EXCLUSIONS

The following exclusions apply to the dental benefits:

A. Any dental services not listed above including, but not limited to:

1. Hospital calls and/or consultations.
2. General anesthesia given in connection with services not covered by this Plan.
3. All local anesthesia for which there is a separate charge made.
4. Laboratory and pathological examinations.
5. Replacement of any denture or of any bridgework except as provided in paragraph 7c of the Covered Dental Services section above.
6. Equilibration procedures.
7. Treatment of disorders of the temporomandibular joint (TMJ) or TMJ syndrome.

VISION BENEFITS ARE PROVIDED THROUGH VISION SERVICE PLAN (VSP)

COVERAGE WITH A VSP DOCTOR:

Well Vision Exam focuses on your eye health and overall wellness
- $10 copay……..every calendar year

Prescription Glasses
- $25 copay

Lenses……..every calendar year
- Single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

Frame…….every other calendar year
- $120 allowance for a wide selection of frames.
- 20% off the amount over your allowance.

Contact Lens Care
- No copay…….....every calendar year

$120 allowance for contacts and the contact lens exam (fitting and evaluation). If you choose contact lenses you will be eligible for a frame one calendar year from the date the contact lenses were obtained.

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

The time limit for filing optical claims is the same as any other claim.

Vision correction procedures are covered by the Plan and the Plan has signed an agreement with a preferred provider network for vision correction procedures. The Plan will pay up to $2,000.00 per person per lifetime for vision correction surgery.
Safety Glasses are covered for the member only.

DEATH BENEFITS

PARTICIPANT DEATH BENEFIT	$10,000.00
DEPENDENT DEATH BENEFIT	$5,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS COVERED PARTICIPANT ONLY

Proof that the Participant died or lost a limb or eye by accidental means (as opposed to intentional or natural causes) must be verified through a coroner's report, police report, death certificate, medical reports, doctor's report, or an affidavit of witnesses.

Principal Sum	$10,000.00

COVERED PARTICIPANT DEATH BENEFITS:

The death benefit stated above will be paid to the participant's designated beneficiary in the event of his death from any cause while his coverage is in force.

A Participant may designate any person as beneficiary except his employer. The Participant may change the beneficiary at any time by completing the proper form. If no beneficiary is designated by an Eligible Participant, or if the designated beneficiary predeceases the Eligible Participant, the death benefit shall be payable to the first of the following classes of beneficiaries: your: (a) widow or widower; (b) surviving children; (c) surviving parents; (d) surviving brothers and sisters; or (e) your estate.

1. In the event a Participant's marriage is dissolved, any designation of such Participant's spouse as a beneficiary shall be null and void as of the date of dissolution unless the Participant re-designates such prior spouse as his or her beneficiary subsequent to the dissolution.

2. Subject to the spousal consent requirements or alternate payee and other restrictions, a Participant shall have the right to change his or her designation of beneficiary, but no change shall be effective or binding unless it is received by the Trust Office prior to the death of the Participant.

All beneficiary designations must be on a form authorized by the Board of Trustees. Any designation of beneficiary by a will, probate proceedings, state statute or requirements, including community property laws, or similar means will not supersede any designation or requirements of the trust.

DEATH, ACCIDENT, AND DISABILITY BENEFITS

COVERED DEPENDENT DEATH BENEFITS:

The Participant will be paid the amount of his Eligible Dependent's death benefit in the event that the dependent dies while covered under this Plan. The amount is shown above.

DEPENDENT'S ELIGIBILITY

The Eligible Participant's dependents are eligible for Death Benefits on the date they first become his Dependents or on the date the Participant first becomes eligible to participate in this plan, whichever is later. Dependents are not eligible for the Accidental Death and Dismemberment benefit.

TERMINATION OF COVERAGE FOR DEATH BENEFITS

Coverage for Participants and Dependents terminates on the earliest of the following dates:

1. The date the Participant's coverage terminates;

2. The date the Participant's Dependents are no longer considered eligible.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – 24-HOUR COVERAGE (Eligible Participants Only)

When bodily injury caused solely by an accident occurring while the Participant's coverage is in force shall directly and independently of all other causes result in any of the following losses within ninety days after the accident, payment will be made for the loss based on the Principal Sum of $10,000.00 in addition to any other benefits under this Plan. The amounts payable are as follows:

The Principal Sum for loss of life.

