GREATER KANSAS CITY LABORERS HEALTH & WELFARE FUND
FREQUENTLY ASKED QUESTIONS & ANSWERS

Q. HOW DO I BECOME ELIGIBLE FOR HEALTH & WELFARE BENEFITS?

A. You can become eligible and receive benefits by working a sufficient number of hours for a *Contributing Employer* who makes contributions to The Fund.

Q. HOW MANY HOURS DO I NEED TO WORK?

A. You must work for a *Contributing Employer* a minimum of **250 hours** during a qualifying period (quarter); up to **1,000 hours** during four (4) consecutive qualifying periods (quarters). See the chart below for the qualifying periods:

ELIGIBILITY CONTRIBUTION REQUIREMENTS				
To be eligible for benefits during this period:	You must have contributions made on your behalf in *one* of the following amounts…			
	250 hours of contributions this work period:	**500** hours of contributions this work period:	**750** hours of contributions this work period:	**1,000** hours of contributions this work period:
Jan 1 – March 31	Sept 1 – Nov 30	June 1 – Nov 30	March 1 – Nov 30	Dec 1 – Nov 30
April 1 – June 30	Dec 1 – Feb 28	Sept 1 – Feb 28	June 1 – Feb 28	March 1 – Feb 28
July 1 – Sept 30	March 1 – May 31	Dec 1 – May 31	Sept 1 – May 31	June 1 – May 31
Oct 1 – Dec 31	June 1 – Aug 31	Mar 1 – Aug 31	Dec 1 – Aug 31	Sept 1 – Aug 31

Q. WHEN WILL MY COVERAGE BEGIN?

A. You become eligible for coverage on the first day of a quarter (January 1st, April 1st, July 1st or October 1st) based on the number of hours of contributions made on your behalf to the Fund.

Q. WHAT HAPPENS IF I LOSE MY ELIGIBILITY BECAUSE OF A REDUCTION IN HOURS, TERMINATION OF EMPLOYMENT, OR CERTAIN OTHER EVENTS?

A. You will be notified by The Fund Office that your Health Care Coverage has terminated and you will be given the opportunity to continue coverage by electing COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).

Q. WHAT IS COBRA CONTINUATION COVERAGE?

A. Federal law requires that sponsors of group health plans offer Covered Participants and their families a temporary extension of their health care coverage under the Plan in exchange for self-contribution payments to the Plan. (Find detailed information regarding COBRA in the *Summary Plan Description)*

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Q. CAN I CONTINUE MY COVERAGE AFTER I RETIRE?

A. You can become eligible for retiree benefits under the Plan if you:

- Accrued 10 or more benefit credits with the Greater Kansas City Laborers Pension Fund; and
- Had been eligible for active Plan coverage under the Greater Kansas City Laborers Welfare Fund **12 out of the last 20-consecutive quarters** immediately before retirement; and
- Are receiving regular, early, disability, deferred, partial or pro-rata benefits from the Greater Kansas City Laborers Pension Fund (or for any other reason for the first 18 months following retirement)

Q. WHO QUALIFIES AS A DEPENDENT ON MY COVERAGE?

A. Eligible Dependents can include:

- Your spouse;
- Unmarried children under age 19;
- Unmarried children over age 19, but under than 23, provided they:
  - Are registered students in regular full-time attendance at an accredited college or university or vocational, technical, vocational-technical or trade school or institute, or secondary school, and
- Children between the ages of 19 and 26 (regardless of marital status) provided they:
  - Do NOT have their own employer sponsored health care coverage ***available*** through their employer or their spouse's employer;
  - Whose coverage under the Plan already ended;
  - Who were previously denied coverage under the Plan; and
  - Who were not previously eligible to enroll in the Plan because eligibility for dependent coverage under the Plan previously ended before the child reached age 26.

- Unmarried dependent children incapable of self-sustaining employment because of physical handicap or mental retardation provided:
  - They are dependent upon you for support;
  - Their incapacity started before reaching age 19; and
  - Proof of their incapacity is provided to the Fund Office no later than 31 days after reaching age 19.
- Under the Plan, children include those children for whom you have an obligation to support, including:
  - Natural children;
  - Stepchildren;
  - Legally adopted children;
  - Children placed with you for adoption
  - Children for whom you have been appointed legal guardian by a court of competent jurisdiction; and
  - Children for whom coverage must be provided because of a Qualified Medical Support Order (QMCSO).

Q. HOW DO I ADD A NEW DEPENDENT?

A. If you need to ass a newborn child, spouse, step-child, etc., Contact the Fund Office at (913) 236-5490 and request a new *Enrollment Card*. You will need to provide a birth certificate; marriage certificate; divorce decree; or some other legal documentation, whichever applies to your situation.

Q. HOW DO I REMOVE MY SPOUSE FROM MY COVERAGE PLANS?

A. Before a spouse could be terminated from the Plan, the Fund Office would need a copy of the divorce decree or the court document showing you are legally separated. Contact The Fund Office at (913) 236-5490 with this documentation and your coverage plan can be changed.

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Q. WHAT WILL BE MY OUT-OF-POCKET EXPENSES FOR HEALTHCARE BENEFITS?

A. All benefits are subject to a deductible and copayment. The following tables show the deductible and co-payment amounts for the plan:

Comprehensive Medical Benefits
(for Active Employees, Retired Employees and Dependents):

Coverage Type	Calendar Year Deductible		Calendar Year Co-Insurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$350	$700	80%	60%
Family	$600	$1,200		

Dental Benefits
(for Active Employees, Retired Employees and Dependents):

Coverage Type	Calendar Year Deductible		Calendar Year Co-Insurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$25	$25	80%	60%
Family	$50	$50		

The deductible must be met before the Plan will begin to pay benefits. The Plan pays 80% of covered charges from an in-network provider and 60% of covered charges for an out-of-network provider.

