

OMAHA CONSTRUCTION INDUSTRY
HEALTH AND WELFARE PLAN

RESTATED PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective October 1, 2004

Revised: 03/10/2005

A Letter From Your Trustees

Dear Participants and Beneficiaries:

We are pleased to distribute this new Restated Plan Document and Summary Plan Description describing the Benefits provided under your Plan. If you do not see the information you are seeking in this booklet, please contact the Fund Office.

This booklet contains the general Plan provisions, Eligibility Rules for participation in the Plan, the Benefits provided to those who are eligible and the procedures which must be followed when filing a claim for Benefits.

There have been a number of changes to the Plan since the last booklet was distributed. As a result, you should **READ THIS BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

From time to time, other changes and improvements to the Plan may be made. When this occurs, we will make every attempt to advise you of them. In order to assist us in keeping you up to date, **IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT HOME ADDRESS AT ALL TIMES.** This is the only way to be sure that you receive notice of any Plan changes.

This is your copy of the booklet describing your Plan. Please take the time to read it in its entirety and refer to it when you have any questions about the Plan. You should keep this booklet in a safe (but handy) place for future reference. If, at any time, you have questions about the Plan, please feel free to call or write the Fund Office at:

Omaha Construction Industry Health and Welfare Plan
Westwood Plaza, Suite 80
12165 West Center Road
Omaha, Nebraska 68144-3980
Telephone: (402) 330-2060 Fax: (402) 330-2797

Office Hours: Monday through Friday, 8:00 AM to 4:30 PM

We look forward to serving you.

The Board of Trustees or designated Committee shall have the full discretion and authority to interpret, construe and apply all terms of the Plan Document, Summary Plan Description (SPD), the Amended Trust Agreement and/or any rules and regulations established by the Board of Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature of amount and duration of benefits, in reaching a decision on the Claimant's request for review of the denial of the claim.

The decision of the Board is final.

ABOUT YOUR PLAN

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a Family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advance planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by Sickness or Injury.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established a Plan, which provides a specific, dependable plan of health and welfare Benefits. Since it's beginning in 1962, the Plan has been managed in order to provide the best Benefits possible consistent with sound financial management.

The Plan, known as the Omaha Construction Industry Health and Welfare Plan, was established and is maintained as a result of Collective Bargaining Agreements (sometimes referred to as "labor contracts") between the Omaha Building Contractors Employers Association and the Union.

The Plan receives the majority of its income through Employer contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives income from investments.

Decisions on Plan operations are made by a joint Board of Trustees which is comprised of an equal number of Employer representatives and Union representatives. Working together, the Trustees establish rules of eligibility, levels of Benefits, supervise the investment of the Plan's money and see that the Fund is in compliance with all applicable federal and state laws.

This, then, is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your Family become eligible for Benefits from the Plan and what your responsibilities are under the Plan. Of course, if you have any questions about the Plan, please feel free to contact the Fund Office. The staff will gladly answer your questions.

FILING AN ENROLLMENT CARD

IF YOU HAVE NOT FILED AN ENROLLMENT CARD, DO SO NOW!

When you first became employed under the terms of the Collective Bargaining Agreement, you should have received an “**ENROLLMENT CARD**” from either the Union or the Fund Office.

This card requests certain basic information that is needed for your records in the Fund Office. This information is your full legal name and the full legal names of all of your Eligible Dependents, your address, your Social Security number and the Social Security number of all of your Eligible Dependents (if applicable), your date of birth and the dates of birth of all of your Eligible Dependents, and the name of your Beneficiary(ies) in the case of your death.

All of this information is vital! Without it, the Fund Office will have difficulty knowing what you and your Family are entitled to under the Plan and in keeping you informed about Plan changes.

If you are not sure whether you have an enrollment card on file at the Fund Office, contact the office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion and return.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, you will be sent notice of the change. This means that in order to notify you, the Fund Office must have your current address. **IF YOU MOVE**, make sure to notify the Fund Office of your new address. **IF YOUR MARITAL STATUS CHANGES**, don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of the marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of claims for Benefits.

If you wish to **CHANGE THE NAME OF YOUR BENEFICIARY**, **DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office will be

unable to pay any Death Benefits to anyone other than the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you need to **ADD OR DELETE DEPENDENTS**, you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, etc. Since the Plan provides Benefits to Eligible Dependents, the Fund Office must know who your dependents are at all times.

If the Plan makes any inadvertent, mistaken or excessive payment of Benefits, the Trustees or their representatives shall have the right to recover the payments.

A WORD ABOUT CONFIDENTIAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable "Protected Health Information" (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care, health care operations or as otherwise allowed by law.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and in ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

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SECTION ONE – IMPORTANT TERMS CONCERNING YOUR MEDICAL BENEFITS

To understand how your Plan works, it is important to become familiar with certain terms commonly used in the health care industry.

A. Annual Deductible

Before Benefits are paid under the Plan, you must satisfy an “Annual Deductible”. This is the dollar amount of Covered Charges that you pay each year before the Plan pays Benefits. The Annual Deductible is listed on the Schedule of Benefits and applies to each Covered Person each calendar year. For a Family, once the Family has combined expenses equal to the annual Family deductible, no further deductibles are required for that calendar year. In addition, Co-Payments or non-covered charges are not applied to meeting your Annual Deductible.

B. Co-Payment and Coinsurance

Certain covered health Services require you to pay either a “Co-Payment” or “Coinsurance”. Co-Payments are typically expressed as a flat dollar amount. Coinsurance, on the other hand, is generally expressed as a percentage and is the amount you pay for Covered Services after you meet the Annual Deductible, if applicable. Co-Payments and Coinsurance amounts are shown on the Schedule of Benefits.

C. PPO Providers

The Fund has contracted with a “Preferred Provider Organization (PPO)” to help manage certain health care expenses for you and the Plan. PPO Providers, such as Hospitals and Physicians, have agreed to charge Negotiated Rates for Services. At times, this booklet will refer to PPO Providers as “In-Network” Providers and Non-PPO Providers as “Out-of-Network” Providers. PPO provider lists are furnished automatically, without charge, as a separate document. If you would like to know if your Physician is a PPO Provider, you may ask your Physician or contact the Fund Office.

D. Annual Out-of-Pocket Maximum

The amount you pay out of your pocket in a calendar year for Covered Charges is referred to as the “Annual Out-of-Pocket Maximum”. After you reach the maximum amount listed on the Schedules of Benefits in a calendar year, the Plan pays 100% of your medical Covered Charges, excluding coinsurance for the Mental Health Benefit, up to the annual or lifetime maximums, whichever is applicable.

The Annual Out-of-Pocket Maximum excludes any Co-Payments you incur for prescription drugs and your Deductible but includes your portion of Coinsurance for all Benefits covered under this Plan except the Mental Health Benefit.

E. Annual and Lifetime Maximums

Each person eligible for coverage under the Plan has a lifetime maximum for all benefit payments. In addition, there are specific lifetime and/or annual maximums for Covered Charges relating to particular Benefits. These maximums are listed on the Schedule of Benefits.

SECTION TWO – SCHEDULE OF BENEFITS

The Plan offers Benefits to the following groups of Participants:

- A. Active Eligible Employees and Eligible Dependents
- B. Retired Participants and Eligible Dependents

EXCEPT WHERE OTHERWISE INDICATED, THE SCHEDULE OF BENEFITS COVERS BOTH OF THESE GROUPS OF PARTICIPANTS. HOWEVER, BENEFITS FOR DISABLED AND RETIRED PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE ARE PAID SUPPLEMENTAL TO MEDICARE BENEFITS.

The Fund has negotiated special contracts with a network of area Physicians and Hospitals known as a Preferred Provider Organization (PPO).

IN-NETWORK SERVICES	FUND PAYS 80%
OUT-OF NETWORK SERVICES	FUND PAYS 70%

The Major Medical Benefit has a \$500,000 lifetime maximum benefit per person. In addition, the calendar year deductible is \$250 per person or \$750 per Family when an In-Network provider is used rather than \$350 per person or \$1,050 per Family when an Out-of-Network provider is used.

LIFETIME MAXIMUM (PER PERSON)	\$500,000
ANNUAL DEDUCTIBLE	
IN-NETWORK	\$250 (PERSON) / \$750 (FAMILY)
OUT-OF NETWORK	\$350 (PERSON) / \$1,050 (FAMILY)

The maximum Out-of-Pocket Limit per Covered Person is \$2,000 per Calendar Year. This Out-of-Pocket Limit applies only to Covered Charges. Once the Out-of-Pocket Limit has been reached within a Calendar Year, Covered Charges in that year will be paid at 100% of Usual Customary and Reasonable Charges up to the Benefit maximum. The Out-of-Pocket Limit does not apply to all Benefits. Please see the table beginning on page 22 for a detailed listing of which Benefits do not apply to your annual Out-of-Pocket Limit.

ANNUAL OUT-OF-POCKET MAXIMUM (PER PERSON)	\$2,000
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YOU ARE NOT REQUIRED TO USE AN IN-NETWORK PPO PROVIDER. FREEDOM OF CHOICE IS YOURS. HOWEVER, CHOOSING AN IN-NETWORK PPO PROVIDER FOR YOUR HEALTH CARE NEEDS WILL SAVE YOU AND THE FUND MONEY.

The most up-to-date information on doctors and facilities in the Midlands Choice network is available to you through Midlands Choice website. You may log on to the website at www.midlandschoice.com or the Midlands Choice link on The Benefit Group (TBG) website at www.TBGCO.com. You may also call Midlands Choice at (800) 605-8259. The best way to be sure you have accurate information is to contact Midlands Choice directly.

Schedule of Benefits

All Coinsurance percentages apply to Usual, Customary and Reasonable Charges allowed by Plan

<u>BENEFIT</u>	<u>AMOUNT</u>
----------------	---------------

Accidental Death and Dismemberment Benefit	\$5,000
<i>Active Eligible Employee Only</i>	

Life Insurance Benefit	\$5,000
<i>Active Eligible Employee Only</i>	

Weekly Loss of Time Benefit
Active Eligible Employee Only

Weekly Benefit Amount	\$175
Waiting Period for Non-Occupational Injury	None
Waiting Period for Sickness.....	7 days
Maximum Period of Benefit during Disability	20 weeks

Chiropractic Expense Benefit

*The Coinsurance percentages apply only after the Deductible has been met.
Employee Coinsurance does not apply to Out-of-Pocket Limits.*

Coinsurance (*Fund pays*)

In-PPO-Network	80%
Out-of-Network.....	70%

Maximum number of manipulations (per Calendar Year)..... 30 per person

Dental Benefit

Maximum Benefit (Calendar Year) \$300 per Family

Diagnostic X-Ray and Laboratory Benefit

The 100% Coinsurance applies to the first \$100 per person. Thereafter, Benefits will be subject to the Major Medical Deductible & Coinsurance.

Coinsurance (*Fund pays*)

In-PPO-Network or Out-of-Network	100%
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Maximum Benefit (Calendar Year) \$100 per person

Hospice Benefit

The Coinsurance percentages apply only after the Deductible has been met.

Coinsurance (*Fund pays*)

In-PPO-Network	80%
Out-of-Network.....	70%

Maximum Lifetime Benefit \$25,000 per person

Major Medical Benefit

The Coinsurance percentages apply only after the Deductible has been met.

Coinsurance (<i>Fund pays</i>)	
In-PPO-Network	80%
Out-of-Network.....	70%
Treatment of Emergency Medical Condition (In- or Out-of-Network).....	80%
Calendar Year Deductible	
In-PPO-Network	\$250 per person \$750 per Family
Out-of-Network.....	\$350 per person \$1,050 per Family
Maximum Lifetime Benefit	\$500,000 per person
Maximum Out-of-Pocket Limit (Calendar Year)	\$2,000 per person

Maternity Benefit (Employee or Dependent Spouse Only)

The Coinsurance percentages apply only after the Deductible has been met.

Coinsurance (<i>Fund pays</i>)	
In-PPO-Network	80%
Out-of-Network.....	70%
Calendar Year Deductible.....	included in Major Medical Benefit Deductible
Maximum Lifetime Benefit	included in Major Medical Benefit Maximum

Mental Health Benefit

The Coinsurance percentages apply only after the Deductible has been met.

Employee Coinsurance does not apply to Out-of-Pocket Limits.

Coinsurance (<i>Fund pays</i>)	
In-PPO-Network	50%
Out-of-Network.....	40%
Calendar Year Deductible.....	included in Major Medical Benefit Deductible
Maximum Lifetime Benefit	included in Major Medical Benefit Maximum

Organ and Tissue Transplants

The Coinsurance percentages apply only after the Deductible has been met.

Coinsurance (<i>Fund pays</i>)	
In-PPO-Network	80%
Out-of-Network.....	70%
Maximum Benefit.....	\$200,000 per transplant

Prescription Drug Benefit

Employee Co-Payment does not apply to Deductible or Out-of-Pocket Limits.

Retail Co-Payment (Employee pays)

- Level 1 – Generic Greater of \$5 or 15% of cost of drug
- Level 2 – Formulary Brand Name Greater of \$20 or 20% of cost of drug
- Level 3 – Non-Formulary Brand Name Greater of \$35 or 25% of cost of drug
- Maximum days of medication allowed..... 34 days per person per Co-Payment

Mail Order Co-Payment (Employee pays)

- Level 1 – Generic.....\$10
- Level 2 – Formulary Brand Name\$40
- Level 3 – Non-Formulary Brand Name\$70
- Maximum days of medication allowed..... 90 days per person per Co-Payment

THE ANNUAL INDIVIDUAL AND FAMILY DEDUCTIBLES DO NOT APPLY TO THE PRESCRIPTION DRUG BENEFIT.

Preventative Routine Care Benefit (Employee and spouse only)

Coinsurance (Fund pays)

- In-PPO-Network or Out-of-Network 100%
- Maximum Benefit (Calendar Year)\$250 per person

Rehabilitative Therapy Benefit

Coinsurance (Fund pays)

- In-PPO-Network 80%
- Out-of-Network..... 70%
- Calendar Year Deductible..... included in Major Medical Benefit Deductible
- Maximum Lifetime Benefit included in Major Medical Benefit Maximum

Skilled Nursing Care Benefit

Coinsurance (Fund pays)

- In-PPO-Network 80%
- Out-of-Network..... 70%

Skilled Nursing Care Facility Benefit

Coinsurance (Fund pays)

- In-PPO-Network 80%
- Out-of-Network..... 70%
- Maximum Benefit (Calendar Year) 60 days

Surgery – Out-Patient

Coinsurance (*Fund pays*)

In-PPO-Network	90%
Out-of-Network.....	80%

Surgical Expense Benefit

The Coinsurance percentages apply only after the Deductible has been met.

Coinsurance (*Fund pays*)

In-PPO-Network	80%
Out-of-Network.....	70%

Well Child Benefit (Eligible Dependents through Age 12)

Coinsurance (*Fund pays*)

In-PPO-Network or Out-of-Network	100%
Maximum Benefit (Calendar Year)	\$100 per person

SECTION THREE – ELIGIBILITY

The following topics are discussed under this Section on Eligibility:

-
- | | |
|--|---|
| A. Initial Eligibility | J. Termination of Eligibility for Eligible Employees |
| B. Continuation of Eligibility | K. Termination of Eligibility for Dependents |
| C. Reinstatement of Eligibility | L. Withdrawal of Local Union |
| D. Employment Outside the Jurisdiction | M. Eligibility Under the Family and Medical Leave Act (FMLA) |
| E. Self-Employed Persons | N. Continuation of Coverage (COBRA) |
| F. Reciprocal Eligibility | O. Service in the Armed Forces |
| G. Eligibility for Active Employee Age 65 or Older and Eligible Dependents | P. Uniformed Services Employment and Reemployment Rights Act (USERRA) |
| H. Eligibility for Retirees | |
| I. Effective Date of Dependent Coverage | |
-

All Employees working for a contributing Employer or Employers within the various jurisdictions of the Plan for whom sufficient contributions have been paid shall be eligible to receive Benefits after meeting the following eligibility requirements.

