CHICAGO LABORERS' WELFARE PLAN

Summary Plan Description | 2012 EDITION

Retiree Medical Plan
Retiree Basic Medical Coverage Plan

BOARD OF TRUSTEES

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Benefits Consultant	The Segal Company	

Only the Board of Trustees is authorized to interpret the Retiree Medical Plan and Retiree Basic Medical Coverage Plan – "The Plans" described in this booklet. No Employer, Union, or any representative of any Employer or Union, is authorized to interpret the Plans nor can any such person act as an agent of the Trustees. You may only rely on information regarding the Plans that is communicated to you in writing and signed on behalf of the Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

Benefits under the Plans will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with the terms of the Plans.

Nothing in this booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan Documents. The Trustees reserve the right and have been given the sole and unrestricted discretion to amend, modify, or discontinue all or part of the Plans whenever, in their sole judgment, conditions so warrant. If all or a part of either Plan is terminated, the Trustees would provide for payment of expenses incurred up to the date of termination, arrange for a final accounting of the Plans and distribute the balance of the assets in a manner consistent with the terms and conditions of the Trust Agreement establishing these Plans under the Fund.

IMPORTANT
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This booklet contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Chicago Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, IL 60154. Office hours are from 8:30 AM to 4:00 PM, Monday through Friday. For assistance, you can call the Fund Office at 708-562-0200 or 866-906-0200.

Este folleto contiene un sumario en Ingles de sus derechos y beneficios bajo el Plan. Si tiene dificultad en entender cualquier parte de este folleto póngase en contacto con el Chicago Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154. Las horas de oficina son de 8:30 AM a 4:00 PM, de Lunes a Viernes. Para obtener asistencia también puede llamar a las oficinas al 708-562-0200 or 866-906-0200.

Questo opuscolo contiene un sommario in lingua inglese dei vostri diritti e delle vostre indennità secondo questo Piano. Se avete difficoltà a capire qualsiasi parte di questo opuscolo, contattate il Chicago Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154. L'orario d'ufficio è dalle 8.30 alle 16.00, dal lunedì al venerdì. Per ottenere assistenza, potete telefonare all'ufficio, al numero 708-562-0200 or 866-906-0200.

Ta broszura zawiera streszczenie w języku angielskim Państwa praw i korzyści wynikających z tego Planu.W przypadku trudności ze zrozumieniem jakiejkolwiek części tej broszury prosimy o kontakt z Chicago Laborers' Welfare Plan, 11465 W. Cermak Road,Westchester, Illinois 60154. Biuro czynne codziennie od poniedziałku do piątku od 8:30 do 4:00. Pomoc można uzyskać telefonicznie pod numerem 708-562-0200 or 866-906-0200.

CHICAGO LABORERS' WELFARE FUND

Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154
Telephone: 708-562-0200 or 866-906-0200
Fax: 708-562-0716
Email: claims@chilpwf.com
Website: www.chicagolaborersfunds.com

To Plan Participants:

We are pleased to provide you with this revised Summary Plan Description booklet, which outlines your health and welfare benefits in effect as of January 1, 2012. This booklet includes the changes that have been made to the Plans since the last booklet was printed.

Among the improvements described in this booklet are:

- Extension of Dependent Child Coverage;
- Adjustments to Plan Limits;
- Special re-enrollment provisions for individuals who previously reached the Lifetime Limit; and
- Information regarding free or low-cost health coverage to children and families through Medicaid or CHIP (Children's Health Insurance Program).

Read this booklet carefully to see what coverage is available, who is eligible for coverage, and when coverage begins and ends. Keep this booklet with your other important papers so you can refer to it when you need it.

If you have questions about the information in this booklet or about your Plan, please contact the Fund Office. If you would like, you may request to speak to someone in the Claim Department who speaks Spanish, Polish, or Italian.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

INTRODUCTION

The Chicago Laborers' Welfare Plan Retiree programs offer medical, prescription drug (not available under the Retiree Basic Medical Coverage Plan), dental, vision, and death benefits. The benefits described in this booklet apply if you elect Retiree coverage under the Retiree Medical Plan or the Retiree Basic Medical Coverage Plan "The Plans." If you elect to continue coverage under the Active Plan through COBRA Continuation Coverage (see below), those benefits are described in a separate booklet.

The benefits described in this booklet, which are effective as of January 1, 2012, are for eligible participants covered under the Chicago Laborers' Welfare Plan Retiree programs. This booklet includes the changes that have been made to the Plan since the last booklet was printed. This booklet replaces and supersedes any prior Summary Plan Description.

Your Choice

When you retire from active employment in your trade, you may continue coverage under the Active Plan until you are no longer eligible. You may then choose coverage for yourself and your dependents under any of the three options that are offered by the Chicago Laborers' Welfare Fund, as outlined in this booklet, provided you meet the eligibility requirements described beginning on page 5.

If you elect medical coverage under The Plans, you will also receive dental and vision benefits. Retiree death benefits are also available under the Plans; however, you must meet certain requirements for these benefits (see page 5).

Coverage under the Retiree programs does not include Weekly Income or Accidental Dismemberment Benefits.

Please note that prior to September 1, 1993 the Retiree Medical Plan was not available. Therefore, if you retired before September 1, 1993, you were eligible for coverage under the Retiree Basic Medical Coverage Plan, and then only up to age 65.

It's your choice at Retirement:

- Pay for comprehensive medical coverage under the Retiree Medical Plan, including prescription drug benefits;
- Receive free limited medical coverage under the Retiree Basic Medical Coverage Plan until age 65; or
- Elect COBRA Continuation Coverage under the Active Plan.

Option 1: Retiree Medical Plan

The Chicago Laborers' Retiree Medical Plan is available to eligible Retirees age 50 and over and, in addition to the benefits described above, includes comprehensive medical coverage and prescription drug benefits.

If you are eligible for this coverage and you choose this Plan, you must pay a monthly premium for your benefits. If you choose this coverage, you will not be allowed to change to COBRA Continuation Coverage under the Plan for active employees until you return to work in covered employment and reestablish your eligibility for benefits under that plan.

If you are a pre-Medicare Retiree and you and your dependents have coverage under options 1 or 2, you must use the Blue Care Connection Utilization Review program, which includes Utilization Management and Enhanced Case Management (see page 17).

IMPORTANT: Coverage under the Retiree Medical Plan will only be offered to you once, at your initial application for retirement benefits. If you choose not to enroll in this coverage at that time or discontinue coverage at any time, you may not enroll or attempt to reenroll in the Plan later.

Option 2: Retiree Basic Medical Coverage Plan (For Retirees Before Age 65)

If you meet the eligibility requirements when you retire, you and your dependents will receive, at no cost to you from age 50 to 65, a limited level of medical coverage in addition to the Retiree dental and vision benefits. In addition, you are eligible for the Retiree death benefit (see page 48).

You should note that the Retiree Basic Medical Coverage Plan does not include prescription drug benefits.

This basic coverage is available at no cost to you if you are between age 50 and 65 when you retire, you meet the eligibility requirements on page 5, and you:

- Do not enroll in the Retiree Medical Plan;
- Enroll in the Retiree Medical Plan, but stop making premium payments for the coverage; or
- Discontinue coverage under the Retiree Medical Plan for you and/or your dependents for any reason.

If you discontinue coverage or fail to make the required premium payments under the Retiree Medical Plan you will be, if eligible, defaulted to the Retiree Basic Medical Coverage Plan. You will not be eligible to resume participation in the Retiree Medical Plan.

Option 3: Active Plan COBRA Continuation Coverage

You may choose to elect COBRA Continuation Coverage when your eligibility for coverage under the Plan for active employees "Active Plan" ends. You will be notified of your COBRA continuation rights when your eligibility under the Active Plan ends.

By electing COBRA Continuation Coverage under the Active Plan, you permanently lose eligibility to the Retiree Medical Plan. You should review the Summary Plan Description for active employees or contact the Fund Office for details about COBRA Continuation Coverage under the Active Plan.

Network Providers

Medical Care

The Plans offer you Medical Benefits through the **Blue Cross Blue Shield of Illinois (BCBSIL) Preferred Provider Organization (PPO)** network. Within this network, you have access to many participating Physicians and Hospitals throughout the area where you live. By using the services of network Providers (Physicians and Hospitals in the BCBSIL network) you receive services at a pre-negotiated discounted rate and receive a higher level of benefits.

To select a Physician, Hospital, or other Provider in your area, contact BCBSIL by calling 800-810-2583 or visiting **www.bcbsil.com**.

Convenient Care Clinics

You now have access to Convenient Care Clinics (CCC) in which you may receive care. These clinics are typically located in retail stores, supermarkets, and pharmacies. These clinics are typically staffed by a Nurse Practitioner or Physician Assistant.

Examples of Convenient Care Clinics are (1) CVS Minute Clinic and (2) Walgreens Take Care Clinic.

Smoking Cessation

The Retiree Medical Plan offers Smoking Cessation Benefits, including laser treatments when performed by Laser Concepts of Chicago. This benefit is not available to those participating in the Retiree Basic Medical Coverage Plan.

Prescription Drugs

Available in the Retiree Medical Plan only. The Retiree Medical Plan offers Prescription Drug Benefits through **CVS/Caremark, a Pharmacy Benefit Manager (PBM)**. There are more than 50,000 Pharmacies that participate in the CVS/Caremark network nationwide, including almost all of the major retail drug chains. Visit the CVS/Caremark website at **www.caremark.com** for a list of participating Pharmacies. You must show your prescription drug program ID card when you fill your prescription at a CVS/Caremark Pharmacy to receive your prescription drug medications at discounted prices. If you do not use a participating Pharmacy or do not show your ID card when you fill your prescription, you will be responsible for 50% of the cost of the prescription medication. In addition, this Coinsurance amount does not apply to your $2,500 out-of-pocket maximum. **This benefit is not available to those participating in the Retiree Basic Medical Coverage Plan.**

Dental

Dental Benefits are provided under both of The Plans through **Delta Dental of Illinois, a dental Preferred Provider Organization (PPO)**. Your level of coverage will depend on whether or not your Dentist or orthodontist is a Delta Dental network Provider. To receive the most benefits and the highest level of discounts, your Provider must participate in the Delta Dental PPO Network. You should contact Delta Dental toll-free at 800-323-1743 before seeking dental care. Delta Dental can help you select a network Dentist or orthodontist and answer specific questions relating to your Dental Benefits. You may also use Delta Dental's website at **www.deltadentalil.com** to find a network Provider.

Routine Vision Care

The Plans have contracted with **VSP** to provide discounted vision care such as annual eye exams, glasses, and contact lenses. You can find a network provider by visiting the VSP website at **www.vsp.com**, selecting the CHOICE network, or by calling VSP Member Services at 800-877-7195, Monday-Friday, 7:00 AM – 9:00 PM

Vision Correction Surgery

Available in the Retiree Medical Plan only. The Plan has contracted with QualSight, Inc. to provide discounted vision correction Surgery, see page 35. To find out if you may be a candidate for vision correction Surgery, contact QualSight directly by calling 877-718-7676.

Be a Wise Health Care Consumer

To help save money for you and the Fund, be a wise health care consumer. You can do so by taking advantage of cost-saving features built into the Plans. Whenever possible:

- **Use network Providers.** Hospitals, Physicians, Pharmacies, and other health care Providers that participate in the Fund's network have agreed to negotiated rates, which are generally less than other Providers.
- **Get regular physical exams.** Getting regular physicals can help you live a healthier life by identifying potential health risks earlier, which could mean fewer health care problems overall.
- **Request generic equivalents.** The cost of a generic medication can be significantly lower than the cost of a brand name medication and, by law, both medications are required to be equivalent.
- **Review your medical bills to ensure that they are accurate.** If something does not seem right, or if you are charged for a procedure or supply you never received, question the bill. Keep copies of Explanation of Benefits forms and Provider bills for your files for later reference.

Health Care Providers Contact Information

- Blue Cross Blue Shield (BCBSIL) (Medical)
  800-810-2583
  www.bcbsil.com
  Group No.: P15412
- Laser Concepts of Chicago (Smoking Cessation)
  866-908-7848
  www.laserconceptschicago.com
- CVS/Caremark (Prescription)
  www.caremark.com
  Group No.: T 190
- Specialty Drug Program
  866-387-2573
  Group No.: S 190
- Delta Dental of Illinois (Dental)
  In Illinois: 630-964-2400 or
  800-323-1743
  Outside Illinois: 800-331-0538
  8:30 AM – 5:00 PM
  Monday – Friday
  www.deltadentalil.com
  Group No.: 1133
- VSP (Routine Vision Care)
  800-877-7195
  7:00 AM – 9:00 PM
  Monday – Friday
  www.vsp.com
- QualSight, Inc.
  (Vision Correction Surgery)
  877-718-7676
  www.qualsight.com
- Fund Office
  708-562-0200 or
  866-906-0200
  Office hours: 8:30 AM – 4:00 PM
  Monday – Friday
  Call Center: 8:00 AM – 5:00 PM
  Monday – Friday

Questions About Your Benefits

Please take some time to review this booklet. If you are married, or have other covered dependents, share the information with them and let them know where you file this information for future reference.

If you have any questions about the benefits described in this booklet, contact the Fund Office at 708-562-0200 or 866-906-0200. If you would like, you may request to speak to someone in the Claim Department who speaks Spanish, Polish, or Italian.

IMPORTANT:

The Affordable Care Act requires publication of the table below. Please note that the limitations described in the table apply only to the Retiree Basic Medical Coverage Plan (For Retirees Before Age 65). The limitations do not apply to any other Plan option described in this booklet.