Double the Principal Sum for loss of:

1. Both hands;
2. Both feet;
3. Both eyes; or
4. Any two such members

One-half the Principal sum for loss of:

1. One hand;
2. One foot; or
3. One eye

"Loss," with reference to hand or foot, means complete and permanent severance through, or above, the wrist or ankle joint and, with reference to eye, means the irrecoverable loss of the entire sight in that eye.

If more than one specific loss results from any one accident, the amount provided for the greatest loss sustained will be paid.

These payments will be made directly to the Covered Participant if living, otherwise to his beneficiary. The beneficiary may be changed at any time by completing the proper form.

These benefits are payable whether the injury occurs on or off the job.

Accidental Death and Dismemberment benefits are not payable for loss caused by suicide, or any attempt thereof, nor loss caused by war or any act of war (declared or undeclared), or caused by military or naval service of any country.

LOSS OF TIME BENEFITS (Eligible Participants Only)

Payments will be made at the weekly Loss of Time rate when an Eligible Participant is wholly, continuously, and totally disabled by an accidental bodily injury or sickness that prevents him from working or otherwise drawing wages. The Participant must be under the care of a legally qualified physician or surgeon. Benefits are payable only if the disability commences while the Participant is eligible for benefits under this Plan. Dependents are not eligible for this benefit.

The weekly rate is $300.00 (minus applicable taxes required to be withheld), payable for total disability from the eighth day after initial date of injury or illness, not to exceed 13 weeks in any calendar year and/or not to exceed 13 weeks for any single or related disability.

Loss of Time benefits are not payable to any participant who is (1) already substantially disabled from employment, or (2) drawing benefits under any other benefit program, including but not limited to Worker's Compensation, or (3) paying extended self-contributions.

Successive periods of disability due to the same or related causes, not separated by return to full-time active employment at regular full time duties for one full month, shall be considered one period of disability.

These benefits do not cover any loss of time caused by accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or sickness for which the Eligible Participant may be entitled to benefits under any Worker's Compensation or Occupational Disease Law. In addition these benefits do not cover any loss of time occasioned by any Eligible Participant's own acts which could be construed to be intentional regardless of whether the effects are direct or indirect.

Eligibility Hours for Participants Receiving Benefits:

A. Any Bargaining Unit employee eligible for and/or receiving Loss of Time benefits or Worker's Compensation or Occupational Disease Law benefits, shall, beginning with the eighth day of his disability, receive 3.62 hours of contribution credit for each day he is entitled to or is drawing such benefits. Credit shall be extended for a maximum of three hundred thirty (330) hours for any one injury or illness or related illness in any calendar year.

B. Proof of disability shall be verified by a legally qualified physician's or surgeon's signed statement.

C. This contribution credit accumulation shall cease when said benefits cease or when such contribution credits total three hundred thirty (330) hours per injury or illness, whichever occurs first.

D. If you have filed FMLA (Family Medical Leave Act) with an employer with over 100 employees, you are not eligible for hours to be paid in for you by the plan.

LONG TERM DISABILITY BENEFITS (Eligible Participants Only)

Long Term Disability benefits are paid monthly at the rate of $100.00 (less applicable withholding taxes) per month, payable after the 15th week of **Permanent and Total Disability** and for not more than 60 Monthly Payments.

Only Eligible Participants covered under the Plan are eligible for Long Term Disability benefits. Long Term Disability benefits are not payable to any participant who is (1) already substantially disabled from employment, or (2) drawing benefits under any other benefit program, including but not limited to Worker's Compensation, or (3) already paying extended self-contributions prior to the disability.

A Participant shall be eligible for a Long Term Disability benefit if his employment is terminated by reason of **permanent** and total disability. Long Term Disability benefits shall commence on the first day of the fifteenth (15th) week after the disability begins, but shall not be paid more than five (5) years. The Long Term Disability Benefit shall be payable so long as the participant remains eligible for benefits under the Plan and is totally disabled, and shall continue until the Participant's death or for five (5) years, whichever is shorter. The last payment shall be made as of the first day of the month in which the death of the Participant occurs or disability ceases.

The Trustees shall require and accept as sole proof of permanent and total disability, the determination by the Social Security Administration that the Participant is entitled to a Disability Insurance Benefit under the Federal Social Security Act.