A. Initial Eligibility

The following rules govern obtaining initial eligibility:

An Employee who has worked at least 500 hours in a five consecutive month period will become initially eligible for Benefits on the first day of the month following the month in which the 500 hours have been accumulated.

Example: An Employee began working for a contributing Employer on January 1, 2005. As of May 31, 2005, (five months after he or she began working) he or she had worked at least 500 hours. The employee became eligible for benefits on June 1, 2005, (the first day of the calendar month following a five-month period in which Employer contributions were made).

B. Continuation of Eligibility

The following rules govern continuation of eligibility:

Once an Employee has satisfied the Initial Eligibility requirements, he/she will remain eligible for Benefits for that month. Thereafter, he/she will remain eligible for Benefits as long as he/she is credited with at least 250 hours of Employer contributions in the first three months of the immediately preceding seven-month-period, or 1,000 hours in the first 12 months of the immediately preceding 16-month-period as set forth in the following table.

TABLE OF HOURS WORKED FOR CONTINUED ELIGIBILITY FOR HOURS WORKED ON OR AFTER OCTOBER 1, 2004

250 hours of work in:	or	1,000 hours of work in:	Employees are eligible during:
June, July and August		September – August	January
July, August and September		October – September	February
August, September & October		November – October	March
September, October & November		December – November	April
October, November & December		January – December	May
November, December & January		February – January	June
December, January & February		March – February	July
January, February & March		April – March	August
February, March & April		May – April	September
March, April & May		June – May	October
April, May & June		July – June	November
May, June & July		August – July	December

An Employee who is receiving Weekly Loss of Time Benefits or who is entitled to benefits under any Workers Compensation or Occupational Disease Law, or who is receiving weekly benefits under the applicable Unemployment Compensation Laws of the State in which the Employee resides, will receive 16 hours of contribution credit for each week he or she is entitled to or receiving such benefits beginning with the eighth day of disability. This credit accumulation will end when Weekly Loss of Time Benefits (or any other benefit under applicable Unemployment Compensation Laws) end or when credits total 250 hours in a calendar year, whichever occurs first.

C. Reinstatement of Eligibility

An Employee will be eligible again on the first day of the calendar month following three consecutive months, or fewer, during which 250 hours of Employer contributions are credited within 12 calendar months from the date his or her employment ended.

If, after becoming eligible, a Participant loses his/her eligibility and has been ineligible for more than 12 months, the Participant will be considered a new Employee and must satisfy the Initial Eligibility Rules (500 hours of Employer contributions in a five month period).

D. Employment Outside the Jurisdiction

An Employer may make contributions to this Fund for Employees working outside the territorial jurisdiction of the Fund, provided he or she pays for all Employees coming from within the jurisdiction of this Fund, if

1. He or she maintains his or her principal office within the jurisdiction of the Fund, or
2. He or she has previously paid contributions to the Fund in behalf of said Employees, and
3. He or she is party to a Collective Bargaining Agreement for the craft being paid on that requires payments to the Fund when working within the jurisdiction of the Fund, or
4. The Trustees agree to accept contributions from the Employer.

E. Self-Employed Persons

The Health and Welfare Plan does not cover, nor accept contributions on behalf of, self-employed persons.

F. Reciprocal Eligibility

A reciprocity agreement has been entered into between the Contractors, Laborers, Teamsters and Engineers Health and Welfare Fund and the Omaha Construction Industry Health and Welfare Fund. This agreement was entered into in March 2005 and applies to hours worked on or after October 1, 2004.

Under the agreement, an Employee who is a member of a local union affiliated with the International Union of Operating Engineers, the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, or the Laborers International Union of North America, may request in writing that contributions received by the Fund on the Employee's behalf be transferred to the Employee's "Home Fund". The "Home Fund" is the Fund which has the greatest number of hours for which contributions have been received pursuant to a Collective Bargaining Agreement between an Employer and any one or more of the Laborers, Teamsters or Operating Engineers Unions.

No hours or Employer contributions will be transferred unless a written request is submitted to the transferring Fund's office. A Fund cannot transfer any contributions which were received more than one hundred eighty (180) days prior to the date the written request for the transfer is received by the transferring Fund's office. The Trustees for the Fund receiving the transfer of hours and Employer contributions will determine the manner in which the hours and Employer contributions will be credited.

G. Eligibility for Active Employees Age 65 or Older and Eligible Dependents

Federal law affects the way employers provide coverage to eligible active Employees and their spouses ages 65 and over. This federal law provides that eligible active employees and their spouses ages 65 and over may elect to continue full Benefits under the employer group benefit plan or choose Medicare as their primary coverage. If Medicare is elected as the primary carrier (the plan which pays first), this Plan will not pay the deductibles or any other Benefits afforded under this Plan. If this Plan is elected as the primary carrier (the Plan which pays first), Medicare becomes the secondary coverage.

H. Eligibility for Retirees

The following rules govern eligibility for Retirees and their Eligible Dependents:

1. Early or Normal Retirees

An eligible Employee who is: (a) receiving benefit payment under the Omaha Construction Industry Pension Plan, or the National Roofing Industry Pension Plan with a retirement date of January 1, 1987; and (b) was eligible for Benefits (including eligibility through the benefit bank and/or COBRA Continuation Coverage) under the Omaha Construction Industry Health and Welfare Plan for 24 months out of the previous 36 months immediately preceding the effective date of his or her retirement benefit, will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

2. Retirees due to portability

Employees who retire due to portability from the Lincoln Building and Construction Industry and Contractors, Laborers, Teamsters and Engineers' Health and Welfare Funds will be allowed to carry retiree coverage through the Omaha Construction Industry Health and Welfare Plan if they were eligible in the Plan within the 24 months out of the previous 36 months immediately preceding the effective date of his or her retirement benefit, will become eligible for continuing Benefits provided under this Plan by making required self-payments.

3. Limitations for all Retirees

Retirees are **not** eligible for Life Insurance, Accidental Death and Dismemberment Insurance or Weekly Loss of Time.

I. Effective Date of Dependent Coverage

Benefits for Eligible Dependents will become effective on the **latest** of the following dates:

1. The date the eligible Employee's or Retiree's Benefits become effective, or
2. The date the eligible Employee or Retiree acquires an Eligible Dependent, or

3. The date specified in a Qualified Medical Child Support Order.

If an eligible Employee or Retiree acquires a dependent while eligible for Benefits, such dependent will automatically become covered. Coverage will begin at birth for your newborn child. Please notify the Fund Office within 31 days of a marriage or adding a new dependent, so that they may update your records and to avoid any future delay in the payment of claims.

J. Termination of Eligibility for Eligible Employees

Eligibility for Benefits will terminate on the date the:

1. Plan terminates;
2. Last payment is made by the Trustees for the Employee's coverage period;
3. The Employee fails to satisfy the requirements set forth under the Continuation of Eligibility as explained in Section Three B;
4. The Employee fails to elect COBRA Continuation Coverage;
5. The Employee fails to make a required self-payment;
6. Employee enters full-time military service; or
7. Employee stops being in the classes of Employees eligible for coverage under the Plan.

When an Employee enters military service, his or her eligibility and that of his or her Eligible Dependents will terminate on the last day of the calendar month in which he or she is inducted or enlisted. However, any accumulated eligibility will be kept on record and will be made available to the Employee upon his or her return from military service, provided he or she notifies the Fund in writing that he or she is entering military service, unless they or their Eligible Dependents request the use of such eligibility at any time during his or her military service. In this case, the accumulated eligibility will begin from the time the request for Benefits is granted.

K. Termination of Eligibility for Dependents

The eligibility for Benefits for Eligible Dependents will terminate upon the occurrence of the first of the following:

1. The individual fails to satisfy the definition of Eligible Dependent as defined on page 88,
2. The individual fails to elect Continuation of Coverage (COBRA),

3. The individual fails to make a required self-payment.

Upon the death of an eligible Employee, the eligibility of that Employee's Eligible Dependents shall be extended to the end of the eligibility period based upon the deceased eligible Employee's accrued hours. Thereafter, the eligibility for Benefits will be governed by the Continuation of Coverage (COBRA) provisions.

Upon the death of an eligible Retiree, the eligible spouse shall be allowed to continue coverage for 36 months by self-paying the prevailing COBRA contribution rate.

After the COBRA eligibility period elapses, the spouse shall be eligible to continue coverage by self-paying the prevailing COBRA contribution rate until he or she remarries or becomes eligible for Medicare.

L. Withdrawal of Local Union

If a local Union terminates its participation in this Plan or no longer provides in its Collective Bargaining Agreement for the required Employer contribution, the eligibility and benefit rights of that local's Employees, Retirees and dependents become subject to special rules and limits including the following:

1. Eligibility is terminated as of 31 days following the date contributions are no longer required regardless of any hour bank accumulation.
2. After eligibility is terminated, all rights to qualify in the future for continued eligibility due to Total Disability, Retiree Benefits and reciprocity are ended.
3. Retiree eligibility is terminated as of 31 days following the date contributions are no longer required because of the local Union's termination. For this purpose any Retiree who was a member of a terminating local Union will be subject to this rule.

M. Eligibility Under the Family and Medical Leave Act (FMLA)

Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits shall be extended to Covered Employees and their Eligible Dependents if the Covered Employee has been granted unpaid leave by his/her Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund.

If a Covered Employee has been granted FMLA leave, the Employer shall notify the Fund Office at least 14 days before the onset of the leave, except in an emergency, and then no later than seven days after the leave begins, to prevent a loss of eligibility. The Fund Office shall obtain a certificate of the Covered Employee's eligibility from the Employer. The Employer shall advise the Fund Office of the beginning date and ending date of the leave. The Employer shall

notify the Fund Office of the date a Covered Employee advises the Employer that he/she does not intend to return to work.

The Employer will be required to pay the cost of continuing coverage in an amount equal to contributions for 25 hours of work per week for each week the Covered Employee is on FMLA leave. The Employer shall remit payment monthly, in arrears, upon billing by the Fund Office.

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

If you have any questions regarding the FMLA, please contact the Fund Office.

N. Continuation of Coverage (COBRA)

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

What is COBRA Continuation Coverage?

If a Covered Employee or Eligible Dependent loses health care coverage due to a reduction in hours, termination of employment, or certain other events (called qualifying events), the Covered Employee and the Eligible Dependent(s) have the right to elect to continue health care coverage by making premium payments to the Plan.

1. COBRA Continuation Coverage will be offered to a Covered Employee if coverage under the Plan ends for the following reasons:
 - a. The Covered Employee's hours of employment are reduced;
 - b. The Covered Employee's layoff; or
 - c. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct.
2. COBRA Continuation Coverage will be offered to the spouse of a Covered Employee if coverage under the Plan ends for the following reasons:

- a. The Covered Employee's hours of employment are reduced;
 - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;
 - c. The Covered Employee dies;
 - d. The Covered Employee becomes enrolled in Medicare; or
 - e. The Covered Employee and spouse become legally separated or divorce.
3. COBRA Continuation Coverage will be offered to an Eligible Dependent Child if coverage under the Plan ends for the following reasons:
- a. The Covered Employee's hours of employment are reduced;
 - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;
 - c. The Covered Employee dies;
 - d. The Covered Employee becomes enrolled in Medicare;
 - e. The Covered Employee and spouse become legally separated or divorced;
or
 - f. The dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

How long will COBRA Continuation Coverage last?

1. 18 months
If the Covered Employee and/or the Eligible Dependent lose coverage due to a reduction in the Covered Employee's hours, or due to the end of the Covered Employee's employment, for reasons other than gross misconduct, COBRA Continuation Coverage is available for a maximum of up to 18 months.
2. 29 months
If the Covered Employee and/or Eligible Dependent is disabled (as determined under Titles II or XVI of the Social Security Act) at the time his or her coverage would otherwise terminate because of a reduction of hours or termination of employment, for reasons other than gross misconduct, or who becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, the Covered Employee and/or Eligible Dependent can receive up to

an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months of COBRA Continuation Coverage.

3. 36 months

COBRA Continuation Coverage lasts up to 36 months if the Covered Employee's spouse or Eligible Dependent child's health care coverage ends due to:

- a. The Covered Employee and spouse become legally separated or divorce;
- b. The Covered Employee becomes enrolled in Medicare;
- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

4. Second Qualifying Event

COBRA Continuation Coverage may also be extended for up to 36 months if your Family experiences another event, called a "qualifying event" while receiving COBRA Continuation Coverage. If the Covered Employee or Eligible Dependent is receiving 18 or 29 months of COBRA Continuation Coverage and a second qualifying event occurs, the Covered Employee and/or Eligible Dependent is eligible for an extension of COBRA Continuation Coverage up to a maximum period of 36 months. Examples of second qualifying events are:

- a. The Covered Employee and spouse become legally separated or divorce;
- b. The Covered Employee becomes enrolled in Medicare;
- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

Keeping the Fund Office Informed of Changes

In order to protect your Family's rights, the Fund Office should be informed of any changes concerning your Family. The Covered Employee and any Eligible Dependent has the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or of a dependent child's loss of dependent status. **Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in the Covered Employee's hours, termination of employment, enrollment in Medicare, or Covered Employee's death, the Covered

Employee or Eligible Dependent should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

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

Electing to Continue Coverage

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

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

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

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except for the Life and Accidental Death and Dismemberment Benefits.

Payments

The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees.

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

Termination of COBRA Continuation Coverage

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

1. A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;
2. The Covered Employee or Eligible Dependent becomes covered under another group health plan;
3. The Covered Employee or Eligible Dependent becomes entitled to Medicare;
4. The Fund no longer provides group health care coverage; or
5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

O. Service in the Armed Forces

Each Covered Employee, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within the time periods described in this Section Three, Paragraph P.4., below shall become eligible under this Plan on the date of commencement of such active work, subject to USERRA.

If a Covered Employee's eligibility terminates because of entry into active duty with the Armed Forces of the United States, any Benefits hereunder with respect to any Eligible Dependent of such Covered Employee on the date of such termination shall be continued in force while such Dependent continues to be an Eligible Dependent but not beyond the end of the eligibility quarter, subject to USERRA.

P. Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following rules govern your rights under USERRA:

1. Effective Date

The United Services Employment and Reemployment Rights Act of 1994 was signed into law on October 13, 1994 to protect the eligibility of an Employee and to offer contribution coverage to the Employee and the Employee's dependents after the Employee enters into Military Service.

2. Return to Work Coverage Guaranteed

USERRA requires an Employer, or a multi-employer health care plan, to protect any health care Benefits an Employee has already earned up to the time an Employee enters Military Service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

The Employee's eligibility status must be "frozen" when the Employee enters Military Service and must be fully restored when the Employee re-applies for work with the same Employer or, in the case of a multi-employer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

When an Employee returns from Military Service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered Military Service.

3. Continuation of Coverage While in the Military

USERRA requires a group health care plan to offer identical health care coverage **up to 18 months** to persons who have coverage in connection with their employment but who are absent from such employment due to Military Service. In effect, Military Service is treated as if it is a "qualifying event" for COBRA purposes.