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by the Chicago Laborers' Welfare Fund, Retiree Basic Medical Coverage Plan, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of:

- **$3,200 for covered outpatient medical services (hospital services and supplies for therapeutic treatment, emergency room treatment for an illness, and for outpatient x-rays and laboratory tests)**
- **$10/visit limited to 50 visits per year for covered physician office visits (including physical therapy) for the retiree only**
- **$3,000 for covered inpatient hospital services and/or emergency room treatment for accidents**
- **$400 for diabetes education**

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov. If you have any questions or concerns about this notice, contact the Fund Office at 708-562-0200 or 866-906-0200.

In addition, you can contact: Illinois Department of Insurance, 100 Randolph Street, 9th Floor, Chicago, IL 60601, 877-527-9431, http://www.insurance.illinois.govDOI.Director@illinois.gov.

ELIGIBILITY

Once you decide to retire from covered employment, you should contact the Pension Department at the Fund Office. Depending on your age and prior work history, you may be eligible to elect coverage under the Retiree Medical Plan and pay monthly premiums or elect coverage under the Retiree Basic Medical Coverage Plan for free (if you do not elect COBRA Continuation Coverage under the Active Plan). If you qualify for the Retiree Medical Plan and fail to enroll, decline coverage or terminate coverage, you will be covered under the Retiree Basic Medical Coverage Plan, if you are eligible. Retiree medical coverage options will only be offered to you at the time you apply for a pension. These coverage choices are only offered once.

Retiree Eligibility

You are eligible for Retiree coverage if you:

- Are at least age 50;
- Are receiving benefits from the Chicago Laborers' Pension Fund or from the Laborers' International Union of North America (LIUNA) Industrial Pension Fund;
- Have earned at least 15 years of participation with the Chicago Laborers' Welfare Fund; and
- Have at least 500 hours reported to the Chicago Laborers' Welfare Fund in three of the last five fiscal years immediately preceding your pension retirement effective date.

No Duplicate Coverage
You cannot be eligible for active and Retiree benefits at the same time.

A year of participation is defined as having at least 800 hours reported to the Chicago Laborers' Welfare Fund for each of 15 fiscal years.

A fiscal year begins June 1 and ends May 31.

If you are retired on a Disability Pension from the Chicago Laborers' Pension Fund or from the LIUNA Industrial Pension Fund before age 50 but you meet all of the other eligibility requirements outlined above, you are eligible for Retiree coverage under the Retiree Medical Plan. However, you are not eligible for coverage under the Retiree Basic Medical Coverage Plan if you are not age 50 or older when you become eligible for a Disability Pension.

If you die after age 50 and before your retirement date, your surviving spouse may elect coverage under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan if:

- Prior to your death, you met the eligibility requirements for Retiree medical coverage; and
- Your surviving spouse is receiving a pension from the Chicago Laborers' Pension Fund or LIUNA Industrial Pension Fund.

Retiree Medical Plan Eligibility

If you are eligible for Retiree coverage, you will receive coverage under the Retiree Medical Plan if you elect coverage under this program and you either:

- Have the required monthly premium payments deducted from your pension check; or
- Make the required monthly premium payments for such coverage only if receiving a pension from the LIUNA Industrial Pension Fund.

When you are eligible for Medicare (due to attainment of age 65 or disability), you may continue your Retiree coverage under the Retiree Medical Plan as long as:

- The Plan has not been terminated or amended to exclude coverage for Medicare-eligible participants;
- You are receiving a pension from the Chicago Laborers' Pension Plan or LIUNA Pension Fund;
- You continue to deduct or pay the monthly premium payments; and
- You enroll in Medicare Part B and supply proof of this coverage to the Fund Office.

Your benefits under this Plan will be coordinated with Medicare when you are eligible for Medicare even if you do not enroll.

Retiree Basic Medical Coverage Plan Eligibility (Only Available Before Age 65)

If you are eligible for Retiree coverage, you will receive coverage under the Retiree Basic Medical Coverage Plan if you:

- Are not yet age 65 when you retire from covered employment; and
- Fail to elect or decline coverage under the Retiree Medical Plan; or
- Elect to terminate your Retiree Medical Plan coverage; or
- Do not make the required monthly premium payments for Retiree Medical Plan coverage.

You are not eligible for coverage under the Retiree Basic Medical Coverage Plan if you retire:

- At or after age 65; or
- Before age 50 on a Disability Pension.

Once you are covered under the Retiree Basic Medical Coverage Plan, your eligibility for benefits ends when you reach age 65.

Returning to Employment after Retirement

If you engage in disqualifying employment (as defined by the Rules and Regulations of the Laborers' Pension Fund) after you retire, your pension benefits will be suspended. In addition, your coverage under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan will end on the day that you begin working in disqualifying employment. You will not be eligible for COBRA Continuation Coverage. You will regain eligibility for coverage under the Active Plan on the first day of the month following the completion of the required number of hours if you return to work in covered employment. **When returning to work in covered employment after receiving a pension benefit, you will regain eligibility following the completion of 500 hours in a six-consecutive month period or 800 hours in a 12-consecutive month period. These requirements apply regardless of your age.**

Current provisions allow for a retired participant to return to disqualifying employment twice. The third time you return to disqualifying employment, you will not be eligible to participate in any retiree welfare benefit plan.

If you retire and return to disqualifying employment three times, you will no longer be eligible to obtain Retiree Medical Plan or Retiree Basic Medical Coverage Plan coverage. Your only option to continue medical coverage when your eligibility ends, will be to elect COBRA Continuation Coverage under the Active Plan.

If you are a Retiree considering a return to active employment, contact the Fund Office to obtain the most current eligibility requirements and restrictions.

Dependent Eligibility

You may add eligible dependents to the Retiree Medical Plan or the Retiree Basic Medical Coverage Plan during three different enrollment periods providing:

- Your dependent meets the Plan's definition of dependent (see page 10 for the definition of a dependent);
- You follow the proper enrollment procedures; and
- You pay the monthly premiums.

You and your dependents must be enrolled under the same Retiree Medical Plan.

Coverage for your dependents may be limited, based on your dependent's pre-existing conditions. Please see page 8 for more information on pre-existing condition limitations.

Initial Enrollment of Dependents

Your eligible dependents may be covered on the effective date of your coverage as long as the enrollment application is properly completed listing all dependents' names, the enrollment procedures are followed, and the required monthly premiums are paid. However, if your child is eligible for benefits as a working Laborer under the Active Plan, he or she cannot be covered as your dependent under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan.

Pre-existing condition limitations do not apply to your eligible dependents enrolled during the initial enrollment period.

Special Enrollment of Dependents

If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependent during a special enrollment period.

Also, if you decline enrollment for your eligible dependents (including your spouse) during the initial enrollment period because of other health insurance coverage, you may be able to enroll your dependents in the Retiree Medical Plan or the Retiree Basic Medical Coverage Plan in the future, provided you request enrollment within 31 days from the date the dependent's other health insurance coverage ends.

To qualify for special enrollment, you must:

- Apply for enrollment within 31 days of your marriage, your child's birth, adoption, or placement for adoption, or the date of loss of other health coverage, by completing an application;
- Follow all enrollment procedures; and
- Pay the required monthly premiums.

Contact the Fund Office for the current monthly premiums.

Semi-Annual Open Enrollment for Dependents

If you do not enroll your eligible dependents at the time you retire or you fail to enroll your new dependents during a special enrollment period, your eligible dependents may be enrolled during a semi-annual open enrollment period.

The Fund offers two open enrollment periods—April 1 through April 30, and October 1 through October 31. To qualify for open enrollment, you must:

- Apply for enrollment during the open enrollment period;
- Complete an enrollment application;
- Follow all enrollment procedures; and
- Pay the required monthly premium payments.

Coverage Effective Dates

The effective date of your eligible dependents' coverage varies by enrollment period:

- **Initial Enrollment Period.** Your eligible dependents are covered on the date you become covered under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan.
- **Special Enrollment Period.** Your eligible dependents' date of coverage differs based on the special enrollment event:
  - Birth of a Child. Coverage is effective on the date of birth.
  - Adoption or Placement for Adoption. Coverage is effective the date the child is legally adopted or placed for adoption.

- Loss of Other Coverage. Coverage is effective on the first day of the month following the date the Fund Office receives your written application.
- Marriage. Coverage is effective on the date of the marriage. In certain circumstances, your new spouse's dependents may also be eligible for coverage. Please contact the Fund Office for more information.

- **Semi-Annual Open Enrollment Period.** If you do not enroll your eligible dependents during the initial enrollment period or you fail to request enrollment during a special enrollment period, your eligible dependents may enroll during one of the two semi-annual open enrollment periods.

  Coverage effective dates are the same for all dependents enrolled during an open enrollment period. The Fund Office must receive your dependent's written application during the open enrollment period for coverage to begin on the coverage effective date.

Open Enrollment Period	Written Application Due Date[1]	Coverage Effective Date
April 1 – April 30	April 30	May 1
October 1 – October 31	October 31	November 1

[1] If this date falls on a weekend or holiday, the Fund will accept applications no later than the next business day. Applications received after this date will be deferred until the next open enrollment period.

Pre-existing Condition Limitations

In certain circumstances, the Fund may limit a dependent's coverage for specific medical conditions for up to 12 months. However, pre-existing condition exclusions may be reduced or eliminated if your dependent has previous Creditable Coverage.

EXAMPLE

Fred's new wife Jane has high blood pressure. Jane takes medication for this condition each day and is required to see her Physician once a year. As Jane's treatment for high blood pressure includes prescription medication, the Fund may exclude all Claims relating to her high blood pressure for a period of 12 months. However, the pre-existing condition period may be reduced or eliminated if Jane had Creditable Coverage under another health plan preceding the effective date of her coverage under the Retiree Medical Plan.

Pre-existing condition exclusions do not apply to any eligible dependent enrolled during the initial enrollment period. Pre-existing condition exclusions do not apply to newborn dependents or adopted dependents enrolled during a special enrollment period. Pregnancy is a condition that is exempt from pre-existing condition exclusions.

A **pre-existing condition** means any illness or injury, whether physical or mental and regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the coverage enrollment date. Treatment also includes prescription drugs taken for a specific condition, illness or injury. For purposes of this definition, "enrollment date" means the date coverage begins, or if there is a waiting period, the first day of the waiting period.

Creditable Coverage

The pre-existing condition exclusion period may be reduced or eliminated if your dependent can provide proof of Creditable Coverage.

Creditable Coverage is coverage under any health insurance policy or group health plan, including COBRA Continuation Coverage. In addition, coverage under Medicare, Medicaid, or any federal employee benefit or public health program may qualify as Creditable Coverage.

If your dependent had Creditable Coverage for a period of 12 months or more immediately preceding his or her effective date under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan, without a break in coverage, pre-existing condition exclusions do not apply. Also, remember that pre-existing condition exclusions do not apply to newborns or adopted children.

EXAMPLE

Jane had coverage under CBC Company's Health Plan for 12 months until she was laid off. She was without health coverage for 70 days until she obtained coverage through her new employer GRT Company. GRT's health plan had no waiting period and Jane maintained her coverage for eight months before she was laid off on January 31, 2010. Jane's coverage with GRT ended when her employment ended.

She and Fred were married February 2010, and Fred requested enrollment for Jane in the Retiree Medical Plan. Jane receives credit for eight months of Creditable Coverage based on her medical coverage through GRT. She does not receive credit for her health coverage at CBC Company because she had a 70-day break in coverage. Treatment associated with Jane's high blood pressure will be excluded from coverage for only 4 months.

In the Event of Your Death

If you die while covered under the:

- **Retiree Medical Plan**, your surviving spouse and dependents may continue coverage if they meet the Plan's definition of a dependent and the required monthly premium payments for coverage are made; or
- **Retiree Basic Medical Coverage Plan**, coverage for your spouse and dependents ends upon your death.

Once your eligible dependents become entitled to Medicare, benefit payments from the Retiree Medical Plan are coordinated with Medicare even if your spouse or dependent child does not enroll for Medicare coverage. See page 58 regarding Coordination of Benefits with Medicare.

Benefits under the Retiree Basic Medical Coverage Plan end when your eligible dependent reaches age 65 and is entitled to Medicare.

A **break in coverage** is a period of 63 days or more when a dependent has no health plan coverage. This is measured as the time period between the date the dependent's coverage under a health plan or insurance policy is terminated and the effective date of coverage under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan or the effective date of coverage under another health plan or insurance policy. Days in a waiting period are not considered Creditable Coverage nor are these days taken into account when determining a break in coverage.

If Your Spouse Has Employer-Sponsored Benefits

If your spouse has employer-sponsored medical coverage that he or she does not elect, your spouse may not be eligible for coverage under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan, or benefits may be limited. No benefits will be payable under the Chicago Laborers' Welfare Plan if your spouse's employer-sponsored medical plan does not provide your dependent with the same level of benefits provided to other participants in that plan.

If you are married, you will be asked to provide a certified copy of your marriage license. This can be obtained from the county in which you were married. The church record of your marriage is not sufficient.

To ensure that your spouse receives the maximum level of benefits payable under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan, your spouse should elect coverage under any available employer-sponsored medical coverage your spouse is eligible to receive.

Dependent Defined

If your dependent has coverage under another medical plan, coordination of benefits will apply. See page 56 for more information.

Your dependents are:

- Your spouse if you are not divorced.
- Your child who is less than 26 years old. Specifically coverage is determined as follows:
  - A child through age 25;
  - Full time student status is not required;
  - Financial or marital status does not affect eligibility; and
  - The Plans exclude eligibility for enrollment to any child who is eligible for other group coverage through the child's employer or through the employer of the child's spouse, regardless of whether the child enrolls in such coverage.