Notwithstanding any other provision of this section, no Participant shall qualify for a Long Term Disability benefit if the Trustees determine that his disability results from (1) chronic alcoholism, (2) addiction to narcotics, (3) an injury suffered while engaged in a felonious criminal act or enterprise, (4) service in the Armed Forces of the United States which entitled the Participant to a veteran's disability pension, (5) any self-inflicted act, or (6) self-employment.

Disability shall be considered to have ended and a Long Term Disability benefit shall immediately cease upon a determination by the Social Security Administration that the Participant is no longer permanently and totally disabled.

Application required: In order to receive a Long Term Disability benefit, a Participant shall file with the Trustees a written application. Applications for the Long Term Disability benefit can be found at the Fund Office. No participant may ever draw a total of more than five (5) years in Long Term Disability benefits.

COORDINATION (NON-DUPLICATION) OF BENEFITS and THIRD PARTY LIABILITY

NON-DUPLICATION OF BENEFITS – COORDINATION OF BENEFITS

The Fund will not duplicate any payments of benefits made by any other health care plan or make payment for uncovered services. This Plan will coordinate with any other health care plan covering an Eligible Participant or Dependent so that the total payments made by both plans do not exceed the covered charges. This results in a substantial savings to your Fund while providing full payment, in most cases, for all actual allowable expenses when a person is covered under this Plan and another plan.

In no case will the Fund, when acting as secondary payer, pay more than it would as a primary payer.

No benefits shall be paid (whether reduced or not) under this provision, to the extent that it would be inconsistent with any definition, limitation, condition, exception, or other benefit provisions applying to this Plan.

Definitions:

Other Health Care Plan means any plan, policy, or contract providing any type of health care benefits or service under one or more of the following:

A. Group, Blanket, or Franchise Insurance.

B. Group Practice, Blue Cross/Blue Shield, Individual Practice, or other Prepayment Plan.

C. Labor-Management Trustee Plan, Union Welfare Plan, Employer Sponsored Health Care Plan.

D. Medical Benefits provided through any automobile insurance, or similar policy, or any other 3rd party source, including but not limited to, medical benefits from any 3rd party for injury on their premises or for their acts.

E. Government Programs or coverage required, or provided, by any statute.

F. Any other coverage sponsored by, or provided through, any educational or Governmental Institution or Agency.

G. Arrangements for members of associations or organizations.

NOTE: THIS IS INTENDED TO INCLUDE ALL SOURCES OF HEALTH CARE BENEFITS EXCEPT PERSONAL AND PRIVATE INDIVIDUAL HEALTH CARE POLICIES.

COORDINATION (NON-DUPLICATION) OF BENEFITS and THIRD PARTY LIABILITY

COORDINATION OF BENEFITS – Order of Benefit Payment

1. If a claim is received on an Eligible Participant this Plan will process the claim as the primary plan, disregarding any work-related coverage provided the spouse, except that no payments from other sources will be duplicated.

2. If a claim is received on a spouse who is an Eligible Dependent and who is covered by any Other Health Care Plan as defined in the preceding definitions, this Plan will pay as the secondary plan. If it is determined that there is no other plan, this Plan will pay as primary.

3. If a claim is received on an Eligible Child Dependent, the Plan of the parent with the birthday that occurs earliest in the calendar year will be primary. Notwithstanding this provision, if the Eligible Child is the subject of a Qualified Medical Child Support Order that provides for a different order of benefit payments, the terms of that QMCSO will take precedence.

4. If any Participant or Dependent is eligible for benefits under this Plan by virtue of self-payments, this Plan will always be secondary to any Other Health Care Plan.

In all other situations if the person covered under this Plan is also eligible for health care benefits from any Other Health Care Plan, the primary coverage will be the plan with the earliest coverage date.

If you need any help to determine your specific situation, please contact your Fund Office.

SUBROGATION

The Trustees of this Plan have a right of subrogation, up to the amount of benefits paid to you or on your behalf, if you or an eligible dependent are paid benefits by the Plan due to an injury, injuries, or illness for which someone else may be liable.

Subrogation means that the Plan can stand in your place to recover money against the person responsible for your injury (or the person's insurance company), but only up to the amount of benefits paid to you. After the amount paid in benefits (plus the Plan's cost of collection) has been repaid to the Plan, you may keep any remaining amount of money legally owed to you as the result of the accident.