The calendar year out-of-pocket maximum (includes deductibles and copays) is $3,000 per person; $5,000 per family for in-network services and $6,000 per person; $10,000 per family for out-of-network services.

The Fund has contracted with several network medical providers to provide Participants and The Fund with discounts on medical services. By choosing an In-Network Provider for your health care needs, you will save money for yourself and the Fund.

ALL BENEFITS ARE SUBJECT TO LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR SPD FOR FULL PLAN INFORMATION.

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Q. HOW DO I FIND A NETWORK PROVIDER FOR HEALTH CARE BENEFITS?

A. Blue Cross and Blue Shield National Preferred Provider Organization (BCBSKC), offers a nationwide network of medical providers for all your health benefit needs. Below is information that will allow you to search for and determine if your provider(s) are participating in the *Blue Cross Blue Shield PPO Nationwide Network*:

- You can go directly to the *Blue National Doctor and Hospital Finder Website* at **www.bcbs.com**.
- You will need the three digit account specific prefix: **(GKF)**. This is the prefix that will be listed on the front of your identification card.
- You will also need the zip code of the area where you are looking for a participating provider. This will provide you with a detailed search engine where you can look up a provider by name and/or specialty anywhere within the Blue Cross Blue Shield PPO Nationwide Network.
- To determine if a provider is in the Blue Cross Blue Shield PPO Network over the phone, you may contact Blue Cross Blue Shield of Kansas City at **(800) 340-0109** or you can call the *National Provider Finder* number at **(800) 810-BLUE**.

Q. DO I NEED AN ID CARD?

A. Yes. You should carry your Health Care ID Card with you at all times, and provide it to your medical care provider at each visit. The card has information on it so your providers know where to bill for their services, and who to call for benefit and eligibility verification.

Q. HOW DO I GET AN ID CARD?

A. Your Health Care ID Cards will be sent to you by BCBSKC under separate cover. Once received, be sure to carry this card with you, and present to your providers when receiving medical services. This card has all the information needed for your medical providers to bill for your medical expenses.

Q. HOW DO I GET A REPLACEMENT CARD IF MINE IS LOST?

A. You can call The Fund Office to order a replacement card, or you can request a new card online at *www.bluekc.com*.

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Q. DOES THAT COVER PRESCRIPTION DRUG COVERAGE TOO?

A. Yes. Prescription medications are covered under the Welfare Fund Plan.. Prescription drug charges **DO NOT APPLY** to the annual deductible or the out-of-pocket maximum. To use your prescription benefit, present your *Prescription Drug Card* (not your Welfare Health Care ID Card) and prescription to your pharmacist.

Q. WHAT PRESCRIPTIONS ARE COVERED?

A. The medication must have been prescribed by your physician. There are no benefits for certain prescriptions, including fertility or infertility drugs, drugs used for cosmetic purposes, investigational or experimental drugs, genetically engineered drugs, drugs used for weight control and others. Please refer to your Summary Plan Description for the full list of restrictions.

Q. WHERE DO I GET MY PRESCRIPTIONS?

A. The Prescription Benefit Manager (PBM) for the Fund is *LDI Prescription Services*. You can find participating pharmacies by visiting their website at *www.LDIRx.com* or you can call them toll-free at (866) 516-3121.

Q. HOW MUCH WILL MY PRESCRIPTIONS COST?

A. ***For Active Employees and their Dependents*****:**
Prescriptions purchased at a retail pharmacy will cost $5.00 for generic medications (or the cost of the prescription, if less). You will pay a 25% copay, up to $70 for brand name/preferred medications and you will pay a 25% copay, up to $100 for brand name/non-preferred medications.

Prescriptions purchased through LDI's Mail Order Program (up to a 90-day supply), will cost $10 for generic medications (or the cost of the prescription, if less). You will pay a 25% copay, up to $200 for brand name/preferred medications and you will pay a 25% copay, up to $275 for brand name/non-preferred medications.

For Retired Employees and their Dependents**:**
Prescriptions purchased at a retail pharmacy will cost $5.00 for generic medications (or the cost of the prescription, if less). You will pay a 40% copay, up to $85 for brand name/preferred medications and you will pay a 40% copay, up to $110 for brand name/non-preferred medications.

Prescriptions purchased through LDI's Mail Order Program (up to a 90-day supply), will cost $10 for generic medications (or the cost of the prescription, if less). You will pay a 40% copay, up to $230 for brand name/preferred medications and you will pay a 40% copay, up to $300 for brand name/non-preferred medications.

ALL BENEFITS ARE SUBJECT TO LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR SPD FOR FULL PLAN INFORMATION.

Q. WHAT VISION BENEFITS ARE AVAILABLE?

A. **The Plan provides benefits for eyeglasses and vision care if the care ONLY if the care is provided by a participating VSP Signature Vision Care Provider.** Vision exams are covered every 12 months, and prescription lenses are covered after a $25 copay. See the Summary Plan Description for a full list of benefits and restrictions.

ALL BENEFITS ARE SUBJECT TO LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR SPD FOR FULL PLAN INFORMATION.

Q. HOW DO I FIND A NETWORK PROVIDER FOR VISION BENEFITS?

A. Vision Benefits are provided by the VSP Vision Care. To find providers in the VSP Vision Care Network, call Customer Service at **(800) 877-7195** or visit ***www.vsp.com***.

PLEASE NOTE – VISION BENEFITS ARE PROVIDED ONLY IF YOU SEEK CARE FROM A VSP VISION CARE NETWORK PROVIDER.

If you have any additional questions about your benefits or the Welfare Fund, please contact The Fund Office at (913) 236-5490.