**THE EMPLOYEE MUST NOTIFY THE FUND OFFICE
IMMEDIATELY WHEN THE EMPLOYEE KNOWS
HE/SHE IS ENTERING MILITARY SERVICE.**

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 18 months still begins with the initial date of entry into Military Service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office, as soon the Employee knows he/she is entering Military Service **if the Employee wishes to take advantage of contribution coverage. Failure to notify the Fund Office may be taken as an indication that the Employee does not wish to purchase coverage for the Employee or the Employee's dependents.**

4. Re-employment Requirements when Returning from Military Service

The application period for re-employment is based on a time schedule keyed to the length of time spent in Military Service.

Military Service Less than 31 Days

For Military Service of less than 31 days, a Service member must apply for re-employment with a signatory Employer at the beginning of the next regular scheduled work period on the first day after release from Service, taking into account safe transportation plus an eight hour rest period.

Military Service More than 31 Days but Less than 181 Days

For Military Service of 31 days or more but less than 181 days, an application for re-employment must be filed within 14 calendar days (not work days) after the Service member's release from the Service.

Military Service Over 181 Days

For Military Service over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge.

5. Definitions

“Health Coverage” means Hospital, surgical, medical or dental coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modification.

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

“Covered Person” means a Covered Employee or Eligible Dependent as defined in Section Fourteen of this Plan.

“Service in the Uniformed Services” or “Military Service” means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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

6. Continuation of Group Health Coverage

If Health Coverage ends because of Service in the Uniformed Services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the **earlier** of:

- a. The end of the period during which the Covered Employee is eligible to apply for reemployment in accordance with USERRA, or
- b. 18 consecutive months after coverage ended.

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

A Covered Person's continued Health Coverage under USERRA will end at midnight on the **earliest** of:

- a. The day the Plan is terminated,
- b. The day a premium is due and unpaid,
- c. The day the Covered Person again becomes covered under the Plan, or
- d. The day the Health Coverage has been continued for the period of time provided above (or any longer period provided in the Plan).

7. Conflict Resolution

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

SECTION FOUR – MEDICAL BENEFITS

The Benefits listed in the table below are described in this Section. This table is only intended to give you a brief summary of Benefits available. Please refer to the description of Benefits that begins on page 24, immediately after the table to fully understand the benefit and any specific maximums or limitations.

There are separate sections that describe the Plan’s Death and Dismemberment, Weekly Loss of Time, Dental Expense and Prescription Drug Benefits.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED PERSONS. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENT ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

Description of Covered Benefit	Fund Co-Payment/ Coinsurance Amount Co-Payment/ Coinsurance amounts are based on a percent of Usual Customary and Reasonable Charge		Does your Co-Payment/ Coinsurance amount help meet your Out-of- Pocket Limit?	Do you need to meet your calendar year Deductible before receiving Benefit?
	In-PPO- Network	Out-of- Network		
Chiropractic Expense Benefit <i>See Benefit Description for Specific Limitations Max 30 visits</i>	80%	70%	Yes	Yes
Diagnostic X-Ray and Laboratory Benefit <i>See Benefit Description for Specific Limitations</i>	100% up to \$100 per Calendar Year (In or Out-of-Network)		No	No
Hospice Benefit <i>See Benefit Description for Specific Limitations</i>	80%	70%	Yes	Yes
Major Medical Benefit	80%	70%	Yes	Yes
Maternity Benefit <i>(Employee or Spouse Only)</i>	80%	70%	Yes	Yes

Description of Covered Benefit	Fund Co-Payment/ Coinsurance Amount		Does your Co-Payment/ Coinsurance amount help meet your Out-of- Pocket Limit?	Do you need to meet your calendar year Deductible before receiving Benefit?
	In-PPO- Network	Out-of- Network		
Mental Health Benefit <i>See Benefit Description for Specific Limitations</i>	50%	50%	No	Yes
Organ and Tissue Transplants <i>See Benefit Description for Specific Limitations</i>	80% up to \$200,000 per transplant (In or Out-of-Network)		No	No
Preventative Routine Care Benefit (Employee and Spouse only) <i>See Benefit Description for Specific Limitations</i>	100% up to \$250 per person Calendar Year (In or Out-of-Network)		No	No
Skilled Nursing Care Benefit <i>See Benefit Description for Specific Limitations</i>	80%	70%	Yes	Yes
Skilled Nursing Care Facility Benefit <i>See Benefit Description for Specific Limitations</i>	80%	70%	Yes	Yes
Surgery – Out-Patient	90%	80%	Yes	Yes
Surgical Expense Benefit	80%	70%	Yes	Yes
Therapy Services Benefit <i>See Benefit Description for Specific Limitations</i>	80%	70%	Yes	Yes
Well Child Benefit (Eligible Dependents only) <i>See Benefit Description for Specific Limitations</i>	100% up to \$100 per person per Calendar Year (In or Out-of-Network)		No	No

A. Chiropractic Expense Benefit

Benefits for the Chiropractic Expense Benefit will be paid according to the Schedule of Benefits if the treatment is performed by a licensed chiropractor.

Chiropractic Expense Benefits are **NOT** payable for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) allergy therapy, diet or hair analysis,
2. Any diagnostic x-ray or laboratory procedure other than an x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry,
3. Nutritional or food supplements and/or vitamins which may be legally obtained without a Physician's prescription,
4. Pillows, supports or similar devices,
5. More than one treatment per day, or
6. Booklets.

Benefit Limitations

Visits are limited to 30 manipulations per Covered Person per Calendar Year. Benefits for or related to treatment by a chiropractor are subject to the same terms, conditions and limitations governing individual Benefits for any other Sickness or Injury.

B. Diagnostic X-Ray and Laboratory Benefit

Benefits are payable for x-ray and laboratory examinations for the diagnosis of an Injury or Sickness and radiology and pathology Services provided by a Physician, up to the maximum stated in the Schedule of Benefits for all such examinations made in a calendar year.

Benefit Limitations

Maximum Benefit (Calendar Year)\$100 per person

Benefits over the Diagnostic X-Ray and Laboratory Benefit Maximum will be paid subject to the Major Medical coinsurance and deductible unless the service is provided by a chiropractor.

Diagnostic X-Ray and Laboratory Benefits are **NOT** payable for dental x-ray, eye examinations, the fitting of eyeglasses or hearing aids.

C. Hospice Benefit

A hospice is a program of care provided for a person diagnosed as terminally ill and their families. The patient must have a life expectancy of six months or less and the Physician-ordered Services must be appropriate for palliative support or management of a terminal illness.

Benefits, on behalf of a Covered Person, for Covered Services are available for **preauthorized** Hospice Care Services provided by a Medicare-certified Hospice and will be paid according to the Schedule of Benefits.

In-Patient allowed charges are:

1. Room and board charges up to the facility's semi-private room charge, and
2. Services and supplies for pain control and other acute and chronic symptom management.

Out-Patient allowed charges are:

1. Part-time or intermittent nursing by an RN or LPN for up to 6 hours a day,
2. Services such as a part-time or intermittent home health aide for up to 3 hours a day, and
3. Supplies required for pain relief that are prescribed by a Physician.

Hospice Benefits are **NOT** payable for:

1. Services and supplies which are not part of an approved hospice plan of treatment,
2. Services of a caregiver who lives in the Employee's home or is a member of the Employee's Family,
3. Domestic or housekeeping services that are unrelated to the patient's care,
4. Services that provide a protective environment when no skilled service is required, including companionship or sitter services,
5. Services which are not directly related to a Covered Person's medical condition, including (but not limited to):
 - a. Estate planning, drafting of wills or other legal services,
 - b. Bereavement counseling, respite care, pastoral counseling or funeral arrangement or services,

- c. Nutritional guidance or food services such as “meals on wheels”, or
 - d. Transportation services.
6. Expenses for which Benefits are paid under any other provisions of this Plan,
 7. Any requirement that the care be part of an active plan of medical treatment which is reasonably expected to reduce the disability, and
 8. Any of the services or supplies listed under Section Nine, General Plan Exclusions.

Benefits are not available for home health aide, hospice, skilled nursing care or skilled nursing facility care services performed by volunteers; services which are primarily for the convenience of the patient or a person other than the covered patient; pastoral services; home delivered meals; financial or legal counseling; maintenance therapy for non-hospice related home health aide services; telephone calls, telephone consultations or telephonic transmissions; or bereavement counseling.

D. Major Medical Expense Benefit

Medical expenses included under the Major Medical Expense Benefit will be payable based on the Usual Customary and Reasonable Charge for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

Deductible Amount

The Deductible Amount is \$250 per person or \$750 per Family for Expenses Incurred In-PPO-Network; or \$350 per person or \$1,050 per Family for Expenses Incurred Out-of-Network per calendar year. The Deductible Amount must be paid by the Employee before any Benefits under the Plan of Benefits will be paid and will be applied only once per calendar year.

Allowed charges

Medical expenses included under the Major Medical Expense Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

1. Hospital for room and board charges (semi-private room only),
2. Anesthesia,
3. X-ray and laboratory services,
4. Treatment of Emergency Medical Condition,

5. Administration and cost of blood or blood plasma,
6. Prescription drugs and medicine if prescribed by a Physician and dispensed by a licensed pharmacist,
7. Services of a licensed physiotherapist,
8. Durable Medical Equipment that meets each of the following criteria:
 - a. Is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation or rehabilitation of a handicapped person,
 - b. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,
 - c. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),
 - d. Would **NOT** be necessary in the absence of a Sickness or physical or mental disability, and
 - e. Is appropriate for and intended for use in the home

Examples of Durable Medical Equipment include equipment to assist mobility, such as a standard wheelchair, a standard Hospital type bed, oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, braces that stabilize an injured body part, or mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. Non-durable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with Covered Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to Covered Durable Medical Equipment. Requests for Durable Medical Equipment must be accompanied by a Physician's statement describing the Medical Necessity and length of use. The cost of these items will be limited to an amount determined by the Trustees. Rental of Durable Medical Equipment is covered up to the purchase price. **You should contact the Fund Office before purchasing or renting any of these items if you wish to know the cost that will be covered.**

9. Initial placement of contact lenses required due to cataract surgery,
10. Services for cosmetic and reconstructive surgery for injuries received: (a) while the Covered Person was eligible for Benefits, or (b) for reconstruction

of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient,

11. Ambulance service provided to a Covered Person for
 - a. Transportation to the nearest facility where appropriate medical emergency care may be received;
 - b. Transfer of a Covered Person who is an In-Patient at an acute care facility to a facility of a lesser level of care when Medically Necessary or home when bed-ridden; or
 - c. Transfer of a Covered Person to and from the nearest appropriate facility for testing and/or procedures that cannot be performed at the present facility. Transfer from and back to the original facility must occur within a 24-hour period.
12. Prosthetic appliances, including preauthorized special or patented braces,
13. Eyeglasses or contact lenses (or replacement) when ordered by a Physician because of a change in prescription of at least one diopter, as a direct result of covered intraocular surgery or Injury, providing purchase is made within 12 months of surgery or Injury,
14. Anti-rejection drugs dispensed by a registered pharmacist requiring a Physician's prescription and bearing the label, "Caution – Federal law prohibits dispensing without a prescription." Benefits will be limited to no more than a 90-day supply per medication and for each subsequent refill,
15. Services for renal dialysis, including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for up to six sessions of dialysis training or counseling. Such Benefits will be paid for a maximum of 30 months for any individual whose coordination period began on or after July 31, 1996, or as governed by Medicare requirements,
16. Sleep studies,
17. Orthopedic shoes limited to one pair each calendar year for each Covered Person.
18. Newborn care for eligible newborn infants. Covered services include: room and board; Physician's services for a newborn well infant while hospitalized,

including circumcision; newborn screening services for an infant born at home; and medically necessary definitive medical or surgical treatment.

Benefit Limitation for Treatment Connected to Bariatric Surgery

A Covered Person shall not be entitled to payment on a claim for benefits for any charge incurred for any treatment or service for or connected with bariatric surgery performed to correct obesity or to remove fat tissue, even if Medically Necessary. This exclusion includes, but is not limited to charges for gastric bypass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, abdominoplasty, and panniculectomy and any charges that are related to these procedures.

E. Maternity Benefit

Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

MATERNITY BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

Allowed charges are:

1. In-Patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery.
2. In-Patient stay of at least 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefit Limitations

Maternity Benefits are **NOT** payable for postpartum depression, psychosis or any other mental illness, which may be covered under the Mental Health Benefit. In addition, Maternity Benefits are **NOT** payable for pregnancy expenses of eligible Dependent children.

F. Mental Health Benefit

Benefits for Expenses Incurred by a Covered Person for treatment prescribed by a legally qualified Physician for mental or nervous Sickness will be paid according to the Schedule of Benefits for Medically Necessary care and services. Benefits will be payable for services provided by a psychologist (PhD or PsyD) or psychiatrist (PhD); or when supervised and billed by a doctor of medicine (MD), a licensed

special psychologist, licensed clinical social worker, licensed professional counselor or licensed mental health practitioner. All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements will be governed by state law.

Allowed charges are:

1. Mental health evaluations and assessment,
2. Diagnosis,
3. Treatment planning,
4. Referral services,
5. Medication management,
6. Short-term individual, Family and group therapeutic services (including intensive Out-Patient therapy),
7. Crisis intervention, except for as specifically excluded in Section Nine – General Plan Exclusions, numbers 30, on page 52 of this document, and 53, on page 54 of this document.
8. Psychological testing.

Mental Health Benefits are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Physician,
2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed condition(s),
or
3. Behavior disorders, or
4. Treatment for substance abuse or alcoholism.

G. Organ and Tissue Transplants Benefit

Organ and Tissue Transplants will be covered according to the Schedule of Benefits for a Covered Person who is a transplant recipient for Covered Services relating to, or resulting from a transplant of these body organs or tissues: liver, heart, single and double lung, lobar lung, combination heart-lung, heart valve (heterograft), kidney, combination kidney-pancreas, bone graft, cornea or parathyroid. Benefits

are also available for allogeneic and autologous bone marrow transplants for specified conditions.

Benefits are not available for Hospital, medical, surgical or other services provided to a donor, or related to the donation of organs.

All Benefit payments for organ and tissue transplant procedures (except lobar lung, cornea, kidney, parathyroid and heart-valve) must be preauthorized by The Benefit Group. A written request to The Benefit Group must be made before the procedure is performed and be accompanied by documentation from the covered person's Physician demonstrating the Medical Necessity of the proposed procedure. This request should also indicate at which hospital the transplant procedure will be performed and should be directed to:

The Benefit Group
10675 Bedford Avenue
Omaha, NE 68134

(800) 326-0004 or (402) 445-6115

The Benefit Group will respond in writing advising the provider and the Covered Person as to whether or not Benefits are available.

Benefits will be provided for Medically Necessary myeloablative (high dose) chemotherapy with allogeneic stem cell support only when prescribed for:

- advanced non-Hodgkin's lymphoma; advanced Hodgkin's disease (lymphoma);
- advanced neuroblastoma;
- acute lymphocytic or nonlymphocytic leukemia (acute leukemia);
- multiple myeloma treated with up to one course of chemotherapy;
- gonadal germ cell tumor;
- chronic myelogenous leukemia.