The Plan's right of subrogation allows it to be repaid the benefits that have been paid to you or on your behalf, even if you cannot recover the full amount of your loss from the person who caused it. You must consent in writing to have this money paid to the Plan before you will receive any Plan benefits by signing a subrogation agreement. If you refuse to sign this agreement, claims may be denied. The Trustees believe that subrogation will result in the greater good of eligible persons because the cost of medical treatment for accidental injuries will be the responsibility of the person who caused, or contributed to, the accident (or the person's insurance company).

The following gives details about subrogation under this plan. Please read them carefully.

COORDINATION (NON-DUPLICATION) OF BENEFITS and THIRD PARTY LIABILITY

Rules of Subrogation

By paying benefits, the Plan is automatically subrogated on a *first priority basis* to the rights of the Eligible Participant or Eligible Dependent receiving benefits under the Plan. The following rules apply to subrogation under this Plan:

- The Plan's right of recovery extends to any and all individuals, insurers, or entities which are or may be responsible in tort or in contract including, but not limited to, insurers providing liability, medical expense, or medical payment coverage, wage loss benefits, uninsured motorist or underinsured motorist coverages, whether or not the policy of insurance is owned by the Eligible Person or by the individual or entity liable to the Eligible Person.

- The Plan's right of recovery through subrogation will be a first-priority claim. The Plan will be reimbursed to the extent of its payment from the proceeds of recovery *without deduction for attorney's fees or costs*. Any amount remaining may be applied to reimburse the Eligible Person.

- The characterization of any amount paid to you or on your behalf, whether by judgment, compromise, settlement or otherwise, shall not affect the Plan's right to reimbursement and to claim, pursuant to the Plan's reimbursement rights, all or a portion of such payment. The Plan's right to reimbursement applies even if your claims are settled without an admission of fault and even if you recover or have the right to recover no-fault insurance payments. The Plan's benefits will be coordinated as secondary to no-fault insurance payments.

- If the Plan brings an action to recover for benefits paid, the Plan is entitled to recover its costs and expenses related to the action, including its attorney's fees, before any remaining amounts are returned to the Eligible Person.

- The Plan's first priority subrogation rights apply whether or not the Eligible Person has been fully compensated for damages arising from the illness, accident, or death.

- The Plan's first priority subrogation rights includes all portions of the Eligible Person's cause of action notwithstanding any settlement allocation or apportionment that purports to dispose of any portion of the cause of action not subject to subrogation. Benefits will not be paid for charges for any injury or condition that is the result of the actions of a third party to the extent that an eligible individual is awarded future medical costs or general compensatory damages in a lawsuit or settles a claim which includes payments covering future medical expenses or "pain and suffering" damages.

- The Plan's first priority subrogation rights extend to, among others, wrongful death actions and actions brought by minors.

- The Eligible Person must cooperate fully with the Plan, do nothing to prejudice the Plan's subrogation rights, and promptly advise the Plan Administrator, in writing, of any claim being made against anyone who may be liable for the illness or death.

- The Eligible Person must agree to sign a subrogation agreement acknowledging the Plan's right of recovery as a condition of payment of benefits by the Plan. Failure or refusal to execute the subrogation agreement will result in denial of claims by the Plan Administrator where there is possibility of liability on the part of a third party. The acceptance of any benefits or payments will constitute an assignment to the Plan of any amounts recovered from any liable third party, acknowledgement of the Plan's subrogation rights, and recognition by the Eligible Person that the Plan has first priority rights. The failure or refusal of any individual to execute documents at the Plan's request will not defeat the Plan's right of recovery.

- The Plan may sue in the name of the Eligible Person to recover the payments made by it. The Eligible Person will actively cooperate with the Plan in pursuit of the Plan's subrogation rights.

- This subrogation provision applies to claims of Dependents covered by the Plan regardless of whether or not such Dependent is legally responsible for expenses of treatment.

- This subrogation provision applies to all categories of benefits paid by the Plan, but only to the extent of such payments by the Plan.

- In the event it is determined by Trustees that there is no, or can be no, recovery against a third party, the illness or injury will be treated as any other illness or injury under the Plan. The Trustees further will have the authority to compromise claims of subrogation as circumstances warrant.