Under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan, your child is defined as:

- Your natural child;
- Your stepchild;
- Your adopted child or child placed with you, the Eligible Retiree, for adoption;
- Your child who is entitled to coverage pursuant to a Qualified Medical Child Support Order (QMCSO);
- Your unmarried dependent child who has reached age 26, if the child becomes physically or mentally disabled before reaching age 26. The disabled child must depend on you for more than half of his or her financial support and maintain a principal residence with you for more than one-half of the calendar year. If the disabled child does not live with you after a divorce or separation, the child will be a dependent child, provided that:
  - You and the other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six months of the calendar year;
  - You and the other parent provide over one-half of the child's support during the calendar year; and
  - The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.

The disabled child must not be a "qualifying child" of any other taxpayer as defined in Internal Revenue Code Section 152(c).

Physically or mentally disabled means that the child is unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more.

You must give the Fund Trustees written proof of the child's disability. Please contact the Fund Office three to six months before your child's coverage would otherwise end to request a Proof of Incapacitated Child Form for completion. You must provide the Fund Office with this completed form and a copy of your child's medical records for review ***before*** your child's coverage would otherwise end. When the Trustees receive proof of your child's disability, they have the right to have a physician of the Trustees' choice examine the child. The Trustees may require such an examination as often as they believe is reasonable. The Trustees may request continuing proof of your child's disability and will notify you when this proof is required.

- Your child for whom you have legal guardianship, provided that:
  - You, the Eligible Member, are named legal guardian;
  - The child resides in your home in a parent-child relationship;
  - The child depends on you for more than half of his or her financial support;
  - You have taken full parental responsibility and control for the child;

- The child is not temporarily living in your home;
- The child is not still under the control of the social service agency that placed the child with you; and
- The natural parents do not share parental responsibility and control of the child with you. Parental responsibility includes monetary support of any kind, maintenance of health coverage and other supportive functions.

The term child does ***not*** include:

- A child who is living in your household if you are not the legal custodian, unless your divorce or separation decree requires that you provide benefit coverage for the child;
- A child who is in full-time armed forces service; or
- A child who is not otherwise defined as your child, except for a child who is the subject of a paternity order that calls for health insurance coverage, limited as follows:
  - There will be no pre-existing condition coverage before the date of the paternity order;
  - If the paternity order is entered because of knowledge of the child's illness, all coverage will be excluded under the Plan; and
  - If the paternity order is entered into by consent or without contest, the Plan is entitled to and may require verification of paternity through a blood test or other scientifically recognized and commonly used examination to determine paternity.

When Your Eligibility Ends

Your eligibility for benefits under the Retiree programs ends for you at the earliest of the following dates:

- You enter the armed forces;
- You die;
- The Plan in which you are participating ends;
- You no longer meet the eligibility requirements; or
- You lose your right to participate in the Retiree program after you have returned to disqualifying employment three times after you initially retired (see page 6).

In addition, you will no longer be eligible for benefits under the:

- Retiree Medical Plan when you terminate coverage or do not pay the required monthly premium for coverage; or
- Retiree Basic Coverage Plan when you reach age 65.

When Your Dependents' Eligibility Ends

Your dependents' eligibility for benefits under the Retiree programs ends at the earliest of the following dates:

- Your dependent no longer meets the Plans' definition of an eligible dependent (for example, due to a child reaching age 26);
- The Plan in which you are participating ends; or
- Your dependent enters the armed forces.

In addition to the above, your dependents' eligibility for benefits will end if your dependents are covered under the:

- Retiree Medical Plan when you terminate coverage or you do not pay the required monthly premium for coverage; or
- Retiree Basic Medical Coverage Plan when you die or your spouse reaches age 65 and is entitled to Medicare.

Certificate of Creditable Coverage

When your coverage under either Plan ends, the Fund Office will provide you and/or your covered dependents with a Certificate of Creditable Coverage. The Certificate indicates the period of time you and they were covered under the Plan and certain additional information that is required by federal law. The Fund Office will send you the Certificate by first class mail within 45 days after coverage under the Plan ends. If your dependents elect COBRA Continuation Coverage, another Certificate will be provided within 60 days after the COBRA Continuation Coverage ends.

In addition, a Certificate will be provided within 45 days after the Fund Office receives your request for such a Certificate. The Fund Office must receive your request within two years after the latter of the date coverage under the Plan ended or the date COBRA Continuation Coverage ended.

Changes in Eligibility Rules

The Trustees reserve the right, at their sole and unrestricted discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Retiree programs at any time. The Trustees have the authority to establish monthly premium rates and rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

Changes in Social Security Numbers

If you change your Social Security Number (SSN) for any reason, you are required to submit written verification to the Fund Office from your local Social Security Administration (SSA) office. Your local SSA office will also provide you with documentation that your prior work history under an old or temporary SSN has been moved to your new SSN.

If you do not have a valid SSN, the Internal Revenue Service (IRS) can provide you with a Tax Identification Number (TIN). If you are assigned a TIN, you may be asked to provide documentation from the IRS or the SSA to register the new TIN with the Fund Office.

In addition, you must submit your work history documentation to the Fund Office so we may correct your work history records in the Plan's system. Failure to submit the documentation may affect your eligibility for benefits. The Fund Office will also require that you complete a new enrollment card and *Annual Claim Form*.

COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, your dependents may continue health care coverage past the date coverage would normally end.

The COBRA Continuation Coverage will be identical to the coverage your dependents had under the Retiree Medical Plan or the Retiree Basic Medical Coverage Plan on the day before the qualifying event.

Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plans is lost because of a qualifying event **that occurs within the first 18 months of coverage under the Retiree Medical Plan or Retiree Basic Medical Coverage Plan**. Under either Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

For COBRA Continuation Coverage, you or your dependent(s) must notify the Fund Office within 60 days of a:

- Divorce;
- Legal separation; or
- Child losing dependent status.

If you do not notify the Fund Office, your dependent(s) will lose the right to continue coverage under COBRA.

Qualifying Events

Your dependents do not have to show that they are insurable for COBRA Continuation Coverage. It is offered if your dependents lose coverage under either Plan because of a qualifying event. Qualifying events include:

- Your death;
- Legal separation or divorce of you and your spouse; or
- Your child's loss of dependent status under the Plan.

Notifying the Fund Office

You or your dependents must inform the Fund Office of a legal separation, divorce, or child losing dependent status under either Plan within 60 days of the event. If you or your dependents do not notify the Fund Office within 60 days of such an event, your covered dependents lose their right to elect COBRA Continuation Coverage.

Electing COBRA Continuation Coverage

When the Fund Office is notified that one of these events has occurred, your dependents will be notified of their right to elect COBRA Continuation Coverage. To elect continuation coverage, they must complete the election form and submit it according to the directions on the form. They then have 60 days from the later of the date the election notice was received or the date coverage ended due to the qualifying event to return the election form to the Fund Office.

COBRA Payments

Your dependents must pay their COBRA payments on time. Their coverage will be cancelled and cannot be reinstated if their payments are not received by the due date.

Each qualified dependent has a separate right to elect continuation coverage. For example, in the event of your death, your child may elect continuation coverage, even if your spouse does not. A parent may elect to continue coverage on behalf of any dependent child. Your spouse can elect continuation coverage on behalf of all qualified beneficiaries.

In determining whether to elect continuation coverage, your dependents should consider the following consequences if they fail to continue their group health coverage through COBRA:

1. They may have pre-existing condition exclusions applied to them by other group health plans if they have more than a 63-day gap in health coverage. Election of COBRA Continuation Coverage may help them avoid such a gap.
2. They will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if they do not elect COBRA Continuation Coverage for the maximum time available to them.

3. They should take into account that they have special enrollment rights under federal law. They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after their group health coverage ends because of the qualifying event. They will also have the same special enrollment rights at the end of continuation coverage if they elect COBRA Continuation Coverage for the maximum time available to them.

Paying For COBRA Continuation Coverage

The Fund Office will notify your dependents of the cost of COBRA Continuation Coverage when it notifies them of their right to elect such coverage. The Trustees determine the cost for COBRA Continuation Coverage each year. It will not exceed 102% of the cost to provide this coverage.

Premiums are comprehensive. This means that your dependents pay the same amount of money each month for one person as for more than one person. They must remember to remit their premiums each month. Simply electing COBRA Continuation Coverage does not make them eligible.

Your dependents' first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day coverage under the Plan terminated. This payment is due no later than 45 days after the date your dependent signed the election form and returned it to the Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. If payment is not received by the due date, all benefits will terminate immediately. Once your COBRA Continuation Coverage is terminated, it cannot be reinstated.

No payments will be made on Claims presented to the Fund Office until a timely COBRA premium payment is received.

Coverage Period

Your dependents may elect to continue coverage for up to 36 months if coverage ends due to your:

- Death;
- Legal separation or divorce; or
- Dependent child no longer meeting the definition of child and not qualifying for dependent coverage under the terms of the Plan. See page 10 for the definition of dependent under the Plan.

When COBRA Continuation Coverage ends, your dependents will be provided with a Certificate of Creditable Coverage for their length of coverage under the Plan. This Certificate may help reduce or eliminate any pre-existing condition limitation under a new group medical plan.

Loss of Continued Coverage

The period of COBRA Continuation Coverage for your dependents may be cut short for any of the following reasons:

- Your dependents do not make the required COBRA payments within 30 days of the due date;
- The Plan stops providing any group health benefits;
- After the qualifying event, your dependents become covered under another group health care plan (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions); or
- Your eligible spouse becomes entitled to Medicare.

CHANGES IN FAMILY STATUS

When you experience a change in family status, you should contact the Fund Office to report the change. The Fund Office will provide you with any forms you must complete to report the change. This helps ensure that the Fund Office has your correct address and family information on file. It also enables the Fund Office to keep updated information about your marital status, your dependents, and whether you or your dependents have other benefit coverage. This information helps in processing your Claims quickly and accurately.

Notify the Fund Office

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

- Of new dependents; and
- When a dependent is no longer eligible for coverage (you may want to continue their coverage through COBRA).

Adding a Dependent

Depending on your situation, there will be paperwork that you will need to submit to the Fund Office. For example, if you have a baby, you must submit a certified copy of your newborn child's birth certificate within 90 days of birth. In addition, if you adopt a child, or have a child placed with you for adoption, you must submit a copy of the adoption papers (or correspondence from your adoption attorney if the adoption is in process) to the Fund Office. When you notify the Fund Office of a change in family status, they will guide you through the process. See page 7 for enrollment instructions.

Call the Fund Office at 708-562-0200 or 866-906-0200 to notify them of any change in your family status.

Getting Married

If you get married, you will need to submit a certified copy of your marriage license to the Fund Office. You may obtain a certified copy from the county in which you were married. The church record of your marriage is not sufficient. Common-law spouses and same-sex partners are not eligible dependents under the Plan.

If Your Dependent Loses Eligibility for Coverage

If your dependent child loses eligibility for coverage under the Plan by reaching age 26, your child's coverage under the Retiree programs will end. However, your dependent may be eligible for COBRA Continuation Coverage. Contact the Fund Office for more information.

Rescission of Coverage

The Plans may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plans. However, the following situations will not be considered rescissions of coverage and do not require the Plans to give you 30 days advance written notice:

- The Plans terminate your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plans of your termination of employment.
- The Plans retroactively terminate your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plans retroactively terminate your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plans when you should not have been covered, the Plans will cancel your coverage prospectively—for the future—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plans to give you 30 days advance written notice.

Termination of Coverage

The Plans may rescind your or your dependent's coverage for fraud or intentional misrepresentation of a material fact after the Plans provide the individual with notice as required by law. A rescission of coverage is a cancellation of coverage that is retroactive back to the date that the individual should have lost eligibility under the Plans. However, the following situations will not be considered rescissions of coverage:

- The Plans terminate an individual's coverage back to the date of loss of eligibility when there is a delay in administrative recordkeeping between the individual's loss of eligibility and notice to the Plan of the individual's loss of eligibility.
- The Plans retroactively terminate the individual's coverage because of the individual's failure to make timely self-payments for coverage.

For any other unintentional mistakes or errors under which an individual was covered by the Plans when the individual should not have been covered, the Plans will cancel the individual's coverage prospectively once the mistake is identified. Such cancellation will not be considered a rescission of coverage.

In the Event of Divorce

If you obtain a divorce, you must notify the Fund Office immediately and submit a complete copy of your certified divorce decree. If your ex-spouse was covered under your Plan on the day before the divorce and wants to continue coverage under COBRA, you or your ex-spouse has 60 days from the date of the divorce to notify the Fund Office of the divorce and request COBRA information from the Fund Office. See pages 13 and 14 for more information about COBRA Continuation Coverage.

If you get a legal separation, you must provide the Fund Office with the certified documents pertaining to the legal separation.

Qualified Medical Child Support Order (QMCSO)

Both Plans recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs must be submitted to the Plan Administrator who will determine whether the order is qualified as a QMCSO under federal law. A copy of the procedures that the Plans follow to make this determination is available free of charge at the Fund Office.

QMCSO

An official court order that provides benefits for dependent children, or other qualified beneficiaries, in the event of a divorce or other family law action.

If a child is added to coverage based on a QMCSO, the parent seeking reimbursement for medical expenses must submit proof of payment.

In the Event of Your Death

If you die, your surviving spouse or dependents should contact the Fund Office. The Fund Office will assist them in submitting a Claim for the Retiree death benefit.

If you were covered under the Retiree Medical Plan, your surviving dependents may elect to continue coverage under that Plan. Your surviving dependents must make the required monthly premium payment for coverage. If you were covered under the Retiree Basic Medical Coverage Plan, your dependents' coverage will end on the date of your death. However, your dependents may be entitled to COBRA Continuation Coverage. Contact the Fund Office for more information.