Benefits will be provided for Medically Necessary Allogeneic Bone Marrow Transplantation for primary diseases of the bone marrow for:

- aplastic anemias and myelodysplastic syndromes: hereditary or congenital, acquired, toxic or radiation induced;
- Wiskott-Aldrich syndrome;

- severe congenital combined immunodeficiency;
- thalassemia major;
- infantile malignant osteopetrosis (Albers-Schonberg);
- mucopolysaccharidoses: Hurler's, Hunter's, Sanfilippo, Maroteaux-Lamy, Morquio's;
- mucopolipidoses: Gaucher's, metachromatic leukodystrophy, adrenoleukodystrophy;
- severe sickle cell disease;
- polycythemia vera.

Benefits will be provided for Medically Necessary Autologous Bone Marrow Transplants only when prescribed for:

- acute lymphocytic or non-lymphocytic leukemia (acute leukemia);
- advanced Hodgkin's disease (lymphoma);
- advanced non-Hodgkin's lymphoma;
- advanced neuroblastoma;
- multiple myeloma treated with up to one course of chemotherapy;
- Wilms' tumor;
- gonadal germ cell tumor;
- stage III inflammatory breast cancer and all stage IV breast cancer.

No benefits will be provided for any other use or application of Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant.

Benefits are available for the following medically necessary covered services directly related to or resulting from, a covered transplant:

- Services provided for the evaluation of organs or tissue including, but not limited to the determination of tissue matches.

Benefits will not be provided for:

- the purchase of human organs or tissues which are sold rather than donated to the recipient;
- the transplant of a nonhuman or artificial organ or tissue. (This provision does not apply to the implantation of pacemakers.);
- an activation search fee;
- high dose chemotherapy or radiation therapy when supported by bone marrow or stem cell transplant procedures for ovarian cancer or diagnoses other than those identified in the previous paragraphs; or
- organ or tissue transplants except as described previously in this section.

Benefits provided for covered organ and tissue transplant services will not be subject to Exclusion number 3 listed in the Section Nine – General Plan Exclusions for services or procedures which are considered to be experimental.

Benefits provided to noncovered persons shall be secondary to those provided by the person's own health insurance coverage.

Definitions for Allogeneic and Autologous Bone Marrow Transplants

Allogeneic Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood, from a third party donor; (b) processing and/or storage of the stem cells so harvested; (c) the administration of high dose chemotherapy and/or high-dose radiotherapy (this step may be absent in certain applications); (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the high dose chemotherapy and/or high dose radiotherapy.

Autologous Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood from the patient; (b) processing and/or storage of the stem cells so harvested; (c) the administration of high dose chemotherapy and/or high dose radiotherapy; (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of

reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the high dose chemotherapy and/or high dose radiotherapy.

High Dose Chemotherapy: A form of chemotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

High Dose Radiotherapy: A form of radiotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

LIMITED BENEFITS ARE AVAILABLE FOR ALLOGENEIC BONE MARROW TRANSPLANT AND AUTOLOGOUS BONE MARROW TRANSPLANT.

Warning: This section provides Benefits for allogeneic and autologous bone marrow transplants only for certain diseases or conditions and specifically excludes Benefits for those procedures for all other diseases or conditions. You should carefully review the entire Benefit, especially the definitions of allogeneic and autologous bone marrow transplants, high dose chemotherapy and high dose radiotherapy. The limited benefits provided in this section for allogeneic and autologous bone marrow transplants are an exception to Exclusion Number 3 for investigative procedures (see Section Nine – General Plan Exclusions).

The exception of these procedures in limited circumstances from the Exclusion for investigative procedures is not intended to, and does not operate as, a waiver of the Exclusion for investigative procedures. The limited Benefit provided in this Section for allogeneic and autologous bone marrow transplants are subject to all of the other conditions and provisions of the contract including, without limitation, the requirement that the procedure be Medically Necessary.

Benefit Limitations

Coinsurance (*Fund pays*)

In-PPO-Network or Out-of-Network..... 80%

Maximum Benefit\$200,000 per transplant

Covered Services included within the Organ and Tissue Transplant Benefit Maximum are medical, surgical and hospital services for the surgery and follow-up care and prescription medications. Organ and Tissue Transplants Benefits are **NOT** payable for hospital, medical, surgical or other services provided to a donor, or related to the donation of organs.

H. Preventative Routine Care Benefit

Benefits are payable for preventative services and supplies in a calendar year for the Employee and spouse for the Usual, Customary and Reasonable Charges according to the Schedule of Benefits.

Allowed charges are:

1. Lab and x-ray test, including Pap smears and mammograms,
2. Immunizations and inoculations, except for flu shots, and
3. Other preventative diagnostic tests or procedures ordered by the examining Physician.

Benefit Limitations

Maximum Benefit (Calendar Year)\$250 per person
Employee and spouse only

Benefits under the Routine Care Benefit are **NOT** payable for:

1. Any examination or service provided for non-routine purposes, or
2. Any treatment of a condition diagnosed as a result of a routine examination.

I. Skilled Nursing Care Benefit

Benefits are payable, according to the Schedule of Benefits, for **preauthorized** Physician-ordered Skilled Nursing Care in the Covered Person's home for up to eight hours per day. Skilled Nursing Care is services which requires the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.). The patient must be physically unable to be transported to receive medical care (except if receiving home infusion therapy).

Benefit Limitations

Benefits under the Skilled Nursing Care Benefit will not be provided for:

1. Nursing care primarily for the convenience of the patient or patient's Family;

2. Nursing care for bathing, feeding, transporting, exercising, giving oral medication or acting as a companion/sitter to a Covered Person;
3. Nursing services provided by an immediate relative of the patient (by blood, marriage, or adoption) or a member of the patient's household; or
4. Nursing care provided to a patient in a hospital, skilled nursing facility, intermediate care facility or a nursing home.

J. Skilled Nursing Care Facility Benefit

Benefits are payable, according to the Schedule of Benefits, for Skilled Nursing Care Services provided in a semi-private room of a Skilled Nursing Care Facility. The Covered Person must be confined in a free-standing facility licensed by the state as a Nursing Facility (NF) or licensed by the state and/or certified by Medicare as a Skilled Nursing Facility (SNF) or, part of a Hospital with designated beds licensed by state law and/or certified by Medicare as Skilled Nursing or Swing Beds. The facility (or such part of the facility) must provide room and board, and 24-hour-a-day Skilled Nursing Care, as well as other related services for the care and rehabilitation of injured, disabled or sick persons.

Confinement in the skilled nursing facility must be for an unstable health condition, which:

1. Requires daily skilled observation of the patient's medical status;
2. Requires daily therapeutic treatment by a skilled professional; and
3. Interferes with the patient's ability to perform the activities of daily living unassisted.

The Skilled Nursing Facility confinement must be ordered by a Physician, be Medically Necessary and the Covered Person must be receiving Skilled Nursing Care.

Benefit Limitations

Benefits under the Skilled Nursing Facility Benefit will not be provided for treatment in the following facilities:

1. A place that is primarily used for rest;
2. A place for care and treatment of mental illness, alcoholism or drug abuse;
3. A place for custodial care; or
4. A place for educational or non-medical personal services.

In addition, Skilled Nursing Care in a Skilled Nursing Facility does not include:

1. Supportive services of a stabilized condition;
2. Care which can be learned and given by unlicensed or uncertified medical personnel;
3. Routine health care services;
4. General maintenance or supervision of routine daily activities; or
5. Routine administration of oral or non-prescription drugs.

K. Surgery – Out-Patient Benefit

If surgery is recommended by a Physician and can be performed on an Out-Patient basis, the Plan will cover the surgery according to the Schedule of Benefits.

L. Surgical Expense Benefit

When a Surgical Procedure is performed on a Covered Person for treatment of a non-occupational Sickness or accidental bodily Injury, the Plan will pay the surgical fee charged by the Physician performing the surgery according to the Schedule of Benefits.

Definitions

“Surgical Procedure” means certain invasive procedures, as well as the reduction of fractures or dislocations, in addition to recognized cutting procedures. Surgical Procedures may be performed in a Hospital, Physician’s office or elsewhere.

“Surgical Benefits” include charges for necessary and related pre-operative and post-operative care (and any anesthetic customarily administered by the surgeon) as part of the Surgical Procedure.

Successive Periods of Surgery as One Disability

Successive periods of surgery in a Hospital will be considered as one continuous disability and period of surgery for the purpose of determining maximum Benefits payable **unless:**

1. The later surgery is due to causes entirely unrelated to the causes of the prior surgery, or
2. The Surgical Procedures are separated by 31 days, or
3. In the case of an eligible Employee, the Surgical Procedures are separated by a return to covered employment for at least one full working day.

Benefit Limitations

Surgical Expense Benefits are **NOT** payable for:

1. Any Surgical Procedure pertaining to the periodontium,
2. Any dental work or treatment, except as otherwise specifically provided under the Plan,
3. Any elective, cosmetic Surgical Procedure, including but not limited to, rhinoplasty or breast augmentation; except for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient, or as a covered Major Medical Benefit,
4. Any Surgical Procedure not considered Medically Necessary,
5. Charges made by an assistant surgeon will be considered under the Major Medical Expense Benefit, provided such assistance is considered Medically Necessary.
6. A Covered Person shall not be entitled to payment on a claim for benefits for any charge incurred for any treatment or service for or connected with bariatric surgery performed to correct obesity or to remove fat tissue, even if Medically Necessary. This exclusion includes, but is not limited to charges for gastric bypass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, abdominoplasty, and panniculectomy and any charges that are related to these procedures.

M. Therapy Services Benefit

Therapy Services are covered for physical, occupational and speech therapy according to the Schedule of Benefits.

Allowed charges are:

1. Physical therapy sessions provided by a licensed physical therapist or licensed physical therapist assistant. To be an approved provider, the licensed physical therapist assistant must be assigned to, supervised, and billed for, by a licensed physical therapist. Physical therapy must be ordered or prescribed by a Physician.
2. Occupational therapy sessions provided by a licensed occupational therapist or licensed occupational therapist assistant under the supervision and billing of a licensed occupational therapist. Occupational therapy must be ordered or prescribed by a Physician.

3. Speech therapy or cognitive training provided by a licensed speech-language pathologist or registered communication assistant practicing under the supervision of a licensed speech-language pathologist.

N. Well Child Benefit

In addition to other Benefits available to Eligible Dependents, an Eligible Dependent child shall be entitled to coverage of Usual Customary and Reasonable Charges, according to the Schedule of Benefits, for Child Health Supervision Services from birth through age 12.

Definition

“Child Health Supervision Services” means Physician-delivered or Physician-supervised services including routine well-baby care, pediatric preventative services, developmental assessment and appropriate immunizations and laboratory tests which are delivered as stated in the Schedule of Benefits.

Benefit Limitations

Maximum Benefit (Calendar Year) \$100 per Eligible Dependent

SECTION FIVE – DEATH AND DISMEMBERMENT BENEFITS

Active Eligible Employees Only

A. Death Benefit

If an Employee dies while eligible, his or her Beneficiary will receive the amount stated in the Schedule of Benefits. Life Insurance Benefits are payable after receipt by the Fund Office of a certified death certificate and proof of death forms. If there is no surviving Beneficiary at the time of the Employee's death, the amount will be payable in one lump sum to his or her estate, or to any child or children, father, mother, sisters or brothers. A legal guardian or administrator must be appointed when there are minors or multiple beneficiaries.

Total and Permanent Disability - Extended Death Benefit

If an Employee becomes Totally and Permanently Disabled while eligible and then dies within the first year, his or her Beneficiary will receive this Death benefit in the amount stated in the Schedule of Benefits. If this happens, proof of the uninterrupted existence of such disability until death must be furnished to the Trustees.

B. Accidental Death and Dismemberment Benefit

When bodily Injury caused solely through accidental means either on or off the job (24-hour coverage), results in any of the following losses within ninety (90) days after the date of the Accident, Accidental Death and Dismemberment Benefits are payable as follows:

Loss of	Maximum Benefit
Life	\$5,000
Both Hands or Both Feet	\$5,000
Entire Sight of Both Eyes	\$5,000
One Hand and One Foot	\$5,000
One Hand or One Foot and Entire Sight of One Eye	\$5,000
One Hand or One Foot	\$2,500
Entire Sight of One Eye.....	\$2,500

Definition

The following definition applies to the Accidental Death and Dismemberment Benefit:

“**Loss**” with reference to the hand or foot means complete severance through or above wrist or ankle joint, and with reference to the eye means the irrevocable loss of the entire sight thereof. In the event of multiple losses, Benefits will be paid for the greatest loss sustained as a result of any one Accident.

Benefit Limitations

Benefits will **NOT** be paid for any loss caused by:

1. Injuries suffered during combat, war or act of war or as a result of war or terrorism.
2. Injuries which were intentionally self-inflicted unless the Injury is in connection with a medical condition, and
3. Aircraft, except when the eligible Employee is a passenger in a licensed aircraft (other than chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier.

SECTION SIX – WEEKLY LOSS OF TIME BENEFIT
Active Eligible Employees Only

Weekly Loss of Time Benefits will be payable when an Employee is:

1. Wholly and continuously disabled due to an Injury or Sickness; or
2. Unable to perform any of his or her occupational duties; and
3. Not-engaged in any other occupations for pay or profit; and
4. Under the care of a legally qualified Physician or surgeon.

Benefits will begin on the first day of a disability due to an accidental bodily Injury or the 8th day of disability due to a Sickness. Benefits will continue up to the maximum stated in the Schedule of Benefits. During partial weeks of disability, an Employee will be paid at the daily rate of one-seventh of the Weekly Loss of Time Benefit.

Weekly Loss of Time Benefits are only payable for disabilities beginning while eligible under the Welfare Plan.

Note: If an Employee is Totally Disabled because of an occupational Accident, but returns to work before qualifying for the first week's benefit under the State Workers' Compensation Law, Benefits will be paid for the first week or any partial week, for such disability at the Weekly Loss of Time Benefit amount.

Continuous Periods of Disability

Successive periods of disability due to the same or a related cause shall be considered one period of disability unless the Employee returns to active employment for at least two full weeks or unless the Employee is known to be available for active covered employment.

If an Employee is disabled twice by unrelated causes, these periods of disability must be separated by a return to active full-time employment. An Employee will be considered to have returned to active full-time employment if he or she is actively employed with a participating Employer or if he or she has signed an out of work list.

Definition

The following definition applies to the Weekly Loss of Time Benefit:

"Occupational Disease" means a disease for which an Employee is entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar laws; or

Limitations

No Benefits will be payable under this Weekly Loss of Time benefit for any disability:

1. For which an Employee is not under the direct care of a Physician;
2. Due to accidental bodily injuries arising out of and in the course of an Employee's employment;
3. Due to Occupational Disease.
4. Beginning while an Employee is not eligible.

SECTION SEVEN – DENTAL EXPENSE BENEFIT
(Employees, Retirees and Dependents)

To qualify for Dental Expense Benefits, Employees, Retirees and their Eligible Dependents must meet the eligibility rules outlined in this Restated Plan Document and Summary Plan Description.

Note: Retirees may elect the Dental Expense Benefit only if they make the necessary self-payment. The self-payment may change from time-to-time.

Employees, Retirees and Eligible Dependents may choose to receive dental care from the dentist of their choice. Benefits will be paid according to the Schedule of Benefits.

Services must be provided by a licensed dentist or by a licensed hygienist working under the supervision of a dentist. The Expenses must be for treatment received while an Employee, Retiree or his or her dependent is eligible for coverage.

All Benefits payable will be paid directly to the provider of service if the Employee has signed an assignment of Benefits. Any fees over the maximums stated in the Schedule of Benefits will be the responsibility of the Employee, Retiree or Eligible Dependent.