- Monies made available to settle or pay a claim made against a third party first will be applied to reimburse the Plan in full for benefits paid. Thereafter, the remaining balance, if any, may be paid to the eligible individual. Such proceeds from a third party recovery will be allocated in the above order of priority regardless of whether or not the monies are sufficient to fully compensate the injured party, and notwithstanding any settlement allocation or apportionment that purports to dispose of any portion of the cause of action not subject to subrogation. This order of allocation also will apply whether or not the individual on whose behalf benefits were paid is legally responsible for the expenses of medical treatment.

- The Plan's right of recovery will not be limited by any application of any law or principle, such as the "make-whole" doctrine or the "common fund" doctrine.

- The Trustees of the Plan will have the right to adjust, amend, and interpret these provisions regarding subrogation. It is their intent that these rules will be construed in such manner as shall most completely protect the Plan's interest in these matters.

RECOVERY OF OVERPAYMENTS

The Plan reserves the right to recover any overpayment of benefits through any legal or equitable means, including offsetting benefit payments for any Eligible Person.

1. The Plan may recover an overpayment by either a direct recovery from the Eligible Person who received the overpayment or from the medical provider who received the overpayment, or by reducing all subsequent benefits to, for, or on behalf of the Eligible Person, or any member of his or

her family eligible for benefits, and/or the provider(s) until such time as the Fund has made full recovery.

2. Such recovery may also include attorneys' fees and other charges and expenses.

RIGHT TO RECEIVE AND RELEASE INFORMATION

Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and under other plans. This Plan may get the facts it needs from, or may provide necessary facts to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. This Plan or its claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable. Failure to provide necessary information may result in non-payment of benefits.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan have been made under any other plans, this Plan shall have the right, exercisable by the Board of Trustees alone and in its sole discretion, to pay over to any organization making the other payments any amounts the Trustees shall determine to be warranted in order to satisfy the intent of these rules. Any amounts so paid shall be deemed to be benefits paid under this Plan, and to the extent of those payments, this Plan shall be fully discharged from liability under the terms of this Plan.

To the extent benefits are not assigned to the provider of the claimed health care, if benefits are payable to or on behalf of a person who is a minor child, this Plan will make payment to the child's custodial parent, without regard to whether that parent is covered under this Plan.

To the extent benefits are not assigned to the provider of the claimed health care, if benefits are payable to or on behalf of a person who is incapacitated or otherwise incapable of giving valid receipt for such payment, this Plan will make payment to the person's legal conservator or guardian, or if no conservator or guardian has been appointed, to any person determined by the Trustees to have assumed the obligations of caring for the person on whose behalf the payment is made.

If the total payments by this Plan as to allowable expenses at any time are more than the maximum payment necessary to satisfy the intent of this provision, this Plan shall have the right to recover the extra amount of such payments from one or more of the following: any persons to, for, or with respect to whom such payments were made, any insurance company owing payment with respect to the claim, and any other person, provider, or organization liable for payment or to whom payment was made.

USE AND DISCLOSURE OF HEALTH INFORMATION

A. The Plan will use and/or disclose Protected Health Information only to the extent and in accordance with the provisions of the HIPAA Privacy Rule. The Plan does not perform any treatment activities, but may disclose information to health care providers treating a participant in order to facilitate the providers' treatment of the participant. The Plan has a need to use and/or disclose protected health information in the course of health care operations and payment activities.

B. The Board of Trustees, as Plan Sponsor, is permitted to use and/or disclose protected health information for the purpose of making benefit claims determinations on review. The Board shall receive and use only the minimum information necessary to decide the appeal, and shall avoid making any disclosure of the information unless necessary to the claim determination, such as for the purpose of obtaining medical, legal, or actuarial advice regarding the claim determination that is being reviewed. When disclosing any such information, the Board shall obtain adequate assurance from the party to whom the information is being disclosed that the party agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to the information. Any business associate agreement entered into between the third party and the Plan shall protect the Board of Trustees to the same extent it protects the Plan.

C. The Board of Trustees, as Plan Sponsor, shall use and/or disclose protected health information when specifically compelled by law, including, but not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a government or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits; and pursuant to requests of the Secretary of HHS or his or her designee. Unless specifically directed by the governing legal document or authority, the Plan Manager and other employees of the Fund Office will ordinarily respond to legal process compelling the disclosure of PHI, without the necessity of any action on the part of the Plan Sponsor.