UTILIZATION REVIEW PROGRAM
(For Pre-Medicare Retirees and Dependents)

If you are a pre-Medicare retiree, the Plan requires you and your dependents to use the Blue Care Connection's Utilization Review (UR) program. Blue Care Connection's UR program is an integrated approach to health care management that assists its members with living healthier and more productive lives. The Program helps you and your dependents maximize your medical coverage by making sure the right care is received at the right time and in the right setting. Administered by Blue Cross Blue Shield (BCBS) of Illinois, the Plan's UR Program provides Utilization Management (UM) and Case Management (CM), described below.

Utilization Management

Utilization Management (UM) evaluates the appropriateness, medical need, and efficiency of health care services, procedures, and facilities based on Plan provisions. Also, UM helps you avoid unnecessary services and treatments and may assist in identifying less costly, equally effective alternatives that achieve the same results as high-cost procedures.

UM includes the following:

- Pre-certification review of proposed health care services before the services are received assures that the admission and length of stay in a facility is medically necessary. Effective immediately, you must pre-certify all health care services such as elective hospital and specialized health care facility admissions, elective surgery, home health care and home infusion services, and higher costing procedures (typically $1,000 or higher). Pre-certifying your care assures that you are using your health care resources as wisely as possible.

  You must obtain pre-certification for an Inpatient admission to a health care facility by calling 800-433-3232 as follows:

  – One business day in advance of all scheduled admissions; and
  – Within two business days following an emergency admission.

  Failure to pre-certify will incur a $200 reduction in benefits for non-compliance.

- Concurrent review is the ongoing assessment of the health care as it is being provided, especially but not limited to, inpatient confinement in a hospital or specialized health care facility. Concurrent review includes services such as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and advising a patient's physician of various options available under the medical plan.
- Retrospective review is the review of health care services after they have been provided. All claims for medical services or supplies that did not undergo pre-certification or concurrent review may be subject to a retrospective review to determine whether the services are/were medically necessary.

Enhanced Case Management

Case Management (CM) services include the process where you, the patient, your family, and the physician or other health care providers work together under the guidance of Blue Care Connection to coordinate a quality, timely, and cost-effective treatment plan. Examples include the following CM services:

- Integrating services for participants with complex medical conditions to assist in navigating the health care system when overwhelmed by the complexity, severity or pervasiveness of a medical condition;
- Helping to effectively manage care that is likely to exhibit high use of health care resources and/or benefit dollars;
- Actively monitoring the Plan to identify cases where a patient might benefit from other CM services, even when participation in other programs was refused. If an opportunity arises, Blue Care Connection will initiate services automatically.

RETIREE MEDICAL PLAN

When you retire, you may choose to enroll in and be covered under the Retiree Medical Plan if you meet the eligibility requirements and you make your monthly premium payments. Medical coverage under the Retiree Medical Plan includes prescription drug coverage. Your coverage begins on the first day of the month following the month your coverage under the Active Plan ends. Your coverage under the Active Plan of benefits will continue in retirement until your eligibility runs out. After that, you may elect coverage under the Retiree Medical Plan, Retiree Basic Medical Coverage Plan, or COBRA Continuation Coverage under the Active Plan.

Remember: If you qualify for Retiree benefits, you have only one opportunity to elect coverage for you and your eligible dependents. However, if you initially choose single coverage for yourself, you may be able to add your eligible dependents later during an open enrollment period or during a special enrollment period if they experience a qualifying special enrollment event.

Statement of Grandfathered Plan Status

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 708-562-0200 or 866-906-0200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Monthly Premium Payments

You must make monthly premium payments for coverage under the Retiree Medical Plan. The amount is automatically deducted from your monthly pension check. If you are receiving pension benefits from the LIUNA Pension Fund and you are eligible to participate in the Retiree Medical Plan, you must make monthly premium payments directly to the Fund Office.

Once you are eligible for Retiree coverage, you will be notified of the current monthly premium payment rate for coverage. The amount of your monthly premium payment is based on:

- Your years of service earned under the Chicago Laborers' Pension Plan (if you are disabled or if you worked under the LIUNA Pension Fund, your service reported to the Chicago Laborers' Welfare Fund may count toward your years of service); and
- Whether or not you elect dependent coverage (you may elect coverage for yourself only or for yourself and your dependents, which may include your spouse, spouse and children or children only).

Monthly premium rates are subject to change and are reviewed annually by the Trustees; you will be notified of any change in rates. In addition, at the time you contact the Pension Department to apply for pension benefits, you will be notified of the current monthly premium rate.

If you or your dependents exceed your Plan Year maximum, the Laborers' Welfare Fund will continue to deduct premiums from your pension benefit for the remainder of your or your dependent's Plan Year maximum or for a period the Trustees deem appropriate. If you do not receive a pension from the Laborers' Pension Fund and send a check each month to the Laborers' Welfare Fund for monthly premium payments, you must continue to pay your monthly premium payments for the remainder of your or your dependent's Plan Year maximum, or for a period the Trustees deem appropriate.

Coverage for Your Survivors

In the event of your death, your surviving spouse and dependents may continue Retiree Medical Plan coverage by making monthly premium payments. Your dependents must contact the Fund Office. When your dependents contact the Fund Office regarding your death, the Pension Department will provide information regarding any survivor pension benefits as well as information regarding continuing medical coverage and the amount of the required monthly premium payments for that coverage.

Schedule of Retiree Medical Benefits

The following chart outlines the benefits payable under the Retiree Medical Plan. As a participant in the Retiree Medical Plan, you receive the benefits listed below, in addition to Retiree Basic Medical Coverage Plan benefits. Benefits are paid on a calendar year basis. All eligible expenses are covered at the Usual and Customary (U&C) Charge rates in effect at the time of service. See page 20 for the definition of Usual and Customary charges.

Benefit	Amount Paid by Retiree Medical Plan
Emergency Room Deductible	$50 per visit
Pre-certification for Inpatient admissions (pre-Medicare Retirees and Dependents only)	Call 800-433-3232 to obtain pre-certification for an Inpatient admission to a health care facility: • One business day in advance of all scheduled admissions; and • Within two business days following an emergency admission. **There will be a $200 reduction in benefits for failing to obtain pre-certification.**
Coinsurance[1] BCBS Network Provider Non-Network Provider	The Plan pays: 90% of Covered Services 80% of Covered Services
Annual Out-of-Pocket Maximum[1]	Once you pay $2,500 per person per calendar year the Plan pays 100% of additional covered expenses up to your lifetime maximum
Plan Year Maximum	$750,000, effective June 1, 2011; $1,250,000, effective June 1, 2012; $2,000,000, effective June 1, 2013; Unlimited effective June 1, 2014
Chiropractic Care Annual Maximum	30 visits per person per calendar year
Hearing Aids[2]	$1,500 maximum benefit every three years
Prosthetic Devices Initial or replacement device for Member, Spouse, and children	Subject to Coinsurance Limited to one prosthetic device per limb every five calendar years
Hospice	Up to 365 days per lifetime
Home Health Care Services and Skilled Nursing Facility Services Annual Maximum	180 days per calendar year
Wellness Benefits for Retirees and Spouses	Plan pays 100% of covered expenses
Colonoscopy or flexible sigmoidoscopy (Retiree and Spouse only)	Plan pays 100% of covered expenses Coverage limited to once every five years
Smoking Cessation (Retiree and Spouse only)	Plan pays 100% of covered expenses up to $1,000 per person per lifetime
Nebulizers	Plan pays 100% of covered expenses Coverage limited to once every three years
Transplant Benefit	Contact Fund Office to determine coverage

Benefit	Amount Paid by Retiree Medical Plan
Prescription Drug Benefits[3] CVS/Caremark Participating Network Pharmacy Non-Participating Pharmacy	Plan pays: 80% 50%; your 50% Coinsurance does not apply toward your out-of-pocket maximum
Dental Benefits	See explanation and schedule on pages 43 – 44
Vision Benefits	See explanation and schedule on pages 45 – 47
Vision Correction Surgery (Retiree and Spouse only)	See explanation on page 35
Death Benefit (Retiree only)	See explanation on page 48

[1] Eligible expenses are covered at the Usual and Customary (U&C) Charge rates in effect at the time of service.
[2] Not subject to the Plan's Coinsurance provisions.
[3] Prescription drug benefits are provided through CVS/Caremark Network. When you have your prescription filled at a CVS/ Caremark Network participating Pharmacy, you will receive your prescription at a discounted price.

How the Retiree Medical Plan Works

You and the Plan share expenses. The Retiree Medical Plan pays a percentage of Covered Services (known as Coinsurance). After the amounts you pay for Coinsurance reach your out-of-pocket maximum of $2,500 during the calendar year, the Plan pays 100% of eligible covered medical expenses for the remainder of that calendar year up to the Plan Year maximum.

Emergency Room Deductible

You must pay a $50 deductible each time you or your dependent use the emergency room for your Medical Care and treatment.

Coinsurance

Each year, the Plan pays a percentage of Covered Services and you pay the rest, up to the annual out-of-pocket maximum. This is known as Coinsurance.

The Plan offers benefits and care from a network of Physicians and Hospitals that participate in the Blue Cross Blue Shield (BCBS) BlueCard Preferred Provider Organization (PPO). See page 2 for more information about the BCBS PPO.

The Plan pays:

- 90% of Covered Services when you use a network Provider; or
- 80% of Covered Services when you use a non-network Provider.

All eligible expenses are covered at the Usual and Customary (U&C) Charge rates in effect at the time of service.

To Find a Network Provider, contact:

Blue Cross Blue Shield (Medical)
800-810-2583
www.bcbsil.com

Fund Office:
708-562-0200 or 866-906-0200

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

Call Center: 8:00 AM–5:00 PM, Monday–Friday

Emergency Room Deductible: $50 per visit

PPO

A network of Physicians and Hospitals that have agreed to charge negotiated rates. Since network Providers have agreed to these negotiated rates, you help control health care costs for you and the Plan when you use a network Physician or Hospital. You always have the final say about the Physicians and Hospitals you and your family use.

Usual and Customary Charge

- The charge that is no higher than 400% of what Medicare would pay for the services.
- For multiple or bilateral surgeries performed at the same time, 100% for the primary procedure and for the secondary procedures, an amount determined after medical review;
- For surgical assistance by a Physician, 20% of the charge allowed for the Surgery; and
- For PPO Providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

When you use a network Provider, you save money for yourself and the Plan because network Physicians and Hospitals have agreed to charge a negotiated price for their services. Here's how it works:

EXAMPLE: How Using a Network Provider Can Save You Money

Let's compare what Joe pays for his hospitalization when using a network Hospital versus a non-network Hospital. Joe is eligible for benefit coverage and when Joe has Surgery, his share of the costs is determined as follows:

	Network Hospital	Non-Network Hospital
Expenses Charged for a 2-day Hospital Stay	$3,200	$3,200
Network Discount	– $600	– $0
Adjusted Charges	$2,600	$3,200
Plan Pays	**$2,340 (90%)**	**$2,560 (80%)**
Joe Pays	**$260 (10%)**	**$640 (20%)**

This example assumes a BCBS PPO savings rate of approximately 20%. The actual savings may vary.

Joe saves $380 by using a BCBS network Hospital.

If You Are Eligible for Medicare

If you or your eligible dependents are eligible for Medicare, the Retiree Medical Plan coordinates benefits with your or your dependent's Medicare benefits. The Plan pays Covered Services after Medicare pays benefits. Covered Services include your or your dependent's Medicare Part A and B deductibles and copayments.

The Plan provides prescription drug benefits if you and your dependents are eligible for Medicare. These benefits are not provided through a Medicare Part D Prescription Drug Plan. If you or your dependent chooses to have prescription drug coverage under Medicare Part D, you and your covered dependents will lose eligibility for the Plan's prescription drug benefits. You or your dependent cannot have benefits under both Medicare Part D and this Plan. The Plan does not coordinate prescription drug benefits with Medicare Part D. Claims incurred during any period in which you or your dependent is enrolled in Medicare Part D will not be covered by this Plan.

Since the Plan treats you or your dependent as having enrolled in both Medicare Part A and Part B when you or your dependent is first eligible, if you or your dependent fail to obtain Medicare Part B coverage for the month you or your dependent is first eligible, your or your dependent's benefits will be reduced by the amount the Plan estimates Medicare would have paid had you or your dependent enrolled for Medicare Part B coverage.

Coordination with Medicare

If you or your dependent is eligible for Medicare, your or your dependent's benefits will be coordinated with Medicare. If you or your dependent fails to obtain Medicare Part B coverage, your or your dependent's benefits will be reduced by the amount the Plan estimates Medicare would have paid had you or your dependent enrolled for Medicare Part B coverage.

Enroll in Medicare Part B prior to the month in which you are eligible.

When you are eligible for Medicare, the Plan treats you as if you were enrolled in both Medicare Part A and Part B, so you should enroll in Part B (or, alternatively, Part C) in the three-month period prior to the month in which your initial eligibility date occurs to avoid paying for expenses that Medicare Part B would have otherwise covered.

While, in general, people who are eligible for Medicare are not required to file an application for enrollment in Medicare Part A (Hospital Insurance), they are required to file an application for enrollment in Medicare Part B (Supplemental Medical Insurance). To be entitled to receive Medicare Part B benefits in the month in which you become first eligible, you must file an application for Part B in the three-month period prior to the month in which you become first eligible.

For example, if you reach age 65 on April 15, you must file your Part B application during the preceding January, February or March to become entitled to receive Part B benefits on April 1. If you file your application in the month in which you become age 65, you will not be entitled to receive Part B benefits until the month following the month in which you apply. Using the example above, if you filed your application in April, you would not be entitled to receive Part B benefits until May 1, and you will be responsible for the payment of medical expenses incurred during April that Medicare Part B would have paid had you enrolled. After you have enrolled in Medicare Part B, you must provide the Fund Office with proof of your eligibility.