If an Employee chooses a private dental insurance provider outside of this Plan, the Fund will reimburse the Employee, up to the \$300 per Family per calendar year maximum, for the cost of obtaining that private dental insurance policy (the premium). The Employee must provide the Fund Office with proof of the paid premium and he or she will be reimbursed, up to the remaining available portion provided by this Plan.

A. Filing a Dental Expense Claim

Upon completion of treatment, the dentist is requested to complete the American Dental Association (A.D.A.) claim form and the Employee or his or her dependent must sign the claim form attesting to the fact that the treatment was actually performed. Claim forms can be obtained from:

Omaha Construction Industry
Health and Welfare Plan
12165 West Center Road, Suite 80
Omaha, Nebraska 68144-3980

Telephone: (402) 330-2060
Fax: (402) 330-2797

Completed claim forms should be submitted to the above address.

B. Dental Expense Limitations

The following limitations shall apply:

1. Examination, charting and prophylaxis - Limited to once every six months.
2. Standard X-Rays or panorex - Limited to 14 every 24 months.
3. Bitewing X-Rays - Limited to four every 12 months.
4. Intra-Oral film - Occlusal - Limit one film every 12 months.
5. Temporomandibular Film - Limit one film every twelve 12 months.
6. Anterior - Posterior film head and jaws - Limit one film every 12 months.
7. Lateral film of head and jaws - Limit one film every 12 months.

C. Dental Expense Exclusions

No payment shall be made for the following:

1. Any professional fees whatsoever other than the fees of the dentist performing the treatment.
2. Dental fees incurred for any treatment:
 - i. Due to Sickness resulting from Occupational Disease. For this purpose the term "Occupational Disease" shall mean a disease for which such Employee or dependent with regard to whom a claim is submitted is entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation;
 - ii. Due to accidental bodily Injuries arising out of and in the course of such Employee's or dependent's employment; or
 - iii. Performed in a Hospital owned or operated by the United States Government, or elsewhere at Federal Government expense, or by a Dentist employed by the Federal Government; or for which the person is not required to pay; or any Federal, State or County Institution.
3. Expense Incurred for cosmetic purposes.
4. Dental Expenses Incurred for prosthetic devices, and the fitting thereof, which were ordered while the individual was ineligible.
5. Expenses Incurred for a lost or stolen appliance (bridgework and dentures).

6. Replacement of covered, full or partial, dentures more often than once every five years, or for replacement of existing, full or partial, dentures or bridgework installed less than five years prior to its replacement unless it is satisfactorily shown that the existing denture or bridgework cannot be made serviceable.
7. Charges which are not necessary, or charges which exceed Usual Customary and Reasonable Charges.

SECTION EIGHT – PRESCRIPTION DRUG BENEFITS

Express Scripts, Inc.

Benefits are available for drugs and insulin requiring a Physician's or dentist's prescription and dispensed by a registered pharmacist. Benefits are also available for covered diabetic supplies. This Benefit includes both retail pharmacies and a mail order service. A prescription filled at a retail pharmacy can provide medication for no more than 34 days per Co-Payment. A prescription filled through the mail order service can provide your medication for 90 days per Co-Payment.

Whenever appropriate, generic drugs will be used to fill prescriptions. If you prefer a brand name drug, you will be responsible for the difference in cost in addition to the Co-Payment amount. You must present your Omaha Construction Industry Health and Welfare Fund identification card to the pharmacist when obtaining a prescription at a participating pharmacy. Your identification card will identify Express Scripts, Inc. (ESI) as the Pharmacy Benefit Manager.

If the prescription or supply is purchased at a pharmacy not participating with ESI, you must file a claim with The Benefit Group (TBG) and you will be reimbursed at 75% of the allowable charge, less the applicable Co-Payment amount. If you have your prescription or supply filled at a participating pharmacy, but you do not present your ID Card, you must submit the claim directly to The Benefit Group (TBG) and Benefits will be provided at the same level as a nonparticipating pharmacy.

Benefits are not available under the Prescription Drug Benefit for the following items:

- Over-the-counter or non-prescription medications.
- Investigative drugs.
- Anti-rejection drugs (Benefits are available in Section Four, Major Medical Expense Benefit).
- Drugs or medicinals for treatment of fertility/infertility.
- Sexual arousal/erectile dysfunction agents including, but not limited to Viagra, Caverject, Muse and Alprostadil.
- Diet or appetite suppressants.
- Dietary supplements.
- Health or beauty aids.
- Non-prescription vitamins.

- Nicorette, Nicoderm, Prostep, Habitrol, or Nicotrol (or any other medication whose primary purpose is to treat addiction).
- Topical minoxidil.
- Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program.
- Home medical equipment, devices or supplies of any type including, but not limited to: ostomy supplies, contraceptive devices; therapeutic devices; or artificial appliances.

Benefit Limitations

- Dexedrine. This drug is covered through age 21. After age 21, preauthorization is required.
- Retin-A, Differin, Azelex and Renova. These drugs are covered through age 40. Preauthorization is required for anyone over the age of 40.
- IVIG requires preauthorization of Benefits.
- Regranex requires preauthorization of Benefits.
- Taxorac requires preauthorization of Benefits.

Preauthorization must be initiated in writing prior to the initial purchase. The preauthorization must be accompanied by documentation from the Covered Person's Physician. This written request should be directed to:

Express Scripts, Inc.
 PO Box 66773
 St. Louis, MO 63166

Express Scripts, Inc. will respond in writing advising the Physician and the Covered Person if the Benefits will be covered.

GENERIC DRUGS CAN SAVE MONEY!

GENERIC DRUGS ARE LABELED BY THEIR CHEMICAL NAME RATHER THAN A BRAND NAME. ALL DRUGS MUST MEET THE SAME GOVERNMENTAL STANDARDS FOR SAFETY AND EFFECTIVENESS.

WHY PAY MORE FOR A BRAND NAME IF ITS GENERIC TWIN IS AVAILABLE AT A LOWER COST? ASK YOUR PHYSICIAN TO PRESCRIBE GENERIC DRUGS WHENEVER POSSIBLE.

SECTION NINE – GENERAL PLAN EXCLUSIONS

The Plan provides Benefits only for those Medically Necessary Covered Services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS EXCLUDED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

Benefits **WILL NOT** be paid for or shall be limited as follows:

1. Services and supplies or days of care which are not Medically Necessary for the diagnosis or treatment of an Injury, Sickness or symptomatic complaint. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a Covered Charge, even though the service or supply is not specifically listed as an exclusion. The final determination of Medical Necessity remains with the Trustees.
2. Services not described as Covered Services in this Restated Plan Document and Summary Plan Description.
3. Services or procedures which are not customary and generally accepted by the medical profession and Services or procedures which are experimental or for the purpose of research.
4. Services and supplies for which the individual is not required to pay, or for which no charge would be made if this coverage did not exist.
5. Medical or Dental Benefits for 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; or any accidental bodily Injury or Sickness for which the Covered Employee, Retiree or Eligible Dependent is entitled to any benefits under any Workers' Compensation or Occupational Disease Law.

When a claim is made for Injuries or Sickness apparently sustained or arising out of or in the course of employment, which is covered by Workers' Compensation or similar legislation, the Plan will require the Covered Person to seek the appropriate remedy under such laws. A claim must be filed and a final ruling obtained from the Workers' Compensation court system. The Covered Person will

not be required to initiate an appeal of an adverse decision by the Workers' Compensation court or subsequent appeals court. Failure on behalf of the Covered Person to file for Workers' Compensation benefits where the Injury or Sickness appears to have arisen out of the course of employment shall constitute a forfeiture of any right under this Plan for Benefits.

Life Insurance and Accidental Death and Dismemberment Insurance Benefits will be paid for losses incurred in the course of employment.

6. Services provided in or by a Veterans Administration Hospital for a condition related to military service or in a non-participating hospital owned, operated or controlled by a government agency or hospital authorities, unless for care provided to a non-active duty Covered Person in a medical facility.
7. Services and supplies for diseases contracted or injuries sustained as a result, directly or indirectly, by war or act of war (declared or undeclared), sustained while performing military duties or the result of terrorism.
8. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, orthotics or impression casting for prosthetics and appliances, including prescription therefore.
9. Orthotics for the feet, which include such devices as foot supports and arch or heel supports.
10. Any Service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character or for convalescent or custodial services, when the constant attention of trained medical personnel is not required.
11. Services or procedures which are not customary and generally accepted by the medical profession and Services or procedures which are experimental or for the purpose of research.
12. Services or supplies provided for, or related to sex transformation surgery or sexual dysfunction or inadequacies.
13. Services, procedures, supplies or drugs provided for treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.
14. Eye examinations, eye refractions, eye exercises or visual training or therapy (orthotics); eyeglasses or contact lenses, except as covered under Major Medical Expense Benefit.
15. Routine hearing tests and audiograms that are not performed in connection with an Sickness, Injury or medical condition.

16. Services provided :
 - a. To or for anyone who doesn't qualify as an Eligible Dependent; or
 - b. Anyone before the effective date of coverage, or
 - c. After the effective date of cancellation or termination.
17. Therapy which is primarily of a recreational or educational nature; including music therapy, work-hardening therapy; pre-vocational training or forms of non-medical self-care or self-help training; including any related supplies or diagnostic testing.
18. Loss suffered for which the contributing cause was the Covered Person's commission of or attempt to commit a felony or the Covered Person's engaging in an illegal occupation.
19. Dietary counseling, treatment and diagnostic procedures primarily for obesity or for weight reduction, regardless of diagnosis, except covered surgical operations excluding bariatric surgery.
20. Maternity or obstetrical care Services for a dependent daughter.
21. Services for voluntary abortions, unless the attending Physician certifies that the abortion is necessary to safeguard the life of the covered mother, or that the unborn child's viability was threatened by continuation of the pregnancy. Benefits will be payable for any complications which are a result of an elective abortion.
22. Fertility testing, diagnosis, evaluation and treatment. This shall include, but is not limited to, any procedure, treatment or drug designed to facilitate the production or transit of the ovum and/or sperm or the implantation of the fertilized ovum; or evaluation and treatment of ovarian or tubal dysfunction, pelvic adhesions, endometriosis, dysmennorrhoea or menstrual disorder when the purpose is to facilitate the production or transit of the ovum and/or sperm or the implantation of the fertilized ovum;
23. Artificial insemination, in vitro fertilization and embryo transfer procedures.
24. Services provided for, or related to the reversal of voluntary sterilization.
25. Genetic treatment or engineering. This includes any Services performed to alter or create changes in genetic or chromosomal structure.
26. Tooth extractions, (with the exception of boney impactions), or other dental work or surgery which involves any tooth or tooth structure, alveolar process, abscess

- or periodontal disease or diseases of the gingival tissue except as otherwise provided under the Dental Expense Benefit, or when treatment is provided within 120 days following an accidental Injury to the jaw, sound natural teeth, mouth or face.
27. Any expense or charge for dental work or surgery including appliances or adjustment of occlusion for TMJ (temporomandibular joint dysfunction).
 28. Repairs, maintenance or adjustment of home medical equipment, except as previously described in Section Four Major Medical Expense Benefit, or repairs, maintenance or adjustment for home medical equipment by persons other than a medical supply company.
 29. Alternative Treatments as defined by the Office of Alternative Medicine of the National Institutes of Health. Examples of some treatments not covered are acupuncture, aromatherapy, hypnotism, massage therapy and rolfing.
 30. Treatment for behavioral, conduct and impulse control disorders.
 31. Charges for personal care items that are primarily for personal comfort or convenience, including, but not limited to, diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, incontinence pads, ramps, snug seats, recreational items, home or automobile purchases, renovations or improvements, home appliances, spas, wigs and braces for sports.
 32. Personal expenses while hospitalized, such as guest meals, TV rental and barber services.
 33. Equipment for purifying, heating, cooling or otherwise treating air or water.
 34. Charges for implantable spinal column stimulator, ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 27, is NOT a covered Benefit. Any nondurable supplies related to equipment that is not covered will also not be a covered Benefit.
 35. Services and supplies for cosmetic purposes, including cosmetic surgery designed primarily to improve or enhance the appearance of normal or of abnormal structures without having a significant impact on the function of that structure. Covered reconstructive surgery is Medically Necessary surgery designed to improve the function of abnormal structures, including those caused by Sickness, Accident, covered surgery or congenital malformation where there are objective functional defects. The presence of a psychological or emotional condition by itself does not make a surgical procedure reconstructive.

Examples of excluded cosmetic surgery include but are not limited to removal of excess skin or tissues, augmentation procedures, liposuction, scar removal and cosmetic use of Botox. Examples of covered reconstructive surgery include treatment of severe burns, repairs of the face or extremities following an Accident or correction of birth defects in a child that cause a functional defect. In addition, in accordance with the Women's Health and Cancer Rights Act, the Plan provides Benefits for reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications for all stages of mastectomy, including lymphedemas.

36. Services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea for correction of myopia and/or astigmatism, including radial keratotomies. (Benefits are not available for eyeglasses or contact lenses following such procedures.)
37. Treatment of hair loss including wigs, toupees, hairpieces, hair implants or transplants and drugs to treat hair loss.
38. Home Health Care except as provided for under the Hospice Benefit. The following are examples of excluded Services:
 - a. Visiting teachers, friendly visitors, vocational guidance and other counselors, and Services related to diversional occupational and social activities,
 - b. Services rendered by registered or licensed practical nurses, other health professionals and other allied health workers who are not employed by or functioning pursuant to a contractual arrangement with a Community or Hospital Home Health Care Agency, and
 - c. Services provided to persons who are not essentially homebound for medical reasons.
39. Over-the-counter drugs, including non-prescription vitamins.
40. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.
41. Physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility, and diversion or general motivation.
42. Growth hormone medications and similar biopharmaceuticals.

43. Blood, blood plasma or blood derivatives or fractionates; or Services by or for blood donors; except administration charges for blood furnished to a Hospital by the American Red Cross or county blood bank or other organization not charging for blood and used for a Covered Person.
44. Services for medical treatment and/or drugs, (whether compensated or not) which are directly related to or resulting from a Covered Person's participation in a voluntary, investigative test or research program or study.
45. Hospital or Physician charges for standby availability.
46. Charges for routine or periodic physical examinations or for screening purposes, except as otherwise provided under the Plan.
47. Expenses Incurred for lodging or travel, even though prescribed by a Physician, for the purpose of obtaining medical treatment.
48. Charges made for filling out claim forms or furnishing any other records or information or special charges such as dispensing fees, admission charges, Physician's charges for Hospital discharge Services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service. Charges for telephone consultations or missed appointments.
49. Interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or home medical equipment, other than those surcharges or assessments made directly upon Employers or third party payers.
50. Charges made while the patient is temporarily out of the Hospital.
51. Programs of co-dependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. In addition, Benefits are not available for residential or day rehabilitation Services for mental illness.
52. Expenses Incurred for alcohol or drug addiction, treatment or rehabilitation.
53. Expenses for treatment incurred as a result of a self-inflicted Injury, Sickness or other condition or attempt at self-destruction unless the Injury is in connection with a Medical Condition (except for Death Benefit). The term "Medical Condition" means any condition, whether physical or mental, including, but not limited to, any condition resulting from Sickness, Injury (whether or not the Injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

54. Hospital, medical or surgical treatment provided for or by the U.S. Government or any agency thereof. Services available at government expense, except if payment is required by state or federal law, the obligation to provide Benefits will be reduced by the amount of payments a Covered Person is eligible for under such program (except Medicaid); or for persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide Benefits will be reduced by the amount of payment or Benefits such person receives from Medicare. This provision will not apply if the Employee is still actively at work and has elected this Contract as primary. Services provided for renal dialysis and kidney transplant Services will be provided pursuant to federal law.
55. Services provided by a member of your immediate family (by blood, marriage or adoption).
56. Services required by an Employer as a condition of employment, including, but not limited to immunizations, blood testing, work physicals and drug tests.
57. Services by a health care provider which are not within his or her scope of practice, or charge by a person who is not an approved provider.
58. Charges in excess of Usual, Customary and Reasonable Fees.
59. Services for allogeneic or autologous bone marrow transplants not specifically covered under the Organ and Tissue Transplant Benefit on page 30.
60. Organ or tissue transplant donor expenses.
61. The reduction or elimination of snoring, unless Medically Necessary.
62. Services for Injury caused directly or indirectly from sky diving, competitive auto or sport car racing, or motorcycle racing.
63. Treatment of complications resulting from non-covered care.