D. The Board of Trustees is further permitted to use and disclose de-identified or summary health information for the following purposes, and is permitted to use and/or disclose personally identifiable health information in connection with the following activities only when the Board is unable to carry out its responsibility to administer the Plan without the particular personally identifiable health information being requested:

1. administering the Plan or amending its provisions, including but not limited to:

a. management activities relating to implementation of and compliance with the requirements of the Privacy Rule,

b. customer service, including the provision of data analyses for participants, participating unions, and contributing employers, provided that protected health information is not provided to the participants, unions, or employers,

c. resolution of internal grievances,

d. the sale, transfer, merger, or consolidation of the Plan with another employee welfare benefit plan, and due diligence related to such activity, and

e. creating de-identified health information or a limited data set;

2. developing protocols, policies, and procedures for the administration of the plan;

3. conducting quality assessment and improvement activities;

4. reviewing the competence or qualifications of health care providers and institutions contracting with the Plan;

5. actuarial and related activities relating to the creation, renewal or replacement of health benefits, and securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

6. conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

7. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

8. to carry out payment activities (as the term "payment" is defined in 45 C.F.R. § 164.501) of the Plan that cannot be delegated to Fund Office staff.

E. The Board of Trustees agrees:

1. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Board or the Plan create, receive, maintain, or transmit on behalf of the Plan;

2. not to use or further disclose the information other than as permitted or required by the Plan documents or required by law,

3. to ensure that any agent, including a sub-contractor, to whom the Board of Trustees or any other representative of the Plan provides protected health information received from the Plan agrees to the same restrictions and conditions that apply to the Board of Trustees with respect to the information,

4. to ensure that any agent, including a sub-contractor, to whom the Board of Trustees or the Plan provide electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information;

5. not to use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan established pursuant to the collective bargaining agreements that establish this Plan,

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

7. to report to the Plan any security incident of which the Board becomes aware;

8. to make available protected health information in accordance with 45 C.F.R. § 164.524,

9. to make available protected health information for amendment and to incorporate any amendments to protected health information in accordance with 45 C.F.R. § 164.526,

10. to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528,

11. to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of HHS for purposes of determining compliance with the Privacy Rule by the Plan,

12. if feasible, to return or destroy all protected health information received from the Plan that the Board of Trustees still maintains in any form and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and

13. to ensure that the adequate separation between the Plan and the Board of Trustees, as required by the HIPAA Privacy Rule, is established and is supported by reasonable and appropriate security measures.

F. All employees of the Fund Office (that is, employees of the Plan), including the Plan Manager, claims processor(s), and customer service representative(s), do and shall have access to protected health information in the course of the services they perform for the Plan. All such employees shall protect the privacy of personally identifiable health information received, created, or maintained in the course of their employment, and shall use and/or disclose such information only in accordance with the terms of this Plan document.

G. Any Plan employee who fails to comply with the preceding paragraph shall be subject to the disciplinary procedures and sanctions established by the Plan or by the Board of Trustees relating to unauthorized use or disclosure of protected health information.

H. The Plan shall develop and distribute to all participants a Notice of Privacy Practices, which notice shall comply with 45 C.F.R. § 164.520, shall be approved by the Board of Trustees, shall describe the uses and disclosures of protected health information that may be made by the Plan, and shall describe the policies and procedures that the Plan will follow with respect to protecting the privacy of protected health information.

It is expected that the Board of Trustees will not have a need for access to Protected Health Information except in connection with review of an adverse benefit determination or in unusual circumstances. The Board has delegated the daily responsibility for administering the Plan to the Plan Manager and his or her staff. The Plan Manager and Fund Office staff will carry out their administrative duties on behalf of the Plan, such as claims processing and regular Plan administration, without disclosing protected health information to the Board of Trustees unless such a disclosure is necessary, and then shall disclose only the minimum information necessary to carry out the purpose of the disclosure to the Board of Trustees, and only in accordance with the terms of the Privacy Rule and this Plan document.

GENERAL PROVISIONS

1. **Discretionary Authority.** Any statements made by an Employer, individual Trustees, trust employees, or any other person affiliated with this Plan shall be deemed representations and not warranties and are in no way binding upon the Plan. No person or persons shall have authority to change this Plan or waive any of its provisions, except the Board of Trustees. No employer or union, nor any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board, nor can an employer or union act as an agent of the Board of Trustees.

   The Board of Trustees shall have exclusive discretion to decide any claims questions and to interpret the Plan or any of its provisions, and its decision shall be final and binding on all persons. If any Plan provision, on account of errors in drafting, does not accurately reflect its intended meaning, as determined by the Board of Trustees in its sole discretion, the provision will be construed by the Board of Trustees in a manner consistent with the intended meaning.