EXAMPLE: How the Retiree Medical Plan Coordinates With Medicare

Pete incurs $1,100 in Covered Services from his Physician. Under the Retiree Medical Plan, since Pete is eligible for Medicare, Medicare will pay first and then the Plan will pay. However, the maximum amount the Plan will pay is calculated without considering what Medicare will pay. The following shows what Medicare, the Plan, and Pete will pay. This example assumes Pete does not use a network Provider.

What Medicare Will Pay	
Covered Services	$1,100
Medicare Part B deductible	– $135
Remaining Covered Services	$965
Medicare Part B Coinsurance	x 80%
Medicare pays	$772
Maximum Plan Will Pay	
Covered Services	$1,100
Plan Coinsurance	x 80%
Maximum Plan will pay	$880
What Pete Will Pay	
Covered Services	$1,100
Medicare pays	– $772
Remaining amount not paid by Medicare	$328
Amount Plan pays	**$328**

In this example, Pete incurs no out-of-pocket costs.

Out-of-Pocket Maximum

Once the amount you pay toward covered medical expenses reaches your annual out-of-pocket maximum of $2,500 for the calendar year, the Retiree Medical Plan pays 100% of eligible covered medical expenses for the remainder of that year up to the Plan Year maximum.

Plan Year Maximum

Effective June 1, 2011, the Retiree Medical Plan pays up to a Plan Year maximum of $750,000 per person in Covered Services. Effective June 1, 2012, the Plan Year maximum increases to $1,250,000. Effective June 1, 2013, the Plan Year maximum increases to $2,000,000. Effective June 1, 2014, the Plan Year maximum is eliminated and you will have unlimited lifetime benefits.

Medically Necessary

Services, treatments, or supplies ordered by your Physician that are:

- Required to identify or treat an injury or illness;
- Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, illness or injury;
- In keeping with acceptable National Standards of Good Medical Practice; and
- The most appropriate that can be safely provided to you under the circumstances on a cost-effective basis.

Retiree Medical Plan Covered Services

The Retiree Medical Plan covers the actual Usual and Customary Charges for the Medically Necessary services and supplies that are listed below. Limitations on the number of treatments and the dollar amount for the treatment are contained in this section and in the Schedule of Retiree Medical Benefits on pages 19 and 20.

- *Acupuncture* if treatment is by a licensed acupuncturist for the treatment of pain management only.
- *Alcoholism and/or Substance Abuse treatments* are treated like other medical illnesses. An Inpatient treatment center must meet the following criteria:
  - Be nationally recognized by an accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));
  - Have full-time permanent bed care facilities for five or more resident patients;
  - Have the regular services of a Physician;
  - Provide 24-hour-a-day services by a licensed medical professional;
  - Perform mainly diagnostic and therapeutic Medical Care of patients, or provide care and treatment for Substance Abuse;
  - Not be a nursing, convalescent, or rest home or residence for the aged; and
  - Be licensed to operate where it is located.

To find a network Provider, contact:
BCBSIL
800-810-2583
www.bcbsil.com

- *Ambulance Service* deemed Medically Necessary and not for patient convenience. The Fund may request additional information on your medical condition to evaluate Medical Necessity for transport via ambulance.
- *Ambulatory Surgical Centers*, including supplies and facility charges are covered based on Medical Necessity for surgical procedures performed on an Outpatient basis.
- *Anesthetic and Anesthesia Services*. However, for charges from both an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA) for services provided on the same day, the Plan will only pay for services performed by one Provider. Payment will be made in the order in which the charges are received.
- *Assistant Surgeon* charges by Physicians or Certified Surgical Assistants may be covered; however, the Plan may review the Medical Necessity of the assistance during the Surgery performed. The Plan does not cover charges for Physician Assistants and Nurse Practitioner assistance during Surgery. Please contact the Fund Office for more information.
- *Breast Reconstructive Surgery* and breast prosthesis following a mastectomy.

  Under the federal Women's Health Act and Cancer Rights Act, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain Reconstructive Surgery. If you or your dependent are receiving benefits under the Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage as determined by you and your Physician for:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

  This coverage is subject to the same Coinsurance provisions applicable to other physical conditions covered under the Plan.

Reconstructive Surgery may be covered under the Plan only if such procedures or treatment is intended to improve bodily function and/or correct deformity resulting from a congenital anomaly that causes a functional effect or results from a prior covered therapeutic procedure.

- *Breast Reduction Surgery* that is not cosmetic in nature, but is deemed Medically Necessary by the Fund's Medical Consultant(s). Please contact the Fund Office before Surgery.

- *Certified Surgical Assistants (CSA)*. The Plan pays the Usual and Customary Charge amount of 85% of the 20% allowed amount of the surgeon's charges for Covered Services provided by Certified Surgical Assistants (CSA).
- *Chemotherapy* for cancer treatment.
- *Chiropractic and spinal manipulation* if treatment is for back-related care only up to 30 visits per calendar year. No other payment from any other portion of the Plan will be made.
- *Cochlear implants* are covered as follows:
  - Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 27);
  - Other expenses (such as Hospital, pathology, radiology, and anesthesia) are covered the same as other Medical Benefits; and
  - Associated Speech Therapy may be covered (see page 28 for more information about Speech Therapy coverage).

When you need to see a Physician:

- Call to make an appointment.
- Write down any questions that you want to review with your Physician so you won't forget to ask them during your appointment.
- Make a list of any medications you're taking and how often you take them.
- Show your ID card when you go to your appointment.

Your Physician's office will file a Claim for you with the local BCBS office.

- *Colonoscopy or flexible sigmoidoscopy* is covered for routine screening purposes. This benefit is available to the Retiree and eligible spouse only.
- *Convenient Care Clinics (CCCs)* are used for treating common/uncomplicated minor illnesses (i.e., colds, ear infections, sprains) and for receiving preventive health care services (i.e., health screenings, vaccinations). CCCs are clinics located in retail stores, supermarkets, and pharmacies and are also referred to as walk-in medical clinics, retail-based clinics, and/or mini-clinics. The Plan pays the Usual and Customary Charge for Covered Services.
- *Cosmetic Surgery* that is necessary to repair damage caused by an accident if performed within two years of an accident.
- *Diabetes education* up to $400 per person per calendar year for participation of you and your family in a diabetes instruction program.
- *Diagnostic Service* as ordered by a Physician to determine treatment of a medical or psychological diagnosis. Procedures may include X-rays, blood tests, MRIs, ultrasounds, and other laboratory tests.
- *Dialysis Treatment*, which may include hemodialysis or peritoneal dialysis.
- *Doctors' or Physicians' services* may be provided either in or out of a Hospital and include surgical procedures and other Medical Care and treatment. For benefits to be payable, the individual must be legally qualified and acting within the scope of his or her license when services are performed.
- *Durable medical equipment* is covered under the Plan and includes equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Rental of durable medical equipment is only covered up to the purchase price of the same equipment.
- *Erectile dysfunction treatment*, provided the dysfunction is physical, not psychological, in nature. Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 27).
- *Gardasil injections* for prevention of cervical cancer are covered under the Plan's wellness benefits, see page 28. (Gardasil would not be covered for dependent children on retiree plans since they do not have wellness benefits.)
- *Hearing aids* are covered up to $1,500 over a three-year period. The Coinsurance provisions do not apply to these expenses.
- *Home health care* following your Hospital stay, up to a maximum of 180 days per calendar year (combined with Skilled Nursing Facility Services). Covered expenses include care by a nurse (RN or LPN), evaluation and development of a plan of home care by a Registered Nurse (RN), Licensed Clinical Social Worker, Physical or Occupational Therapist, and medical supplies, drugs, and medications prescribed by your Physician to the extent they would be covered had you been hospitalized. Covered expenses do not include home health aid services. The program of care should be established by a public or private agency that:

- Is properly licensed in the state in which the patient is receiving care and where it provides services or is certified under Medicare;
- Provides therapeutic and Skilled Nursing Services;
- Has its policies governing services set by a professional group;
- Provides for supervision of its services by a Physician or registered nurse;
- Provides mainly therapeutic and Skilled Nursing Services; and
- Maintains clerical records of all patients.

These expenses are combined with Skilled Nursing Facility expenses for a calendar year total benefit of 180 days.

- *Hospice Care* for the Hospice Care program services described below when rendered by a Hospice Care program Provider. To be eligible for Hospice Care benefits, the patient must be diagnosed as terminally ill, as certified by the attending Physician. Terminally ill refers to an individual with a medical prognosis of six months or less to live. Once eligible for Hospice Care benefits, the patient will no longer benefit from standard Medical Care or has chosen to receive Hospice Care rather than standard Medical Care. A family member or friend should be available to provide custodial type care between visits from Hospice Care program Providers if Hospice Care is being provided in the home.

  Preparing for a Hospice Care period:

  - Oral or written certification of the terminal illness by the medical director of the hospice or the patient's medical Physician must be submitted to the Fund Office within 13 calendar days after Hospice Care is initiated (that is, by the end of the fourteenth day). Oral certification can be provided by calling 708-562-0200 or 866-906-0200 and asking to speak with the Fund's Nurse Consultant. If oral or written certification is submitted 15 or more days after Hospice Care is initiated, the hospice benefit will begin on the date the certification is received.
  - The first period of certified Hospice Care will last for 90 calendar days. Oral or written recertification of the patient's status must be provided within the two-week period before the expiration of the 90-day period, but no more than 14 calendar days after the expiration of the 90-day period or benefits will be suspended until recertification is received. Oral or written recertification must be submitted every 90 days thereafter, up to a maximum of one-year of Hospice Care.

  The following services are covered under the Hospice Care program:

  - Medical appliances, supplies, and dressings;
  - Nursing services provided by a registered nurse or licensed practical nurse;
  - Home health aide services provided under the general supervision of a registered nurse;
  - Occupational, Physical, and Speech Therapy services provided for purposes of symptom control;
  - Pain management services;
  - Physician visits; and
  - Individual and family group counseling by qualified medical practitioners as defined by the Plan.

Doctors, Physicians, and other Practitioners

Benefits may be paid for Medically Necessary services provided by certain legally qualified and licensed practitioners. Such professionals include:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Podiatric Medicine;
- Doctor of Optometry;
- Doctor of Ophthalmology;
- Doctor of Chiropractic Medicine;
- Doctor of Naprapathy;
- Licensed Acupuncturist
- Clinical Psychologist;
- Licensed Clinical Social Worker;
- Licensed Clinical Professional Counselor;
- Licensed Marriage and Family Therapist;
- Licensed Physical and Occupational Therapist;
- Licensed Speech Therapist;
- Certified Registered Nurse Anesthetist;
- Certified Surgical Assistant;
- Nurse Practitioners;
- Physician Assistants; or
- Doctor of Dental Science and Doctor of Dental Medicine if the individual provides Medically Necessary medical and/or surgical services or treatment.

The following services are not covered under the Plan's Hospice Care benefits:

- Home delivered meals;
- Food in liquid form for the purposes of feeding through a feeding tube to sustain life and prescription drugs, except as covered under the Plan's Prescription Drug Benefits;
- Homemaker or caretaker services and any services or supplies not solely related to the care of the patient, including sitter or companion services for the patient who is ill, house cleaning, and general maintenance of the patient's home;
- Transportation, including, but not limited to, Ambulance Service;
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition;
- Funeral arrangements;
- Pastoral or bereavement counseling;
- Respite Care Services;
- Financial or legal counseling;
- 24-hour Private Duty Nursing Service fees; or
- Hospice Care that extends beyond a one-year period.

Some expenses may be covered by other provisions of the Plan. Contact the Fund Office for more information.

A Hospital must:

- Be a nationally recognized accredited agency;
- Have full-time permanent bed care facilities for five or more resident patients;
- Have the regular services of a Physician;
- Provide 24-hour-a-day nursing services by registered nurses;
- Perform mainly diagnostic and therapeutic medical and surgical care of patients, or provide care and treatment for Substance Abuse;
- Not be a nursing, convalescent or rest home or residence for the aged; and
- Be licensed to operate where it is located.

- *Hospital room and board and charges* for services and supplies include:
  - Charges for a semi-private room with general nursing services;
  - Charges for a private room if Medically Necessary (such as for contagious or communicable diseases);
  - Intensive care units;
  - Nursery charges for newborns;
  - Emergency room treatment; and
  - Charges made by the Hospital for services and supplies for care received while an Inpatient or Outpatient. These services and supplies do not include room and board, Physicians' fees, or specialized or Private Duty Nursing Service fees.
- *Mammography*, annually covered by the wellness benefit for Eligible Retirees and spouses. See page 28.
- *Mastectomy* related services, see Breast Reconstructive Surgery on page 23.
- *Mental health treatment* (including nervous disorders) is treated like other medical illnesses. Family counseling may be covered with appropriate diagnosis. An Inpatient treatment center must meet the following criteria:
  - Be nationally recognized by an accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));
  - Have full-time permanent bed care facilities for five or more resident patients;
  - Have the regular services of a Physician;
  - Provide 24-hour-a-day services by a licensed medical professional;
  - Perform mainly diagnostic and therapeutic Medical Care of patients;
  - Not be a nursing, convalescent, or rest home or residence for the aged; and
  - Be licensed to operate where it is located.

Mental Health Disorders

A Mental Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health disorders include, but are not limited to, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.