SECTION TEN – CLAIMS AND APPEAL OF DENIED CLAIMS PROCEDURES

A written notice of Injury or Sickness upon which a claim may be based **MUST** be given to the Preferred Provider Organization (PPO) within **one year** of the date of the commencement of the first loss for which Benefits arising from the Injury or Sickness may be claimed. **FAILURE TO PROVIDE SUCH NOTICE WILL RESULT IN DENIAL OF THE CLAIM.** Employees should contact the Fund Office for the address of the PPO. Notice given by or on behalf of a Claimant to the Plan, at the Fund Office with the following information will be deemed to be a satisfactory notice to the PPO and Plan:

1. The name of the Covered Employee,
2. The Covered Employee's Social Security number,
3. The Covered Employee's address,
4. The name of the Eligible Dependent, if the claim is for a dependent,
5. The age and Social Security number of the Eligible Dependent, if the claim is for a dependent.

In the case of a continuing loss, written proof of loss must be furnished to the Fund Office within 90 Days after the termination of a period for which the Plan is liable for Benefits. In the case of a claim for any other loss, written proof of loss must be furnished to the Fund Office within one year after the date of such loss.

Upon presentation of proper proof, Benefits for loss of life, if any, will be paid to the Covered Employee's Beneficiary, if surviving the Covered Employee; or, if none, to the Covered Employee's estate, in the same manner as to any other Beneficiary. Any payment made by the Plan in good faith shall fully discharge the Plan from any further obligation.

The Plan has the right and opportunity to have a Physician of the Trustees' choosing examine the person whose Injury or Sickness is the basis of a claim when and so often as it may reasonably be required during the pendency of a claim.

The Trustees have the full authority and sole discretion to determine all questions concerning the nature of, amount and duration of Benefits to be provided based upon an estimate of what the Fund can provide without depletion or excessive accumulation, provided: however, no Benefits other than Medical, Life and Dental and related Benefits may be provided for or paid under the Plan.

The Board of Trustees or its Committees shall have the authority and sole discretion to interpret, construe and apply all terms of the combined Plan Document and Summary Plan Description, the Amended Trust Agreement and/or any rules and regulations

established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of Benefits, in reaching a decision on the Claimant's request for review of the denial of the claim.

How to File a Claim

Claim forms and instructions may be obtained from The Benefit Group (TBG). If possible, call TBG at (402) 964-9900 or toll free at (800) 326-0004 to request a claim form a few days before you or your dependent will need the form. In the case of a medical emergency, please have the Hospital or a relative call as soon as possible. Please make sure that the person making the call can provide the following information:

1. Your full name and address,
2. Your Social Security number, and
3. The full name of the patient.

The claim form is to be completed by you and the attending Physician and returned to TBG. If you wish for the Plan to pay the Benefits directly to the provider of Services, **you must complete the "Assignment of Benefits" section on the claim form or request a separate form from the provider of Services.** To complete the claims payment, the Fund Office must have the following:

1. The completed claim form,
2. An itemized statement from the Hospital, if you were confined,
3. An itemized surgery bill, if surgery (**In or Out-Patient**) was performed,
4. A completed Assignment of Benefits,
5. Bills for ambulance radiology or anesthesia charges involved with the claim,
6. If eligible for Medicare, a copy of the "Explanation of Medicare Payments" along with the claim form.

Prompt processing of your claim for Benefits is dependant upon your returning the completed claim form along with all of the required bills.

**USE THE CORRECT CLAIM FORM AND PROVIDE ALL
REQUESTED DATA TO AVOID DELAYS IN CLAIMS PROCESSING.**

OUR EXPERIENCE INDICATES THAT ONE OF THE MAJOR REASONS FOR A DELAY IN THE PROCESSING OF CLAIMS IS THE FAILURE ON THE PART OF THE EMPLOYEE TO USE THE CORRECT FORM OR TO PROVIDE ALL OF THE INFORMATION REQUESTED ON THE FORM.

BEFORE YOU MAIL A CLAIM, make sure that you have the correct form. If you are not sure, call the TBG.

TAKE TIME TO REVIEW THE FORM BEFORE YOU MAIL IT to make sure that every question is answered. Be sure and attach the original bills or receipts to support the claim. Do not send copies of statements, bills, receipts or canceled checks, as these will **NOT** be considered for payment.

YOU SHOULD KEEP A COPY OF ANYTHING YOU SUBMIT TO THE FUND OFFICE FOR YOUR RECORDS.

Each bill should clearly indicate the name of the patient, the date the service was performed, the diagnosis and a complete breakdown of all charges.

REMEMBER: Filing a claim is **NOT** complicated. However, it does require that you follow certain specific procedures and provide all information requested on the form. Compliance with these instructions will save you time and assure prompt processing of your claim. If you need any assistance in completing the claim form, please call the Fund Office.

Your claim will be reviewed by the claims administration staff at TBG and will be approved or denied within the time periods listed in Subsection B, titled **Time Periods for Initial Determination**, beginning on page 61, unless special circumstances require additional time for processing. All decisions of the claims administration staff are subject to final review by the Board of Trustees.

Procedure for Initial Benefit Determinations, Notices of Denial of a Claim and How to Appeal a Denial of a Claim for Benefits

ALL PROCEDURES DESCRIBED IN THIS SECTION MUST BE FOLLOWED AND EXHAUSTED BEFORE A CLAIMANT MAY INSTIGATE ANY LEGAL ACTION. FAILURE TO NOT FOLLOW AND EXHAUST ALL PROCEDURES MAY RESULT IN A NEGATIVE RULING AND MAY IMPAIR OR CAUSE THE LOSS OF THE RIGHT TO BRING ANY FURTHER LEGAL ACTION.

The following procedure to process claims and appeals will apply to any claim filed with the Omaha Construction Industry Health and Welfare Plan (Fund). These procedures have been adopted to comply with regulations issued by the U.S. Department of Labor, at 29 CFR 2560.503.1. For all claims filed prior to the date of this Restated Plan Document and Summary Plan Description, procedures are on file with the Fund Office.

The Board of Trustees (Board) is both the Plan Administrator and the fiduciary responsible for all benefit determinations on appeal. The Board may delegate all fiduciary responsibility for claims determination to an Appeal Committee (Committee). Such Committee shall meet once each calendar quarter at regularly scheduled times.

The Board or Committee shall have the authority to interpret, construe and apply all terms of the Summary Plan Description and Plan Document, the Trust Agreement and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of Benefits, in making an initial benefit determination and a determination on appeal.

A. Definitions

1. Medical Claim

A **“Medical Claim”** is a written or Health Insurance Portability and Accountability Act (HIPAA) compliant electronic post-service request for payment of Benefits from the Fund:

- a. Made by a Claimant,
- b. Received by the Fund Office or applicable PPO within 18 months of the date of service, and
- c. Includes all of the following:
 - i. Participant’s Name,
 - ii. ID Number,
 - iii. Address,
 - iv. Patient Name/Date of Birth/Relationship to Participant,
 - v. Claimant authorization to pay/or not,
 - vi. ICD-9 diagnosis code,
 - vii. Date of Service,
 - viii. Place of Service,

- ix. CPT procedure codes,
 - x. Charges,
 - xi. Provider Federal ID Number, Name and Address, and
 - xii. Patient account number.
- d. A claim is **NOT**:
- i. A verbal inquiry about whether a specific service is a covered benefit.
 - ii. A voluntary pre-service determination of whether a treatment, service or product is covered.
 - iii. An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.
 - iv. An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Claimant to file a claim after the denial.
2. Disability Claim
A **“Disability Claim”** is a claim for benefit by an active eligible Employee for the Accidental Death & Dismemberment Benefit described in Section Five, or a claim for the Weekly Loss of Time Benefit described in Section Six.
3. Claimant
A **“Claimant”** is:
- a. An eligible Participant in the Fund,
 - b. An Eligible Dependent, or
 - c. The duly appointed Authorized Representative of an eligible Participant or Eligible Dependent, as described below.
4. Authorized Representative
An **“Authorized Representative”** is a person who is specially designated by a Claimant to represent the Claimant in respect to a claim for Benefits or an appeal of a denied claim. In order to designate an Authorized Representative, the Claimant must present to the Fund Office a written

statement designating an Authorized Representative. For your convenience, a “Designation of Authorized Representative” form is available at the Fund Office. The statement must include:

- a. The name, telephone number and mailing address of the Authorized Representative,
- b. The name, mailing address, date of birth and Social Security number of the Claimant, and
- c. The signature of the eligible Participant or, in the case of an Eligible Dependent, the individual or a minor child’s parent or legal guardian.

The Board of Trustees has the sole discretion to determine whether a Claimant has properly designated an Authorized Representative.

Assigning a health care provider the right to receive Benefits does not make the provider an Authorized Representative. Any individual wishing to designate a health care provider as an Authorized Representative must provide the Fund Office with a separate written statement designating the provider as such. For your convenience, a “Designation of Authorized Representative” form is available at the Fund Office.

If a Claimant has designated an Authorized Representative, the Authorized Representative will receive all information and notifications, and will be authorized to act on behalf of the Claimant, with respect to all aspects of the claim. This includes, but is not limited to, the initial determination, requests for documents, appeals, and any other communication regarding the claim. The authorization will remain in effect unless or until the Claimant provides the Fund Office with written notification that restricts or cancels the authorization.

5. Days
“**Days**”, for purposes of computing any time period under this Section, shall mean calendar days.

B. Time Periods for Initial Determination

1. Medical Claims
The Fund will make its initial benefit determination within 30 Days of receipt of the claim. The Fund may extend this initial benefit determination period 15 additional Days. The Fund will notify the Claimant within the first 30 Days, if an extension will apply. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include

a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

2. **Disability Claims**

The Fund will make its initial determination within 45 Days. The Fund may extend this initial benefit determination up to two times. These extension periods may be up to 30 Days each. The Fund will notify the Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

C. **Notice of Initial Determination**

The Fund will issue a written or HIPAA compliant electronic notice of benefit determination, which may be a denial of Benefits, also know as an adverse benefit determination. This notice is also called an “Explanation of Benefits”, or EOB. This notice will contain:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific benefit provisions on which the determination is based.
3. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Fund’s review procedures and the time limits applicable to such procedures, including a statement of the Claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request.
6. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant’s medical circumstances shall be provided to the

Claimant, or a statement that such explanation will be provided free of charge upon request.

D. Time Periods for Appeals – Medical and Disability Claims

A request for review (an appeal) must be submitted in writing to the Fund Office no later than 180 Days after Claimant's receipt of the notice of adverse Benefits determination. The Board of Trustees may delegate to an Appeal Committee the authority to make all benefit determinations on appeal. The Fund shall issue a benefit determination on appeal no later than the next regularly scheduled quarterly meeting of the Appeal Committee of the Board of Trustees. Except that if the appeal is received by the Fund less than 30 Days before the next quarterly Appeal Committee meeting, a benefit determination on appeal shall be made no later than the second quarterly committee meeting after the receipt of the appeal. In addition, if, due to circumstances beyond the control of the Fund, a decision still cannot be made by that time, the Fund may extend the period to make a determination until the next quarterly meeting. If the Claimant requests a hearing, a benefit determination shall be made no later than the third Appeal Committee meeting after receipt of the appeal.

The Fund shall issue its decision no later than five Days following the benefit determination.

E. Claimant's Rights on Appeal

The following rules govern the Claimant's rights on appeal:

1. As stated in Subsection D above, a Claimant shall have at least 180 Days following receipt of a notification of an adverse benefit determination within which to appeal the determination.
2. The review on appeal shall not give deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.
3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who had appropriate training and experience in the field of medicine involved in the medical judgment.
4. The Plan shall provide to Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in

connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

5. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under Paragraph 3 of this Subsection E shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
6. The written decision of the Appeal Committee shall be final, binding and conclusive upon the Claimant.
7. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action including an action or proceeding before any court, administrative agency or arbitrator (legal body). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

F. Content of Notice of Benefit Determination on Appeal

The Plan Administrator will provide a Claimant with written or electronic notification of the Fund's benefit determination on review. Any electronic notification shall comply with the standards imposed by law. In the case of an adverse benefit determination, the notification will include the following, in a manner that is understood by the Claimant:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific benefit provisions on which the determination is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claims for Benefits.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; or

5. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.
6. A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

G. Hearing Procedure

The Board of Trustees establishes the following procedures for hearings:

1. The Claimant and/or duly Authorized Representative shall be afforded an opportunity to appear before the Appeal Committee and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the claim.
2. The proceeding of the hearing shall be preserved by means of tape recordings, stenographic or court reporter's records.
3. In conducting the hearing, the Appeal Committee shall not be bound by the usual common law or statutory rules of evidence.
4. The Claimant or Authorized Representative shall have the right to review the tape recording of the hearing, obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to. The cost of copies or documents shall be 25¢ per page. The tape recording will be furnished for the actual cost of the tape cassette.
5. There shall be copies made of all documents and records introduced at the hearing, and the copies shall be attached to the record of the hearing and made a part thereof. Instead of attaching copies of the documents and records, reference may be made to them on the tape recording, and the tape recording and the copies shall be retained on the Claimant's file.
6. All information upon which the Appeal Committee bases its decision shall be disclosed to the Claimant or Authorized Representative at the hearing or in written decision.

SECTION ELEVEN – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- A. This section of the Plan is effective April 14, 2003, is adopted to effect compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued thereunder by the Secretary of Health & Human Services concerning the privacy of protected health information (together referred to herein as The Privacy Rule). The Privacy Rule is incorporated herein by reference.
- B. All capitalized terms have the meaning as stated in this combination Plan Document and Summary Plan Description or The Privacy Rule.
- C. This section establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees. The Board of Trustees is the Plan Administrator under the Employee Retirement Income Security Act of 1974 (ERISA).
- D. PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows:
 - 1. Underwriting and budgeting;
 - 2. Claims review and processing;
 - 3. Amending or modifying the Plan of Benefits (plan design);
 - 4. Claims assistance;
 - 5. Eligibility review;
 - 6. Any and all general administration of the Plan.
- E. PHI may be disclosed to the Board of Trustees, or individual Trustees as authorized by an individual.
- F. The Omaha Construction Industry Health and Welfare Plan shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.
- G. The Board of Trustees:
 - 1. Shall not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law.
 - 2. Shall comply with verification procedures of the group health plan.