   Oral or written help will be provided upon request to all Participants, Dependents, and/or beneficiaries that do not understand any of the plan documents. However, any statements made by persons other than the Board of Trustees shall be deemed representations only and are not binding upon the Plan.

2. **Right of Examination.** The Plan, through its designated physician and at its own expense, has the right to examine the person whose injury or sickness is the basis of claim when and as often as it may reasonably require during pendency of any claim presented to the Plan.

3. The Trustees believe that this Plan is in full compliance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and all other applicable laws.

4. Pursuant to the Trust, the Trustees are responsible for accumulation of all assets and providing all benefits.

5. The Fund is maintained pursuant to collective bargaining agreements between all participating locals and individual contractor members of the Associated General Contractors of Kansas, Inc. and other contractors who are bona fide employers.

6. Pursuant to other appropriate agreements, employers may also make contributions to the Fund on behalf of employees represented by participating Unions in the Plan.

7. **Plan Sponsor and Plan Administrator.** The Trustees are legally designated as the Plan Administrator and Plan Sponsor. The Trustees have ultimate authority to make decisions affecting the Plan. The Trustees have designated a Plan Manager, whose responsibilities include maintaining the eligibility records, accounting for employer contributions, making benefit payments and attending to other administrative functions.

   Blue Cross and Blue Shield of Kansas ("BCBSKS") provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims.

No network access is available from Blue Cross and Blue Shield Plans outside the BCBSKS service area.

8. **Plan Amendment or Termination**. The Plan may be amended, changed, or terminated at any time by a vote of the Board of Trustees subject to the applicable provisions of the Trust Agreement and the applicable collective bargaining agreements, even if the amendment and/or termination may affect claims which have already been incurred. In the event of a Plan termination, any and all assets remaining after the payment of all obligations and expenses will be used in accordance with a plan adopted by the Trustees to pay benefits and expenses until such assess have been exhausted, or in such manner as will best serve the Plan's purposes.

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and for any reason, but on a non-discriminatory basis:

* To amend or change the Plan's eligibility rules at any time;
* To amend, modify, and change either the amount of or the conditions for payment of any allowed expenses on a retroactive or prospective basis even though such amendment may affect claims which have already been incurred;
* To amend or change any part of the Plan language at any time

9. As required by law, an independent CPA examines the financial and other records of the Plan each year and certifies them as to their accuracy, completeness, and fairness. In addition, the Trustees are required to 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 offices of the Board of Trustees and other specified locations during normal business hours.

10. BMO Harris Bank of Kansas City, Missouri, is the depository for contributions into the Fund.

11. All contributions are initially invested as they are received by the Trustees in United States Government bills, notes, securities, certificate of deposit, money market funds, commercial paper, and bank savings accounts.

12. A complete list of the employers sponsoring the Plan and/or making contributions to the Plan may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and such list is available for examination by participants and beneficiaries at the offices of the Board of Trustees, upon written request, information as to whether a particular employer or employee organization (union) is a Plan sponsor, and the address of the employer or union.

Kansas Building Trades Health & Welfare Trust Fund
4101 SW Southgate Drive
Topeka, Kansas 66609-1276

13. A copy of any collective bargaining agreement may be obtained by participants and beneficiaries upon written request of the Board of Trustees at the above address and is available for examination by participants and beneficiaries at the Fund Office. There will be a $0.20 cent per page charge for all requested copies.

PLAN INFORMATION

Name of Plan: Kansas Building Trades Open End Health and Welfare Trust Fund

Type of Plan: The Plan is a group health plan maintained for the purpose of providing loss of time and health care benefits in the event of illness or accident and benefits in the event of death. All benefits are self-funded directly from the Fund's assets.

The Employer Identification Number is 48-0691769.

The Plan Number is 501

Plan Year: January 1 - December 31

Plan Records: Maintained on a calendar-year basis

If you wish to contact the Board of Trustees or the Plan Manager, write to:

Board of Trustees
Kansas Building Trades Health & Welfare Fund
4101 SW Southgate Drive P.O. Box 5168
Topeka, Kansas 66605-0168
Phone: 785-267-0140
Toll-Free: 800-432-3595

Registered Agent: The Board of Trustees has designated the Plan Manager, Gary Muckenthaler, as the agent for the service of legal process. Service can also be made on any member of the Board of Trustees.