- *Midwife services* are covered for the delivery of a newborn child only when provided by a Certified Nurse Midwife (CNM). For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery.
- *Naprapath* services are covered only if given by a licensed Naprapath.
- *Nebulizers* for Eligible Retirees and eligible dependents, which are paid at 100%, once every three years.
- *Nurse Practitioners (NP)/Physician Assistants (PA) office services*. A NP or PA is a health professional, qualified by academic and clinical training who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a qualified licensed Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plan does not cover NP or PA assistance during Surgery.
- *Nursery care for newborn dependents*, including Physician's charges for circumcision or medical treatment, if the newborn dependent is covered under the Plan.
- *Nutritional counseling expenses* and services are covered for documented cases of anorexia or bulimia.
- *Occupational Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Oral appliances* provided by a Delta Dental PPO Dentist for sleep apnea will be covered under the Plan to match the benefits the Plan provides for TMJ and bruxism appliances. If you are eligible, the Plan will pay 80% for oral appliances for sleep apnea up to $500 per appliance (including the cost of any repairs to the appliance).
- *Orthotics* are covered up to one pair per calendar year. Orthotics must be custom made or custom fit to qualify for reimbursement.
- *Oxygen and oxygen equipment*, including the purchase of or the rental cost up to the amount of the purchase price.
- *Physical Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Pre-admission tests* for Hospital confinement, including X-rays, laboratory examinations, tests, or analyses.
- *Pregnancy expenses* include Physician's fees, Hospital charges, tests, and home birth delivery by an M.D., prenatal office visits, anesthesia, tubal ligations, and other pregnancy-related conditions. For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery. You or your spouse must be covered under the Plan at the time of delivery or at the time of other services for such services and supplies to be covered. The Plan covers charges for pregnancy in the same way it covers any other medical condition.
- *Prosthetic bras*, which include the initial cost of up to three prosthetic bras following a mastectomy. Replacement bras are not covered.
- *Prosthetic Devices* are covered only when ordered by a Physician and only for the standard models. Payment for an initial or replacement device will be covered subject to the Plan's Coinsurance amounts. Replacement devices are covered once every five years for adults and every two years for a child under the age of 16. Charges for Medically Necessary repairs, adjustments, or servicing of the device, due to changes in the covered person's physical condition. All charges are subject to the Plan's Coinsurance amounts.

Hospital Stays in Connection with Pregnancy

The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section.

Health care Providers are not required to obtain authorization from the Plan for Hospital stays within these guidelines. Federal law does not prohibit the Physician, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 (or 96) hours.

Prosthetic Device

A prosthetic appliance (or device) is a type of corrective appliance or device designed to replace all or a part of a missing body part, including but not limited to, artificial limbs and artificial eyes.

- *Second surgical opinion* includes services and supplies necessary to obtain the opinion.
- *Skilled Nursing Facility* services are covered based on Medical Necessity up to a maximum of 180 days per calendar year (combined with Home Health Care Services). A Skilled Nursing Facility provides Skilled Nursing Services 24 hours a day, 7 days a week, under the supervision of a registered nurse and may provide Outpatient rehabilitative services at least five days per week. The emphasis is on Skilled Nursing Services with restorative, Physical, Occupational, and other Therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an immediate care facility. The services provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge when Inpatient services are provided.
- *Social Worker.* The Plan covers specific services by a Licensed Clinical Social Worker; contact the Fund Office for more information.
- *Speech Therapy* may be covered for rehabilitation needs resulting from an injury or accident. Contact the Fund Office for more information.
- *Sterilization procedures*. The Plan covers standard sterilization procedures, such as tubal ligation, hysterectomy, and vasectomy for the Retiree and spouse only. Reversals of such procedures are not covered by the Plan.
- *Substance Abuse treatment* is treated like other medical illnesses. To be covered, an Inpatient treatment center must:
  - Be nationally recognized by an accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));
  - Have full-time permanent bed care facilities for five or more resident patients;
  - Have the regular services of a Physician;
  - Provide 24-hour-a-day services by a licensed medical professional;
  - Perform mainly diagnostic and therapeutic Medical Care of patients or provide care and treatment for Substance Abuse;
  - Not be a nursing, convalescent, or rest home or residence for the aged; and
  - Be licensed to operate where it is located.
- *Suicide attempt.* Medical expenses relating to a suicide attempt are covered once per lifetime.
- *Surgery*. If two or more procedures are performed through the same incision, it will be considered one operation and benefits will be payable for the most expensive procedure.
- *Temporomandibular Joint (TMJ) Treatment*. The Plan covers injections and Surgery related to TMJ treatment when performed by a licensed Physician, Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD).
- *Transplants*. The Plan provides organ and tissue transplant benefits. If you need information about organ and tissue transplants, you should contact the Fund Office at 708-562-0200 or 866-906-0200 and ask to speak to the Nurse Consultant.
- *Vision Correction Surgery*, including corrective procedures such as LASIK Surgery, is covered by the Plan for Eligible Retirees and eligible spouses up to one procedure per eye per lifetime. The Plan does not cover re-treatment warranties or enhancements. All charges are subject to the Plan's Coinsurance amounts. See page 20 for more information.
- *Wellness benefits for Eligible Retirees and eligible spouses* include blood chemistry profile, complete blood count, urinalysis, blood pressure analysis, electrocardiogram, colorectal screening, prostate (PSA blood test), pap test, Physician's exam, routine mammography, HIV testing, and other preventative exams as ordered by your Physician.
- *Wig*, one after Chemotherapy.

The Plan includes a LASIK network, QualSight. When you use a QualSight facility, the Plan pays the PPO allowance for LASIK Surgery costs, including Intralase, subject to the Plan's Coinsurance amounts. If you do not use a QualSight facility, the Plan will reimburse you for the maximum network amount for your particular Surgery. You are responsible for all costs above the maximum PPO allowance. To find a QualSight facility, call 877-718-7676 or go to **www.qualsight.com**.

Smoking Cessation Benefit

The Plan includes a smoking cessation benefit for all Eligible Retirees and their spouses. The Plan reimburses 100% of covered expenses, up to $1,000 per person per lifetime.

Covered medical expenses include:

- Prescription medications;
- Hypnosis; and
- Laser treatments, when performed by Laser Concepts of Chicago.

Laser Concepts of Chicago has four locations in Illinois, as well as locations in Indiana and Wisconsin. For more information about locations and hours, you can call 866-908-7848 or visit **www.laserconceptschicago.com**.

Only treatment that is prescribed by your doctor will be covered by the Plan. Since a prescription is required for all treatments, the first thing you need to do is go to your doctor for treatment; the doctor's visit is a covered expense under this benefit.

While medications are covered, smoking cessation covered expenses are considered medical benefits and are not covered under the Plan's prescription drug benefits. This means you'll need to pay for covered prescription medication expenses up front and then submit a Claim for reimbursement.

Retiree Medical Plan Exclusions and Limitations

Only expenses related to non-occupational injuries and illnesses are covered.

Expenses that are not covered under the Plan's Medical Benefits include, but are not limited to, the following.

Exclusions

Not all of your medical expenses are covered by the Plan. Please read these items carefully to see what is excluded from or limited in coverage. In rare instances, an item excluded under the Plan may be payable for a specific diagnosis. If you have questions regarding coverage, contact the Fund Office.

1. Any expenses incurred during a period in which you or your dependents are not eligible for benefits under the Retiree Medical Plan.
2. Any expenses incurred by a dependent who does not meet the Plan's definition of dependent.
3. Services or supplies that are not Medically Necessary or that exceed the Usual and Customary Charge.
4. Personal items received while confined to a Hospital.
5. Services or supplies while you are not under a Physician's care or you are under the care of a person who does not meet the Plan's definition of doctor or Physician. (See page 79 for the Plan's definition of a Physician or doctor.)
6. Services or supplies that are not recommended or approved by your Physician.
7. Services for conditions other than ones specifically identified as being covered under the Plan.
8. Dental and vision services other than those covered under the dental or vision portion of the Plan. Services that are specifically excluded are:
   a. Dental X-rays.
   b. Dental implants.
   c. Treatment of teeth or gums other than for tumors that need removal by a specialist other than an oral surgeon.
   d. Treatment of other associated structures primarily in connection with treatment or replacement of teeth, unless incurred within two years after an accident that is necessary for the repair or alleviation of damage to natural teeth resulting from that accident.
9. Any expenses relating to appetite control, food addictions, eating disorders, weight reduction, or obesity except for documented cases of bulimia or anorexia that meet standard Diagnostic Service criteria as determined by the Fund Office and the Plan's medical consultants.

10. Nutritional counseling is excluded, except diabetes education and for documented cases of bulimia or anorexia that meet Standard Diagnostic Service criteria.
11. Gastric stapling, gastroplasty, gastric banding, or any other surgeries or procedures related to weight reduction or obesity, including, but not limited to, excess skin removal and complications resulting from any weight reduction Surgery.
12. Hair removal or hair implants.
13. Home health aid except as covered under the hospice benefit.
14. Infertility expenses.
15. Liposuction.
16. All medications, medical supplies, or medical equipment that may be purchased over the counter.
17. Baby formula and breast pumps.
18. Breast reduction Surgery that is cosmetic in nature.
19. Expenses of an elective abortion, except when:
    a. The mother's life is in danger; or
    b. There are medical complications from an abortion procedure; or
    c. The abortion is spontaneous.
20. Injuries, illnesses, or diseases you sustained while working and that are covered by any workers' compensation law, employer liability law, occupational disease law, or similar law.
21. Custodial Care, which includes services or supplies, regardless of where or by whom they are provided that:
    a. A person without medical skills or background could provide or be trained to provide; or
    b. Are provided mainly to help the patient with daily living activities including walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastrostomy feeding, cleaning, preparation of meals, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care treatment plan not reasonably expected to improve the patient's condition, illness, injury, or functional ability.
22. Maintenance or Developmental Care, which includes services or supplies, regardless of where or by whom they are provided, that are:
    a. Provided to a patient who has not previously reached the level of development expected for the person's age in the following areas: intellectual, physical, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency;
    b. Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or
    c. Educational in nature.
23. Cosmetic Surgery, except when it is performed to:
    a. Correct injuries that occurred as the result of an accident within two years of the accident.
    b. Repair defects that result from a Surgery for which the covered individual was paid benefits under the Plan within two years from the date of the Surgery that caused the defect.
24. Sex transformation Surgery or treatment.

25. Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures. These include services and treatments that are:
    a. Not yet officially accepted by the medical community.
    b. Not recognized as having proven beneficial outcomes to the patient.
    c. Not yet approved by the Food and Drug Administration.
    d. Still primarily confined to a research setting.
    e. Are not recommended for an advanced state of an illness or disease.
26. Charges incurred by organ donors that are not related to the original donor transplant procedure or complications that result from such surgeries, procedures, or treatment.
27. Services provided by a government Hospital where governmental coverage is primary.
28. Expenses excluded under coordination of benefits clauses.
29. Expenses that may result from failure to use an HMO, PPO, or EPO Provider when covered under another plan that so requires.
30. Charges for the reversal of previous elective sterilization, including the use of infertility benefits.
31. Premarital examinations.
32. Marriage counseling.
33. Court mandated counseling or therapy.
34. Chelation therapy.
35. Physical Therapy, chiropractic treatment, or Occupational Therapy for developmental delays.
36. Repairs to or replacement of durable medical equipment.
37. Maintenance charges or batteries for durable medical equipment.
38. Expenses for any items that are not corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment. This includes, but is not limited to, air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation including ambulance charges for patient convenience, pillows, mattresses, water beds, and air conditioners.
39. Expenses for corrective appliances and durable medical equipment to the extent that they exceed the cost of standard models of such appliances or equipment.
40. Hospital facility and Anesthesia Service charges for dental procedures, except coverage may be provided for dependent children age two and younger when documented evidence of uncooperative behavior and extensive dental work is provided. Hospital confinement for dental work performed on children older than two may be covered under the Plan if in compliance with the Claim Department guidelines (contact the Fund Office for more information).
41. Massage therapy.
42. Vision therapy, including orthoptic therapy.
43. Sterilization procedures that are not standard.
44. Assistant surgeon charges incurred and billed by Nurse Practitioners or Physician Assistants.
45. Physical examinations required for employment purposes.

46. Multiple charges for office visits by the same Physician on the same date. Only one visit per day is covered.
47. Charges for treatment provided by a patient's family member.
48. LASIK procedures performed on any child who is covered under the Plan and considered a dependent, as defined by the Plan (see page 10).
49. Speech therapy, except in the case of illness, accident, or injury.
50. Medical services, including but not limited to medical visits, injections, and vaccinations rendered by a pharmacist, Nurse Practitioner, or Physician's Assistant not performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider.

Prescription Drug Benefits

Prescription Drug Benefits play an important role in your overall health. The Plan recognizes the importance of this coverage and provides you with prescription coverage through CVS/Caremark Inc., explained on page 2.

To find a participating Pharmacy, contact:
CVS/Caremark Inc.
www.caremark.com
Group No.: T 190

How Prescription Drug Benefits Work Under the Retail Program

- **Coinsurance**. Prescription drugs are treated like other medical expenses under the Retiree Medical Plan. The Plan pays 80% of your prescription drug cost if you use a participating CVS/Caremark Network Pharmacy. You may have your prescriptions filled at any retail Pharmacy. However, to receive the maximum benefits available from the Plan, you must have your prescription filled at a participating Pharmacy and show your ID card.
- **Prescription drug card**. To receive the negotiated rates with participating CVS/Caremark Network Pharmacies, you must show your prescription drug ID card at the time you fill your prescription. If you do not use a participating Pharmacy or do not show your ID card, the Plan will only pay 50% of covered prescription drug expenses. The 50% Coinsurance you pay does not count toward your out-of-pocket maximum.

Use Your Prescription Drug ID Card!

If you do not show your ID card when your prescription is filled or you do not use a participating Pharmacy, you are responsible for 50% of the cost of your prescription medication. Always be sure you use a participating Pharmacy and have your ID card handy to present to your pharmacist when you have your prescription filled.