3. Shall ensure adequate separation between the group health plan and the Plan Sponsor as follows:
 - a. Describe those Employees or classes of Employees or other persons under the control of the Plan Sponsor to be given access to the PHI to be disclosed, provided that any Employee or person who receives PHI relating to treatment, payment under, health care operations of, or other matters pertaining to the group health Plan in the ordinary course of business must be included in such description;
 - b. Restrict the access to and use by such Employees and other persons described in paragraph (G)(3)(a) of this Section to the Plan administration functions that the Plan Sponsor performs for the group health Plan; and
 - c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (G)(3)(a) of this Section with the Plan Document provisions required by this paragraph.
4. Shall not use or disclose PHI for employment related decisions.
5. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
6. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual or pursuant to a Business Associate contract.
7. Report to the Plan any use or disclosure of the information that is inconsistent with the allowed uses or disclosures of which it becomes aware.
8. Make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.
9. Make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporate any amendments to PHI in accordance with HIPAA.
10. Make available to the Plan the information required to provide an accounting of disclosures.

11. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and
 12. Return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- H. Each Trustee shall certify compliance with the Privacy Rule and the Privacy Policy of the Omaha Construction Industry Health and Welfare Plan.
- I. Effective April 21, 2005, the Board of Trustees Plan Sponsor shall:
1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
 2. Ensure that the adequate separation required by §164.504(f)(2)(iii) of the Privacy Rule is supported by reasonable and appropriate security measures;
 3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
 4. Report to the Plan any security incident of which it becomes aware.

SECTION TWELVE – ADMINISTRATIVE INFORMATION

The following topics are discussed under this Section on Administrative Information:

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| A. Coordination of Benefits | F. Reciprocity and Portability |
| B. Determination of Benefits | G. Termination of Plan |
| C. Employer Rights to Contributions | H. Right to Release or Request Information |
| D. Encumbrance of Benefits | I. Subrogation of Benefits |
| E. Facility of Payment | |
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A. Coordination of Benefits

The following rules govern the Coordination of Benefits:

1. Applicability

This Coordination of Benefits (COB) provision applies to This Plan when a Participant or a Participant's Eligible Dependent has health care coverage under more than one plan. "This Plan" and "Another Plan" are defined below.

If this COB provision applies, the Order of Benefit Determination Rules, in Number 3 below should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of Another Plan. The Benefits of This Plan:

- a. Will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before Another Plan; but
- b. May be reduced when, under the Order of Benefits Determination Rules, Another Plan determines its Benefits first. The above reduction is described in Subsection D, "Effect of the Benefits of This Plan".

2. Definitions

- a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in

terms of generally accepted medical practice, or as specifically defined in This Plan.

When a plan provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When Benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

- b. **“Another Plan”** is any of the following which provides Benefits or services for, or because of, medical or dental care or treatment that is not Omaha Construction Health and Welfare Plan:

Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school Accident-type coverage.

Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under a. or b. above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- c. **“Claim Determination Period”** means a calendar year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- d. **“Primary Plan/Secondary Plan”** is determined using The Order of Benefit Determination Rules.

When This Plan is a Primary Plan, its Benefits will be determined before those of Another Plan and without considering Another Plan’s benefits.

When This Plan is a Secondary Plan, its Benefits will be determined after those of Another Plan and may be reduced because of Another Plan’s benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan to one or more other plans, and may be a Secondary Plan to a different plan or plans.

- e. **“This Plan”** is Omaha Construction Industry Health and Welfare Plan.

3. Order of Benefit Determination Rules

a. General

When there is a basis for a claim under This Plan and Another Plan, This Plan shall be Secondary Plan which has its benefit determined after those of Another Plan, unless:

- i. The other Plan has rules coordinating its benefits with those of This Plan; and
- ii. Both those rules and This Plan’s rules, in Subsection b. below, require that This Plan’s Benefits be determined before those of the other plan.

b. Rules

This Plan shall determine its order of Benefits using the **first** of the following rules that apply:

i. Non-Dependent/Dependent

The benefits of the plan which covers the person as an Employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is Secondary to the plan covering the person as a dependent and Primary to the plan covering the person as other than a dependent (e.g. a retired Employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

ii. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph iii. below, when This Plan and Another Plan cover the same child as a dependent of different persons, called “parents”, the benefits of the plan of the parent whose birthday (month and day) falls earlier in a year shall be determined before those of the plan of the parent whose birthday (month and day) falls later in that year. But if both parents have the same birthday (month and day), the benefits of the plan which covered one parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this Paragraph ii., but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

iii. Dependent Child/Separated or Divorced

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined in this order:

- (a) First, the plan of the parent with custody of the child;
- (b) Then, the plan of the spouse of the parent with the custody of the child; and
- (c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan shall be determined first. The plan of the other parent shall be the Secondary Plan. This Paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

iv. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph ii. above.

v. Active/Inactive Employee

The benefits of a plan which covers a person as an Employee who is neither laid off nor retired shall be determined before those of a plan which covers that person as a laid off or retired Employee. The same is true if a person is a dependent of a person covered as a Retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vi. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under Another Plan, the following will be the order of benefit determination:

- (a) First, the benefits of a plan covering the person as an Employee, member or subscriber (or as that person's dependent);
- (b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vii. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered the Employee, member or subscriber longer will be determined before those of the Plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan

The following rules govern the effect on the Benefits of these COB rules:

a. When this Section Applies

This Section 4 applies when, in accordance with Section 3 "Order of Benefits Determination Rules", This Plan is a Secondary Plan as to one or more other plans. In that event the Benefits of This Plan may be reduced under this Section. Such other plan or plans are referred to as "Another Plan" in Subsection b., ii., immediately below.

b. Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

- i. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, and
- ii. The benefits that would be payable for the Allowable Expenses under Another Plan, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under Another Plan do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

c. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts it needs. To the extent allowed under law, This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this, unless required to do so by law. Each person claiming Benefits under This Plan must give any facts This Plan needs to pay the claim.

d. Facility of Payment

A payment made under Another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing Benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

e. Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of:

- i. The persons it has paid or for whom it had paid,
- ii. Insurance companies, or
- iii. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

B. Determination of Benefits

The Trustees have full authority and sole discretion to make determinations of entitlements to and amounts of Benefits. Subject to the right of appeal, the determination shall be final and binding upon all parties claiming Benefits under the Plan.

C. Employer Rights to Contributions

Except in the case of mistaken contributions, the Employers shall have no right, title or interest in the contributions made by them to the Fund and no part of the Fund shall revert to the Employers in the event of a termination of the Fund.

D. Encumbrance of Benefits

No monies, property or equity of any nature whatsoever in the Fund, policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through a Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause any benefit to be subject thereto shall be null and void; provided however, that Benefits may be assigned by the Covered Person or Beneficiary to the health care provider who furnished the Services or supplies for which a benefit is payable.

E. Facility of Payment

Whenever payments which should have been made under This Plan in accordance herewith have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other organization making such payments any amounts which they determine to be warranted in order to satisfy the intent of this provision. Any amounts paid shall be deemed to be Benefits paid under this Plan and the Trustees shall be fully discharged from any future liability.

F. Reciprocity and Portability

The Trustees may enter into or amend portability or reciprocity agreements with other welfare funds.

G. Termination of Plan

The Benefits provided under this Plan are NOT vested benefits and the Trustees have the authority to terminate any Benefit, including Retiree Benefits, or the entire Plan, at any time.

In the event of termination of the Plan, the Trustees shall apply the Fund to pay or provide the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Fund. No part of the corpus or income of the Fund will be used for or diverted to purposes other than for the expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will any portion of the corpus or income of the Fund, directly or indirectly, revert to or accrue to the benefit of the Employers, the Association or the Union.

H. Right to Release or Request Information

For the purpose of determining the applicability and implementing the Coordination of Benefits and/or Subrogation provisions or any similar provisions in other plans, to the extent allowed by law, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem necessary for such purposes. In so acting the Trustees shall be free from any liability that may arise in relation to such action. Any person claiming Benefits

under this Plan must furnish such information as the Trustees may reasonably deem necessary in order to implement this provision.

**THE TRUSTEES WILL HAVE NO OBLIGATION
TO FURNISH ANY BENEFIT UNDER THE PLAN
UNTIL ALL ADDITIONAL INFORMATION
REQUESTED HAS BEEN RECEIVED.**

I. Subrogation of Benefits

For this Section regarding subrogation only, the term “**Injured Person**” shall mean an eligible Participant (Employee or Eligible Dependent), or the heir, guardians, personal representatives or other representative of such Employee, spouse or child.

1. Personal Injury Claims

In the event the Fund pays or is obligated to pay Benefits on behalf on an Injured Person as defined above, for Sickness or Injury to the Injured Person and the Injured Person has any right of recovery from any other person, corporation, insurance carrier or governmental agency arising out of that Sickness or Injury, the Fund will be subrogated to all of the Injured Person’s right of recovery against such person, corporation, insurance carrier or governmental agency to the full extent of payments made by the Fund or for which the Fund is obligated to pay. The Fund does not recognize the “common fund” rule, the “make-whole” doctrine or any other related doctrines or any attorneys fee offset or deduction. To the extent that the doctrine of subrogation does not apply, the Fund reserves the right to seek reimbursement from the Injured Person.

2. Workers Compensation Claims

In the event the Fund pays or is obligated to pay Benefits on behalf of an Injured Person and the Injured Person institutes a claim or cause of action against his or her Employer under the provisions of any Workers’ Compensation Law or regulation, the Fund will be subrogated to all of the rights of recovery of the Injured Person to the full extent of the amount of Benefits paid by the Fund from any and all sums of money recovered by the Injured Person or person acting on his or her behalf, as a result of said Workers’ Compensation claim or cause of action.

3. Rights and Obligations

The Injured Person, or if a minor, the Injured Person’s parent or legal guardian, shall execute and deliver such documents and papers (including, but not limited to a Subrogation Agreement) to the Fund as the Fund may require. The Injured Person will do whatever else is necessary to secure the rights of the Fund, including allowing the intervention by the Fund or the joinder of the Fund in any claims or action against the responsible party or parties.

The Injured Person, or any person acting upon his or her behalf, shall on request, provide the Fund with information the Fund deems necessary to pursue and protect its right of subrogation and shall do nothing to prejudice the Fund's right of subrogation. The Fund shall not be responsible for expenses or fees incurred in connection with any recovery unless the Fund has agreed, in writing, prior to settlement or trial, to pay a portion of those expenses or fees. The Fund does not recognize the "common fund" rule, the "make-whole" doctrine or any other related doctrines or any attorneys fee offset or deduction. To the extent that the doctrine of subrogation does not apply, the Fund reserves the right to seek reimbursement from the Injured Person.

In the event of any failure or refusal by the Injured Person to execute the Subrogation Agreement or any other document requested by the Fund, or to take any other action requested by the Fund to protect the interest of the Fund, the Fund shall withhold payment of Benefits or deduct the amount of any payments made from future claims of the Injured Person. The Injured Person will take no action which will or may prejudice the rights of the Fund.

In the event the Injured Person recovers any amount by settlement or judgment from or against the other person, corporation, insurance carrier or governmental agency, the full amount of Benefits paid by the Fund shall be repaid to the Fund; and no further Benefits for treatment or Services related to the Injury leading to the settlement or recovery will be paid by the Fund.

If the Injured Person refuses or fails to repay such amount, then, in that event, the Fund will be entitled to recover such amounts from the Injured Person (including Fund's attorneys' fees and costs) by instituting legal action against the Injured Person and/or deducting such amounts from future claims submitted by the Participant and Eligible Dependents.

If the Injured Person, or person acting upon his or her behalf, does not attempt a recovery of the Benefits paid by the Fund or for which the Fund may be obligated, the Fund will be entitled to institute legal action against the responsible party or parties in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to or on behalf of the Injured Person.

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

The Fund reserves the right to reduce the amount of the Fund's recoverable interest where circumstances warrant such reduction.

4. Example of Subrogation Procedures

While walking across the street, Mr. Jones is struck by an automobile driven by Mr. White. Mr. Jones submits his claim to the Omaha Construction Industry Health and Welfare Plan for payment and the Fund pays \$1,000 in Benefits for medical and Hospital expenses. Mr. White or his automobile liability insurance company is liable for Mr. Jones' damages including his medical and Hospital expenses. The Fund will contact Mr. Jones and he will be requested to sign an Assignment Form and/or a Subrogation Agreement. The Fund will request the payment of the \$1,000 from Mr. White or his automobile insurance carrier. If Mr. Jones files a claim or action against Mr. White or his insurance carrier, the Fund may intervene or join in the action. If Mr. Jones does not file such a claim or action, the Fund may file a claim or action in its own name for the amount of the Benefits paid. If Mr. Jones settles his claim or suit against Mr. White, the Fund will request repayment of the \$1,000. Should Mr. Jones refuse to reimburse the Fund for the Benefits paid, the Fund may sue Mr. Jones for the Benefits paid or that amount will be deducted from any future claims Mr. Jones or his Eligible Dependents may submit.

SECTION THIRTEEN - PLAN INFORMATION

One of the main goals of the Employee Retirement Income Security Act of 1974 (ERISA) is expanded reporting and disclosure of benefit Plan operations and provisions, that is, reporting to the Department of Labor, Internal Revenue Service and to the Plan Participants and Beneficiaries.

It is the intention of the Trustees to comply with all aspects of ERISA. Thus, the required information in this Section has been reported to the appropriate federal agencies and is hereby “disclosed” to you.

A. Administration of Plan

The Plan Sponsor and Plan Administrator is the Joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association. The names and addresses of the Trustees are listed on page 81. The Board, together with such persons or firms to whom authority for administering the Plan has been delegated, is responsible for managing the Plan and interpreting its provisions. You may contact the Fund Office at:

Omaha Construction Industry Health and Welfare Plan
Westwood, Plaza, Suite 80
12165 West Center Road
Omaha, Nebraska 68144-3980
Telephone: (402) 330-2060

The Trustees have hired an Administrative Manger to perform the day-to-day operations of the Plan, such as maintaining records, making benefit payments and handling general administrative matters. You may contact the Administrative Manager at the address and telephone numbers above.

B. Employer Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is 36-6441012.

C. Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings of the Plan are accumulated in a Trust Fund which is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

D. Name of Plan

The full legal name of the Plan is the Omaha Construction Industry Health and Welfare Plan.

E. Agent for Service of Legal Process

Deborah S. Morris, Administrator
Omaha Construction Industry Health and Welfare Plan
Westwood, Plaza, Suite 80
12165 West Center Road
Omaha, Nebraska 68144-3980
Telephone: (402) 330-2060

Service may also be made on any Plan Trustee or Plan Administrator.

F. Plan Advisors

Fund Attorneys

Dean G. Kratz
McGrath, North, Mullin & Kratz
First National Tower, Suite 3700
1601 Dodge Street
Omaha, Nebraska 68102

John Corrigan
Dowd, Howard & Corrigan
1411 Harney Street
Omaha, Nebraska 68102

Plan Consultant and Plan Actuary

United Actuarial Services, Inc.
11590 North Meridian Street, Suite 610
Carmel, IN 46032

G. Plan Fiscal Year

The Plan Fiscal Year begins January 1 of each year and ends on December 31 of the same year.

H. Plan Number

The Plan Number is 501.

I. Plan Year

The Plan Fiscal Year begins January 1 of each year and ends on December 31 of the same year.

J. Sources of Contributions

This Plan is funded through contributions by the Employers on behalf of their Employees, under the terms of a Collective Bargaining Agreement, and by investment income earned on a portion of the Fund's assets. In some cases, a Covered Person will be entitled to make self-payments in order to maintain eligibility for Benefits.