As of the printing of this document, the Trustees of the Plan are as follows:

EMPLOYER TRUSTEES

JOHN LONKER CENTRAL MECHANICAL PO BOX 1063 MANHATTAN KS 66505	JOEL KRISS KBS CONSTRUCTORS, INC 1701 SW 41ST TOPEKA KS 66609
RICHARD KENDALL KENDALL CONSTRUCTION, INC. 4327 NW 43RD TOPEKA, KS 66618	MIKE GIBSON ASSOC. GEN. CONTRS. KS 200 SW 33RD ST. TOPEKA, KS 66611

STEVE MOHAN MOHAN CONSTRUCTION 125 S. KANSAS AVE. TOPEKA, KS 66603-3614	MATT McGIVERN SENNE & COMPANY 2001 NW US HWY 24 TOPEKA, KS 66618

UNION TRUSTEES

MATT HALL TEAMSTERS LOCAL #696 3600 NE SARDOU AVE., BUILDING #2 TOPEKA, KS 66616-1678	JEREMY ADKINS LABORERS LOCAL #1290 905 E JESUIT LN ST MARYS KS 66536
JOSH FRANKLIN BRICKLAYERS LOCAL #15 632 W. 39TH ST. KANSAS CITY, MO 64111-2910	JEFF PHILGREEN LABORERS LOCAL #1290 2600 MERRIAM LN KANSAS CITY KS 66106
FRANK CARPENTER DC3 LOCAL #2014 9902 E. 62ND ST. RAYTOWN, MO 64133-4002	
RON CHRISTIAN LABORERS LOCAL #1290 2600 MERRIAM LANE KANSAS CITY KS 66106	

PARTICIPATING UNIONS IN THIS PLAN AS OF JANUARY 1, 2024 ARE AS FOLLOWS:

LOCAL UNION	CITY
Bricklayers Local # 15	Wichita, Topeka & Manhattan
DC 3 Local #2014	Topeka, Kansas City & Wichita
Laborers Local #1290	Lawrence, Topeka, Parsons, Wichita, Salina, Emporia & Manhattan
Office & Professional Emp Local #277	Topeka
Teamsters Local #696	Topeka
Teamsters Local #541	Pittsburg, La Cygne
Teamsters Local #795	Wichita

GENERAL PROVISIONS

Cement Masons Local # 518 Topeka & Manhattan

Source of Contributions: All contributions to the Health and Welfare Plan are made by Employers in accordance with their Collective Bargaining Agreements with all participating unions. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per hours worked and/or paid for.

Benefits are provided from the Funds' assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreements, and held in Trust Funds for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The Funds' assets and reserves are held in custody by Midwest Institutional Trust Company in Overland Park, Kansas.

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement
2. Collective Bargaining Agreements
3. Insurance contracts
4. Annual Report Form 5500 filed with the Internal Revenue Service and Department of Labor
5. A list of contributing employers.

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine the report, during business hours, at your union office or at your employer's establishment if at least 50 Plan participants are employed there. To make such arrangements, call or write the Plan Manager at the Fund Office. Copies will be provided on 10 days written notice and proper payment of charges. A summary of the annual report which gives details of the financial information about the Funds' operations is furnished annually to all participants, free of charge.

The Plans are all administered by an unpaid joint Board of Trustees consisting of participating Union representatives and Employer representatives. For purposes of maintaining the Funds' fiscal records, the year-end date is December 31. The federal Tax Identification Number of the Health and Welfare Trust Fund is 48-0691769.

STATEMENT OF ERISA RIGHTS

As a participant in the Kansas Building Trades Open End Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

You may 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.

You may 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 copies.

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

Continue Group Health Plan Coverage

You can 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 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 after you exhaust all administrative procedures and appeal processes set forth in the Plan. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

IN WITNESS WHEREOF, the above Plan was originally signed the 15th day of December 1964, hereby reaffirmed to be effective January 1, 2024.

KANSAS BUILDING TRADES
OPEN END HEALTH & WELFARE TRUST FUND

_____
Rick Kendall, Chairman

_____
Jeremy Adkins, Co-Chairman

_____
Steve Mohan, Secretary-Treasurer

_____
Jeff Philgreen, Ex-Officio