- **Pay for your prescription when you pick it up and submit a receipt**. When you pick up your prescription, you must pay for your medication in full at the Pharmacy. To receive reimbursement from the Plan, you must submit your Pharmacy receipt to the Fund Office. A cash register receipt is not sufficient. The Fund Office requires a Pharmacy receipt that indicates the Pharmacy, drug name, national drug code, and total charges for your prescription. Your receipt will also indicate if you filled your prescription at a CVS/Caremark Network Pharmacy.
- **Contact the Fund Office for early prescription drug refills**. Prescription drug refills are available from your Pharmacy every 30 or 90 days. If you need an early refill of your prescription because you are traveling or are on vacation, you should contact the Fund Office before ordering your refill. The Fund Office will contact you once your early refill is approved through CVS/Caremark.

Using Generics

You can make your Prescription Drug Benefits go a long way and help save the Fund some money by asking your Physician or pharmacist if there is a generic medication available whenever possible. The Food and Drug Administration tests the most common prescription generic medications to ensure their quality is high. So, the next time you or someone in your family needs a prescription medication, be sure to ask your Physician if there is a generic of the prescribed medication available that is less expensive.

EXAMPLE: How Generics Can Save Money

Luke takes a medication on an ongoing basis. The medication is available as a generic and as a brand name medication. The following information shows how much could be saved in one year by using the generic medication:

	Generic	Brand Name
Cost of a one-month supply of medication	$63 x12	$131 x12
Total yearly cost of medication	$756	$1,572
Coinsurance Plan Pays (80%)	**$604.80**	**$1,257.60**
Coinsurance Luke Pays (20%)	**$151.20**	**$314.40**

This example assumes that Luke has his prescription filled at a participating Pharmacy and receives his prescription at discounted prices.

If Luke requests the generic, his total yearly prescription out-of-pocket cost would be only $151.20, which is $163.20 less than if he used the brand name medication. Plus, the Plan pays $652.80 less as well.

Prescription Drug Covered Expenses

The Plan covers the following:

- Legend drugs that are not listed as exclusions.
- Insulin.
- Disposable insulin needles/syringes.
- Growth hormones, in specific cases only. Coverage does not include anti-aging treatments; contact the Fund Office for more information.
- Immunization agents, blood, or blood plasma.
- Compound medications in which at least one ingredient is a legend drug.
- Medications obtained in a foreign country. However, under these circumstances the Plan will reimburse only 50% of the cost of legend prescription medications that are prescribed by a Physician.
- Medications, like Viagra and similar oral medications, for a diagnosis of impotence, limited to 10 tablets per month for Eligible Retiree and eligible spouse only.
- Medications to treat attention deficit disorder and narcolepsy.
- Topical tretinoin, such as Retin-A (restricted to covered individuals age 26 and younger).
- Food in liquid form for purposes of feeding through a gastrointestinal tube to sustain life. This assumes that liquid food is not available as an "over the counter" food supplement in retail Pharmacies. Further, the food will be covered only with a prescription. With the exception of an illness where recovery is not expected, the feeding condition must be expected to improve, otherwise the care will be considered custodial after 12 months. Medical evidence from the patient's Physician must be provided in writing for review by the Fund's medical consultant.

Use of Generics

While the use of generics is not required, you can save money for yourself and the Fund by asking your Physician or pharmacist for a generic substitute if there is one available. The Food and Drug Administration tests the most commonly prescribed generic medications to ensure that their quality is high. So, the next time you or your family member needs a prescription, ask your Physician if there is a less expensive generic medication available.

Expenses Not Covered Under Prescription Drug Benefits

Charges for the following drugs and medications are not covered by the Plan:

1. Anti-wrinkle agents, such as Renova.
2. Dermatologicals, hair growth stimulants.
3. Drugs that are considered Experimental or are determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.

4. Drugs that require a prescription by state law, but not by federal law.
5. Fluoride supplements.
6. Infertility medications.
7. Non-legend drugs, except those specifically listed as covered.
8. Pigmenting/depigmenting agents.
9. Vitamins/mineral supplements, except those prescribed as treatment for a diagnosed medical condition resulting from a covered illness or injury, legend pediatric multi-vitamins with fluoride, and pre-natal vitamins.
10. Drugs labeled "Caution–limited by federal law to investigational use" or Experimental drugs.
11. Medication taken by or administered to a patient in a Hospital, Skilled Nursing Facility, or similar institution that has a facility that dispenses medications operating on its premises.
12. Medications to promote weight loss or suppress appetite.
13. Medications that can be purchased without a prescription.
14. Medications that are covered under any other portion of the Plan.
15. Expenses that result from not using a PPO or other prescription drug plan when coverage under another plan is primary to this Plan.
16. Levonorgestrel (Norplant).
17. Legend contraceptives.

In rare instances, an item excluded under the Plan may be payable for a specific diagnosis. If you have questions regarding coverage, contact the Fund Office.

Specialty Drug Program

The Board of Trustees has implemented a Specialty Drug Program through the Fund's Pharmacy Benefit Manager, CVS/Caremark.

A specialty pharmaceutical or medication is sometimes referred to as a "biotech drug." These medications are designed to treat an ongoing major illness like hemophilia, hepatitis C, multiple sclerosis, osteoarthritis, hypertension, or macular degeneration, to name a few. At times, a specialty medication may be prescribed throughout a patient's lifetime.

How the Specialty Drug Program Can Save You Money

To ensure that you can afford to take what may be a life-saving medication, the Plan includes a Specialty Drug Program for specialty medications to help save you money.

Eligible Retirees and their dependents are required to pay 20% of the cost of the specialty medication, up to a maximum of $1,000 in out-of-pocket expense each calendar year. The Plan pays 80% of the cost of the specialty medication until you reach the out-of-pocket maximum; then the Plan pays 100% of the cost for the remainder of the calendar year.

EXAMPLE: How the Specialty Drug Program Can Save You Money

Ken must use a specialty medication to treat his rheumatoid arthritis. Here's how the program can save him money.

	Specialty Drug Program	Retail Program
Annual Cost of Medication	$18,000	$18,000
Ken's Coinsurance	$1,000	$3,600
Plan Pays	**$17,000**	**$14,400**

Under the Specialty Drug Program, Ken's Coinsurance is 20% of the cost of the medication, with a maximum out-of-pocket expense of $1,000 per calendar year. Under the retail program, the Plan pays 80% of the cost of the medication and Ken pays 20% of the cost of the medication.

The standard prescription drug program (also known as the retail program) and the Specialty Drug Program are unique and separate and cannot be combined. At no time will any Coinsurance paid under the Retail Program apply to the Specialty Drug Program.

Specialty Drug Program Advantages

When you participate in the Specialty Drug Program and use a CVS/Caremark Specialty Pharmacy, you could take advantage of the following:

- **Excellent Service.** The Program provides:
  - Personal attention from a pharmacist-led Care Team that provides condition-specific education, instructions on taking medicines properly, and expert advice to help you manage your therapy;
  - Easy access to pharmacists and other health experts 24 hours a day, 7 days a week; and
  - Informative condition-specific materials.
- **Enhanced Convenience.** The Program provides:
  - A single, reliable source for your specialty medication needs;
  - Easy ordering with a dedicated toll-free number;
  - Confidential and convenient delivery to the location of your choice (i.e., home, doctor's office, vacation spot, home of a relative, etc.); and
  - Helpful follow-up care calls to remind you when it's time to refill your prescription, check on your therapy progress, and to answer any questions you may have.

Please note: Some prescriptions need review prior to filling. Please contact the Fund Office for more information.

Participation in the Specialty Drug Program is Mandatory

If you are an eligible participant presently taking a specialty medication, you are required to enroll in the Specialty Drug Program.

If you are an eligible participant and are prescribed a specialty medication in the future, you will be allowed to fill your prescription at the retail Pharmacy only one time under the current Retail Program benefits. After your initial retail Pharmacy fill, you will be contacted by CVS/Caremark and be sent information on how to enroll in the Specialty Drug Program.

How to Enroll in the Specialty Drug Program

To enroll in the Specialty Drug Program, call CVS/Caremark at 866-387-2573 and identify yourself as a participant of the Chicago Laborers' Welfare Fund. Remember to request that CVS/Caremark contact your doctor directly to fill your next specialty drug prescription through the CVS/Caremark Specialty Pharmacy and assist you with the enrollment paperwork. All prescriptions are delivered to the location of your choice.

Vision Correction Surgery

Vision Correction Benefits

The Board of Trustees has contracted with QualSight, Inc. to provide Eligible Retirees and their eligible spouses with access to discounted vision correction Surgery. This program offers advantages such as:

- **Access to Quality Physicians**. Independent, NCQA-credentialed, Board Certified ophthalmologists.
- **Experience**. QualSight Providers have performed over 1.1 million procedures.
- **Savings**. 40% to 55% off the overall national average cost.
- **Retreatment Warranty**. If your ophthalmologist recommends retreatment within the first year of your procedure, you only have to pay the laser manufacturer's licensing fees of $100 to $300 per eye.

Charges for laser manufacturer's licensing fees and retreatment warranties are not covered under the Plan.

Eligible participants should contact QualSight at 877-718-7676. A QualSight Care Manager will register you and conduct a preliminary screening to ensure that you are a potential candidate for Surgery. The Care Manager will explain the Plan and network vision correction Surgery benefits available to eligible participants. The Care Manager will also discuss surgical procedures and answer your questions.

Next, you will select a local preferred Provider from a nationwide list. The Care Manager will schedule your pre-operative exam with the Provider and provide a confirmation to you via first class mail or e-mail. After a successful pre-operative exam, if you are eligible for benefits, you may choose to have the vision correction Surgery and follow up exams with your Provider.

The Plan pays for one vision correction procedure per eye, per lifetime, for Eligible Retirees and their eligible spouses. Vision Correction Benefits are not available for dependent children.

While you may choose to use the services of any vision correction Provider, your benefits are greater if you use a QualSight preferred Provider.

Pre-operative exam, Surgery, and post-operative exams are covered at 90% if you are eligible for benefits and choose a preferred Provider in the QualSight network. You only have to pay a 10% coinsurance amount at the time of your Surgery. QualSight bills the Plan directly for 90% of your Surgery expenses.

Non-Network Benefits

Non-network benefits are limited and subject to the Coinsurance provisions in accordance with Plan rules. When you receive services from a non-network Provider, benefits are limited to the maximum benefit payable to a network Provider. You are responsible for any amounts over the network-negotiated price per eye for your specific Surgery. You should contact the Fund Office to determine the benefits available to you based on the specific vision correction procedure that will be performed.

EXAMPLE: Using a QualSight Board Certified Ophthalmologist Could Save You Money

Let's compare what you pay when using a QualSight network Provider versus a non-network Provider.

	Network Hospital	Non-Network Hospital
Custom LASIK charges for right eye	$1,300	$2,100
Custom LASIK charges for left eye	+ $1,300	+ $2,100
Total charges	$2,600	$4,200
Plan Pays	**– $2,340**	**– $2,080**
You Pay	**$260**	**$2,120**

This example assumes that you are eligible and use a non-network Provider. Vision correction Surgery pricing varies significantly; your responsibility may be greater.

The Plan does not cover retreatment procedures, insurance, or warranties. However, QualSight offers a retreatment warranty at a discount to eligible participants who chose this option. Payment for any retreatment warranties or repeat surgical procedures are the participant's sole responsibility.

Contact QualSight at 877-718-7676 to find out more about vision correction Surgery and schedule a consultation and exam with a local Provider.

RETIREE BASIC MEDICAL COVERAGE PLAN
(For Retirees Before Age 65)

You may choose not to enroll and pay the monthly premium payments for more comprehensive coverage under the Retiree Medical Plan. If so, and you are an Eligible Retiree between the ages of 50 and 65, you and your eligible dependents will receive a limited level of coverage from the Retiree Basic Medical Coverage Plan (Basic Plan) at no cost to you. You will also receive dental and vision coverage (as well as the Retiree death benefit if you retired before June 1, 2002) as described in this booklet. Please note that prescription drug coverage is not included in the Retiree Basic Medical Coverage Plan.

Important
Prescription Drug coverage is not included under the Retiree Basic Medical Coverage Plan.

Schedule of Retiree Basic Medical Plan Coverage Benefits

The following chart outlines the benefits payable under the Retiree Basic Medical Coverage Plan. Benefits are paid on a calendar year basis. All eligible expenses are covered at the Usual and Customary (U&C) Charge in effect at the time of service.

Benefit	Retiree Basic Medical Coverage Plan Coverage
Outpatient Physician Office Visits (Retiree only) Calendar Year Maximum	$10 per visit 50 visits
Outpatient Medical Services (Hospital services and supplies received as Outpatient, therapeutic treatments, laboratory test and X-rays)	$3,200 per person per year
Hospitalizations Room and Board Intensive Care Intensive Care Hospital Services Physician Hospital Visits Surgery	Covered up to 120 days per incident $200 per day U&C Charge semi-private room $3,000 per person per year $10 per visit, up to 1 visit per day $750 per surgery
Pre-certification for Inpatient admissions (pre-Medicare Retirees and Dependents only)	Call 800-433-3232 to obtain pre-certification for an Inpatient admission to a health care facility: • One business day in advance of all scheduled admissions; and • Within two business days following an emergency admission. There will be a $200 reduction in benefits for failing to obtain pre-certification.
Emergency Room Treatment For Accident For Illness	After a $50 deductible per incident, Plan pays: Up to $3,000 per person per year in combination with Hospital services Up to $3,200 per person per year in combination with Outpatient medical services
Ambulance	$50 per trip up to a maximum of 2 trips per incident
Additional Accident Benefit (for medical services needed as a result of an accident, you must be treated within 90 days of the accident)	$300 per person per incident
Diabetic Education	$400 per calendar year
Hearing Aid Benefit	None
Prescription Drug Benefits	None
Vision Benefits	See explanation and schedule on page 45
Death Benefit (Retiree only)	See explanation on page 48

Retiree Basic Medical Coverage Plan Covered Services

The Retiree Basic Medical Coverage Plan covers the actual Usual and customary charges for the Medically Necessary services and supplies that are listed below. Limitations on the number of treatments and the dollar amount for the treatments are also listed here as well as in the Schedule of Benefits chart on the prior page.