K. Type of Plan

This Plan provides hospitalization, medical, life, accidental death and dismemberment, maternity, dental and other related health care Benefits. It is

maintained pursuant to a Collective Bargaining Agreement between the Union and the Association which is available for examination at the Fund Office. A copy of the agreement may be obtained upon written request to the Fund Office. Upon request, the Fund Office will also inform you if a particular employer or union participates in the Plan and, if so, the address of that Employer or Union.

L. Amendment

The Trustees reserve to right to amend, modify or terminate this Plan as circumstances dictate.

UNION TRUSTEES

Mr. Robert G. Bartak
Bricklayers Local No. 1
4046 Vinton Street
Omaha, NE 68105

Mr. Lyle D. Hightree
Operating Engineers Local 571
4660 South 60th Avenue
Omaha, NE 68117-1206

Mr. Gregg Rhoades
Cement Finishers #538
14515 Industrial Road
Omaha, NE 68144

Mr. Pete Suurvarik
Carpenters Local No. 444
9615 Ida Street
Omaha, NE 68122

EMPLOYER TRUSTEES

Mr. Greg Elkins
D.R. Anderson Constructors
Box 34340, Northwest Station
Omaha, NE 68134

Mr. Jeffrey Green
Davis Erection
5910 South 27th Street
Omaha, NE 68107

Mr. John Taylor
Weitz Company, Inc.
9711 M Street
Omaha, NE 68127-2008

Mr. Charles Vrana
Charles Vrana & Sons Company
4816 F Street
Omaha, NE 68117

Only the Board of Trustees is authorized to interpret the Plan of Benefits described in this booklet. 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 such individual act as an agent of the Board of Trustees.

SECTION FOURTEEN – YOUR RIGHTS UNDER FEDERAL LAW

READ THIS SECTION CAREFULLY. This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

Your ERISA Rights as a Participant

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. As a Participant of the Omaha Construction Industry 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:

A. **Receive Information About Your Plan and Benefits**

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

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care Plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic

information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan administrator.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Restated Plan Document and Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Exclusionary periods of coverage for pre-existing conditions under the Plan may be reduced or eliminated if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from this Plan (any other group health plan), or health insurance issuer when you lose

coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. 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.

D. 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. 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.

However, all review and appeal procedures described in the Plan usually must be followed and exhausted before a Claimant may institute any legal action including any action or proceedings before any court, administrative agency or arbitrator (“legal bodies”). Generally, such legal bodies require a Claimant to follow and exhaust the Fund’s review procedures before allowing a Claimant’s legal action to proceed. If a Claimant files a legal action before following and exhausting the

Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

E. Assistance with your Questions

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

SECTION FIFTEEN – DEFINITIONS

THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

A. Accident	S. Medically Necessary
B. Association	T. Out-Patient
C. Beneficiary	U. Participant
D. Benefits	V. Physician
E. Collective Bargaining Agreement	W. Plan
F. Covered Employee	X. Qualified Medical Child Support Order
G. Covered Person	Y. Retiree
H. Covered Service	Z. Services
I. Eligible Dependent	AA. Sickness
J. Emergency Medical Condition	BB. Totally Disabled and Total Disability
K. Employee	CC. Trust Agreement
L. Employer	DD. Trust Fund
M. Expense Incurred	EE. Trustees
N. Family	FF. Union
O. Hospice	GG. Usual, Customary and Reasonable Charge
P. Hospital	
Q. Injury	
R. In-Patient	

- A. Accident
The term “**Accident**” means a physical Injury, such as a cut, break, sprain or bruise occurring from an unexpected, undesirable and unavoidable act. This does not include overuse of muscles resulting in strains or aching arms and legs. **Intentionally inflicted injuries are excluded.**
- B. Association
The term “**Association**” means The Omaha Building Contractors Employers Association.
- C. Beneficiary
The term “**Beneficiary**” means a person designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or who may become, entitled to receive any type of benefit from the Fund.

When a benefit is payable to a Beneficiary, it will be paid to the Employee-designated Beneficiary on file at the Fund Office. In the event the Employee fails to designate a Beneficiary or if the designated Beneficiary dies before the Employee, the benefit shall be payable to the first of the following, if living:

1. To the legal spouse, or
2. If no legal spouse is living, to the living children in equal shares, or
3. If no legal spouse or children are living, to the living parents in equal shares, or
4. If no legal spouse, children or parents are living, to the living brothers and sisters in equal shares, or
5. If none of the above are living, to the Employee's estate.

The Employee may designate a new Beneficiary at any time by filing a **written** request with the Fund Office.

D. Benefits

The term "**Benefits**" means the Health and Welfare benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

E. Collective Bargaining Agreement

The term "**Collective Bargaining Agreement**" means the labor agreement between a participating Union and the Association and any other employer, group of employers or association of employers.

F. Covered Employee

The term "**Covered Employee**" means an Employee for whom Payments are made to the Fund as provided by a Collective Bargaining Agreement or other written agreement approved by the Trustees and who is covered according to the provisions set forth under the Eligibility Rules.

G. Covered Person

The term "**Covered Person**" means either the Covered Employee or Retiree and their Eligible Dependents.

H. Covered Service

The term "**Covered Service**" means Hospital, medical or surgical procedures, treatments, drugs, supplies, durable medical equipment, or other health, mental health or dental care, including any single service or combination of Services, for which Benefits are payable, while this Plan is in effect.

I. Eligible Dependent

The term “**Eligible Dependent**” is:

1. A Covered Employee's or Retiree's lawful spouse.
2. Each of an Employee's or Retiree's unmarried children (including stepchildren and legally adopted children from the time of placement in the Employee's or Retiree's home) who are under 19 years of age and dependent upon him/her for more than 51% of their financial support. Stepchildren are the natural children of either the Employee or Retiree or the Employee's or Retiree's spouse provided the Employee and spouse or Retiree and spouse are legally married. The Plan does not cover foster children who are not the natural children of either the Employee or Retiree or the Employee's or Retiree's spouse.
3. The Covered Employee's or Retiree's unmarried children under age 23 if enrolled as a fulltime student in an accredited junior college, college university, nurses training center or a vocational or trade school approved by the Department of Education or Labor and who are dependent upon him/her for more than 51% of financial support. Proof of full-time student status and financial dependency must be reported to the Fund Office prior to submitting a claim.
4. An unmarried dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on the Covered Employee or Retiree for more than 50% of financial support and maintenance. Such dependents are eligible after 19 years of age if the Employee submits proof of the dependent's incapacity and dependency within two months before such dependent's attainment of age 19. Proof of the uninterrupted continuance of the dependent's incapacity may be requested at reasonable intervals. If such proof is not received within 60 days of the request, coverage for the incapacitated dependent will automatically terminate.
5. A child for whom coverage must be provided because of a Qualified Medical Child Support Order (“QMCSO”). A QMCSO is a court order, administrative order pursuant to state law or court decree relating to child support under the Plan. To be qualified, the QMCSO must be approved by the Board of Trustees. A copy of the Plan's QMCSO qualification procedures is available from the Fund Office upon request.
6. For dependents working full-time under the age of 19, living at home and having their own health care coverage, this Plan will coordinate and be the secondary payer.

7. In the event that two Employees are married to each other, Benefits will be paid at the rate of 80% as an Employee and an additional 20% as an Eligible Dependent.
- J. Emergency Medical Condition
The term “**Emergency Medical Condition**” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.
- K. Employee
The term “**Employee**” includes any person covered by Collective Bargaining Agreements between an Employer and any participating Union and who is engaged in employment with respect to which the Employer is obligated to make contributions to the Welfare Plan. The term also means full-time salaried officials of the Unions who are not participating in any other Construction Industry Health and Welfare Plan and others who participate through participation agreements.
- L. Employer
The term “**Employer**” includes any employer who now or hereafter has a Collective Bargaining Agreement with any of the Unions which are or shall become a party to this Declaration of Trust and who, in writing, adopts and agrees to be bound by the terms of this agreement and any amendments or modifications thereof. The term also means the Unions for the purpose of providing Benefits hereunder for the full time salaried officials of the Unions for which the Unions are obligated to contribute to the Welfare Plan. Any employer becoming an Employer under this agreement, who is not a member of the Omaha Building Contractors Employers Association, and who does the type of work performed by members of the Omaha Building Contractors Employers Association agrees to abide by all provisions of the Collective Bargaining Agreement between the Unions and the Association or any other Collective Bargaining Agreement with any Union which participates in the Trust.
- M. Expense Incurred
The term “**Expense Incurred**” includes only those charges made for Services and supplies which are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care. All Expenses Incurred will be considered on a Usual, Customary

and Reasonable Charge basis in the given geographical area which shall be no higher than the 90th percentile of prevailing health care charges data.

N. Family

The term “**Family**” means the Employee and any Eligible Dependents.

O. Hospice

The term “**Hospice**” means a licensed agency that provides counseling and medical Services to the terminally ill and which meets **all** of the following tests:

1. Has obtained any required state or governmental Certificate of Need approval,
2. Provides Services on a 24 hour, 7 day a week basis,
3. Is under the direct supervision of a Physician,
4. Has a nurse coordinator who is a Registered Nurse (R.N.),
5. Has a social service coordinator who is licensed,
6. Is an agency that has as its primary purpose the provision of services of Hospice care,
7. Has a full time administrator,
8. Maintains written records of Services provided to the patients, and
9. Is licensed in the jurisdiction in which it is located, if licensing is required.

P. Hospital

The term “**Hospital**” means an institution which meets all of the following requirements:

1. Maintains permanent and full-time facilities for bed care of five or more resident patients.
2. Has a staff of Physicians in regular attendance.
3. Continually provides 24 hour a day nursing services by registered nurses.
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured or sick persons on a basis other than a rest home, nursing home, convalescent home, a place for the aged, or a drug addiction center and such are provided for compensation.

5. Is operated lawfully in the jurisdiction where it is located.
6. Must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Q. Injury

The term “**Injury**” means an accidental bodily injury causing loss beginning after the effective date of coverage and resulting, directly and independently of all other causes in loss covered by the Plan.

R. In-Patient

The term “**In-Patient**” means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

S. Medically Necessary

The term “**Medically Necessary**” means only those Services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical Services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat a Covered Person’s Accident or Sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the eligible individual’s condition, disease, ailment, or Injury,
2. Are appropriate according to standards of good medical practice,
3. Are not solely for the convenience of the Covered Person, Physician or Hospital,
4. Are the most appropriate which can be safely provided to the Covered Person,
5. Are not deemed to be Experimental or Investigative, and
6. Are not furnished in connection with medical or other research.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be “Experimental” or “Investigative” if the use is not yet generally recognized as accepted medical practice, or if the use of any such item requires federal or other governmental agency approval which has not been granted at the time the service or supply is provided, or if the service, supply or procedure is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

1. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty,

2. Has a definite positive effect on health outcome,
3. Over time leads to improvement in health outcomes under standard means of treatment under standard conditions of medical practice outside clinical investigatory settings (i.e. the beneficial effects outweigh the harmful effects), and
4. Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

“**Reliable Evidence**” includes only the following:

1. Published reports and articles in authoritative medical and scientific literature,
2. The written investigational or research protocols and/or written informed consent used by the treating facility or another facility which is studying the same service, supply or procedure, and
3. Compilations, conclusions, and other information which is available and may be drawn or inferred from 1. or 2. above.

Consideration may be given to any or all of the following factors:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, and
2. If Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials to determine its maximum tolerated dosage, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis, or
3. If Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis.
4. Final determination of whether the use of a treatment is Experimental or Investigative shall rest solely in the discretion of the Trustees.

T. Out-Patient

The term “**Out-Patient**” means a person who receives Services and treatments in a Hospital (provided that there is no charge for room and board), ambulatory clinic, free-standing surgical unit, or Physician’s office.

U. Participant

The term “**Participant**” means an Employee or former Employee of an Employer or Retiree who is, or may become, eligible to receive any type of benefit from this Fund or whose Beneficiaries may become eligible to receive any such benefit.

V. Physician

The term “**Physician**” means medical doctors, osteopaths, surgeons, dentists, podiatrists, chiropractors, and psychologists with a Ph.D., when practicing within the scope of their license.

W. Plan

The term “**Plan**” means the Schedule of Benefits and the rules and regulations of the Omaha Construction Industry Health and Welfare Plan and the Trust Fund as established heretofore, or as shall be established from time to time by amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

The Plan was established as of 1963, in accordance with the provisions of the Trust Agreement

X. Qualified Medical Child Support Order

The term “**Qualified Medical Child Support Order**” (“**QMCSO**”) means a medical child support order which creates or recognizes the existence of an alternate recipient's rights to, or assigns to an alternate recipient the right to, receive Benefits for which you are covered under this Plan. The medical support order must clearly specify:

1. Your name and last known mailing address, if any, and the name and mailing address of each alternate recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to your alternate recipient, or the manner in which such type of coverage is to be determined;
3. The period to which such order applies; and, the plan to which such order applies.

The medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of any applicable law.

Any Benefits paid for an alternate recipient will be at the level of Benefits available under the Plan at the time the expense is incurred. Additionally, an alternate recipient is eligible for Benefits only as long as you are eligible for Benefits. In the event you lose eligibility and are later reinstated, any previous QMCSO, which according to its terms is still in effect, will be automatically renewed.

You may obtain a copy of the Plan's procedures governing QMSCOs, without charge, by contacting the Fund Office.

Y. Retiree

The term "**Retiree**" refers to an Employee who retired under the Omaha Construction Industry Pension Plan, or the National Roofing Industry Pension Plan with a retirement effective date of January 1, 1987 or after and was eligible for Benefits (including eligibility through a benefit bank and/or COBRA Continuation Coverage) under the Omaha Construction Industry Health and Welfare Plan within the 24 months out of the previous 36 months immediately prior to the effective date of his or her retirement benefit.

Z. Service

The term "**Service**" means Hospital, medical or surgical procedures, treatments, drugs, supplies, home medical equipment, or other health, mental health or dental care, including any single Service or combination of such Services.

AA. Sickness

The term "**Sickness**" includes physical illness, pain or a fever not caused by an Accident. Sicknesses resulting from intentional use, such as overdose of drugs, are excluded.

BB. Totally Disabled and Total Disability

The terms "**Totally Disabled**" or "**Total Disability**" unless otherwise specifically defined, refers to a disability resulting from a Sickness or accidental bodily Injury which prevents you from engaging in any occupation or employment for compensation or profit or prevents your Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health. Both you and your dependent must be under the regular care and actual attendance of a Physician.

CC. Trust Agreement

The term "**Trust Agreement**" means the Agreement and Declaration of Trust effective August 9, 1962 and any subsequent amendments.

DD. Trust Fund

The term "**Trust Fund**" means the Trust Fund created pursuant to the Trust Agreement and generally the monies or other things of value which comprise the corpus and additions to the Trust Fund.

EE. Trustees

The term "**Trustees**" means the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the "Administrator", the "Plan Sponsor" and the "Named Fiduciaries" of the Trust Fund and of the Plan established and maintained under the authority of the Trust Agreement.

FF. Union

The term “**Union**” means those unions who have executed a Collective Bargaining Agreement with an Employer which provides for payment of contributions to the Omaha Construction Industry Health and Welfare Plan.

GG. Usual Customary and Reasonable Charge

The term “**Usual, Customary and Reasonable Charge**” means that the charge by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90th percentile of prevailing health care data on such charges. The “geographical area” reference is the zip code for the general level of charges being made by a Physician of similar training and experience.