- *Alcoholism and/or Substance Abuse treatments* are treated like other medical illnesses. An Inpatient treatment center must meet the following criteria:
  - Be nationally recognized by an accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));
  - Have full-time permanent bed care facilities for five or more resident patients;
  - Have the regular services of a Physician;
  - Provide 24-hour-a-day services by a licensed medical professional;
  - Perform mainly diagnostic and therapeutic medical care of patients, or provide care and treatment for alcoholism and substance abuse;
  - Not be a nursing convalescent or rest home or place for the aged; and
  - Be licensed to operate where it is located.
- *Ambulance Service* deemed Medically Necessary and not for patient convenience. The Fund may request additional information on your medical condition to evaluate Medical Necessity for transport via ambulance.
- *Anesthetic and Anesthesia Services*. However, for charges from both an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA) for services provided on the same day, the Plan will only pay for services performed by one Provider. Payment will be made in the order in which the charges are received.
- *Breast Reconstructive Surgery and breast prosthesis following a mastectomy*. Under the federal Women's Health Act and Cancer Rights Act, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain Reconstructive Surgery. If you or your dependent are receiving benefits under the Plan in connection with a mastectomy and elect breast Reconstructive Surgery, federal law requires coverage as determined by you and your Physician for:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

  This coverage is subject to the same provisions applicable to other physical conditions covered under the Plan.
- *Chemotherapy* for cancer treatment.
- *Convenient Care Clinics (CCCs)* are used for treating common/uncomplicated minor illnesses (i.e., colds, ear infections, sprains) and for receiving preventive health care services (i.e., health screenings, vaccinations). CCCs are clinics located in retail stores, supermarkets and pharmacies and are also referred to as walk-in medical clinics, retail-based clinics and/or mini-clinics. The Plan pays the Usual and Customary Charge for Covered Services, after the deductible.
- *Diabetes education* up to $400 per person per calendar year for participation of you and your family in a diabetes instruction program.

When you need to see a Physician:

- Call to make an appointment.
- Write down any questions that you want to review with your Physician so you won't forget to ask them during your appointment.
- Make a list of any medications you're taking and how often you take them.
- Show your ID card when you go to your appointment.
- Your Physician's office will file a Claim for you with the local BCBS office.

- *Diagnostic Service* as ordered by a Physician to determine treatment of a medical or psychological diagnosis. Procedures may include X-rays, blood tests and other laboratory tests.
- *Dialysis Treatment*, which may include hemodialysis or peritoneal dialysis.
- *Doctors' or Physicians' services* (Retiree only) may be provided either in or out of a Hospital and include Surgery and other Medical Care and treatment.
- *Hospital room and board and charges* for services and supplies include:
  - Charges for a semi-private room with general nursing services;
  - Charges for a private room if Medically Necessary (such as for contagious or communicable diseases);
  - Intensive care units;
  - Nursery charges for newborns;
  - Emergency room treatment; and
  - Charges made by the Hospital for services and supplies for care received while an Inpatient or Outpatient. They do not include room and board, Physicians' fees or specialized or Private Duty Nursing Service fees.
- *Mammography* benefits include an annual mammogram for you or your spouse only.
- *Mental health treatment (including nervous disorders)* is treated like other medical illnesses. Family counseling may be covered with appropriate diagnosis. An Inpatient treatment center must meet the following criteria:
  - Be nationally recognized by an accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));
  - Have full-time permanent bed care facilities for five or more resident patients;
  - Have the regular services of a Physician;
  - Provide 24-hour-a-day services by a licensed medical professional;
  - Perform mainly diagnostic and therapeutic Medical Care of patients;
  - Not be a nursing, convalescent or rest home or residence for the aged; and
  - Be licensed to operate where it is located.
- *Nutritional counseling expenses* and services are covered for documented cases of anorexia or bulimia.
- *Oral appliances* provided by a Delta Dental PPO Dentist for sleep apnea will be covered under the Plan to match the benefits the Plan provides for TMJ and bruxism appliances. If you are eligible, the Plan will pay 80% for oral appliances for sleep apnea up to $500 per appliance (including the cost of any repairs to the appliance).

A Hospital must:

- Be a nationally recognized accredited agency;
- Have full-time permanent bed care facilities for five or more resident patients;
- Have the regular services of a Physician;
- Provide 24-hour-a-day nursing services by registered nurses;
- Perform mainly diagnostic and therapeutic medical and surgical care of patients, or provide care and treatment for Substance Abuse;
- Not be a nursing, convalescent or rest home or residence for the aged; and
- Be licensed to operate where it is located.

Hospital Stays in Connection with Pregnancy:

This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Health care Providers are not required to obtain authorization from the Plan for Hospital stays within these guidelines. Federal law does not prohibit the Physician, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 (or 96) hours.

- *Pre-admission tests* for Hospital confinement, including X-rays, laboratory examinations, tests or analyses.
- *Pregnancy expenses*, for you or your spouse only, are covered the same as any other medical condition.
- *Surgery*. If two or more procedures are performed through the same incision, it will be considered one operation and benefits will be payable for the most expensive procedure.

Retiree Basic Medical Coverage Plan Exclusions and Limitations

Only expenses related to non-occupational injuries and sickness are covered.

Expenses that are not covered as medical expense benefits under the Retiree Basic Medical Coverage Plan include, but are not limited to, the following:

Exclusions

Not all of your medical expenses are covered by the Plan. Read these items carefully to see what is excluded from or limited in coverage.

In rare instances, an item excluded under the Plan, may be covered for a specific diagnosis. If you have questions regarding coverage, please contact the Fund Office.

1. Any expenses incurred during a period in which you or your dependents are not eligible for benefits under the Retiree Basic Medical Coverage Plan.
2. Any expenses incurred by a dependent who does not meet the Plan's definition of dependent.
3. Services or supplies that are not Medically Necessary or that exceed the Usual and Customary Charge.
4. Personal items received while confined to a Hospital.
5. Services or supplies while you are not under a Physician's care, or you are under the care of a person who does not meet the Plan's definition of Physician. See page 79 for the definition of a Physician or Doctor.
6. Services or supplies that are not recommended or approved by your Physician.
7. Services for conditions other than ones specifically identified as being covered under the Plan.
8. Dental and vision services other than those covered under the dental or vision portion of the Plan. Services that are specifically excluded are:
   a. Dental X-rays;
   b. Dental implants;
   c. Treatment of teeth or gums other than for tumors; and
   d. Treatment of other associated structures primarily in connection with treatment or replacement of teeth, unless incurred within two years after an accident that is necessary for the repair or alleviation of damage to natural teeth resulting from that accident.
9. Any expenses relating to appetite control, food addictions, eating disorders, weight reduction or obesity except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Fund Office and the Plan's medical consultants.
10. Nutritional counseling.
11. Gastric stapling, gastroplasty, gastric banding or any other surgeries or procedures related to weight reduction or obesity, including, but not limited to, excess skin removal and complications resulting from any weight reduction Surgery.
12. Hair removal or hair implants.

13. Home health aid.
14. Infertility expenses, including, but not limited to:
    a. Expenses relating to the diagnosis of infertility and attempts to cause pregnancy, such as artificial insemination or in vitro fertilization;
    b. Any medical expenses related to the services of a surrogate mother or harvesting of or storage of eggs or semen; and
    c. Any other related treatment such as blood tests, medications, lab charges, testing and hormone therapy.
15. Liposuction.
16. Routine health examinations (i.e., physical examinations) for dependent children.
17. All medications, medical supplies, or medical equipment that may be purchased over the counter.
18. Baby formula and breast pumps.
19. Breast Reduction Surgery that is cosmetic in nature.
20. Expenses of an elective abortion, except when:
    a. The mother's life is in danger;
    b. There are medical complications from an abortion procedure; or
    c. The abortion is spontaneous.
21. Injuries, sickness, or disease you sustained while working and that are covered by any workers' compensation law, employer liability law, occupational disease law or similar law.
22. Custodial Care; see page 76 for the definition of Custodial Care.
23. Maintenance or Developmental care; see page 77 for the definition of Maintenance or Developmental Care.
24. Cosmetic Surgery, except when it is performed to:
    a. Correct injuries that occurred as the result of an accident within two years of the accident; or
    b. Repair defects that result from a Surgery for which the covered individual was paid benefits under the Plan within two years from the date of the Surgery that caused the defect.
25. Sex transformation Surgery or treatment.
26. Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures. These include services and treatments that are:
    a. Not yet officially accepted by the medical community;
    b. Not recognized as having proven beneficial outcomes to the patient;
    c. Not yet approved by the Federal Drug Administration;
    d. Still primarily confined to a research setting; or
    e. Are not recommended for an advanced state of an illness or disease.
27. Services provided by a government Hospital where governmental coverage is primary.
28. Expenses excluded under coordination of benefits clauses.
29. Expenses that result from failure to use an HMO, PPO or EPO Provider when covered under another plan that so requires.

30. Charges for the reversal of previous elective sterilization.
31. Premarital examinations.
32. Speech Therapy.
33. Chelation therapy.
34. Marriage counseling.
35. Court mandated counseling or therapy.
36. Organ transplants including charges incurred by organ donors, charges related to a transplant or charges resulting from complications due to a transplant procedure.
37. Oxygen and durable medical equipment.
38. Assistant Surgeon charges.
39. Acupuncture, chiropractic, Naprapath Services, and spinal manipulation for dependents and amounts in excess of $10 per visit for retired employees.
40. Cosmetic Surgery.
41. Erectile dysfunction treatment.
42. Hearing aids.
43. Home health care.
44. Hospice Care.
45. Orthotics.
46. Physical Therapy for dependents and amounts in excess of $10 per visit for Physical Therapy for retired employees.
47. Prostheses.
48. Second surgical opinions.
49. Skilled Nursing Facility Services.
50. Social worker services.
51. Sterilization procedures in excess of $750 when covered under the Plan's Surgery benefits.
52. Transplants in excess of $750 when covered under the Plan's Surgery benefits.
53. Vision correction Surgery.
54. Wigs.
55. Prescription drugs.
56. Nebulizers.
57. Treatment for smoking cessation.

DENTAL BENEFITS

Schedule of Dental Benefits

The chart below highlights the Plans' Dental Benefits. Benefits are paid on a calendar year basis. All covered expenses must be within the guidelines of Usual and Customary Charges.

Additional limitations apply for certain services. These limitations are explained later in this section.

Dental Benefits (Delta Dental)	Network Providers	Non-Network Providers
Non-Orthodontic Benefits Calendar Year Maximum	$2,000 per person for members, spouses and dependent children age 18 or older. Unlimited benefit for dependent children age 17 and younger.	$2,000 per person for members, spouses and dependent children age 18 or older. Unlimited benefit for dependent children age 17 and younger.
Basic Care (exams, X-rays, cleaning)	100% Covered	100% Covered
Fillings	100% Covered	70% Covered[1]
Root Canals, Dental Surgery	100% Covered	70% Covered[1]
Dentures[2] Complete Upper Complete Lower	You pay: $88; then the Plan pays 100% $88; then the Plan pays 100%	 50% Covered[1] 50% Covered[1]
Dental Implants	50% Covered	50% Covered
Orthodontic Benefits Lifetime Maximum	You pay the first $242.11; then Plan pays 100%, $3,757.89 per person[3]	Plan pays 100% $1,000 per person[4]

[1] For services from non-network Providers, the Plans pay this percentage of approved amounts. If your Provider charges more than the approved amount, you will have to pay the difference.

[2] The copayments listed are for standard dentures. Partial dentures or special constructions may require a different amount.

[3] The lifetime maximum for network orthodontic benefits increases each year; this is the current lifetime maximum. Contact Delta Dental of Illinois for any increases to this maximum.

[4] Non-Orthodontic Calendar Year Maximum does not apply to dependent children under the age of 18.

Dental Covered Expenses

Dental Benefits help limit the amount you pay for covered dental care services. The Plans cover up to $2,000 per person each calendar year for your eligible dental expenses, with the exception of dependent children under the age of 18. Coverage is provided through Delta Dental of Illinois, a Preferred Provider Organization (PPO).

Delta Dental has a list of approved amounts for specific procedures. You may contact Delta Dental to:

- Request information about approved costs for specific procedures;
- Find a Delta Dental PPO Dentist; or
- Check the status of a dental Claim.

To find a network Provider, contact Delta Dental of Illinois:

In Illinois:
630-718-4700, or 800-323-1743

Outside Illinois:
800-331-0538
8:30 AM–5:00 PM
Monday–Friday
www.deltadentalil.com

You should always contact Delta Dental before seeking dental care. Delta Dental can help you select a network Dentist. There may be a difference in discounts under the Delta Dental program as Delta Dental has multiple networks. The Plans' benefits are greater if your Dentist is a Delta Dental PPO Dentist because these Dentists have agreed to accept the Delta Dental fee schedule as payment in full for certain services. So check with your Dentist and with Delta Dental to determine the amount you will be responsible to pay for dental services.

If you do not use a Delta Dental PPO Dentist, the Plans' Dental Benefits may pay only a percentage of your eligible dental expenses. Generally, the Plans' Dental Benefits will pay:

Mail dental Claims to:
Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

- 100% of charges up to approved amounts, which are Usual and Customary Charges for services performed, for your basic care (exams, X-rays, and cleaning) received from a non-network Provider.
- 80% of bite guards for bruxism, TMJ and sleep apnea only when obtained through a network Dentist, up to $500 per appliance (including the cost of any repairs to the appliance). Replacement of a bite guard is limited to once every three years. The lifetime maximum for bite guard appliances is $1,000. Biteguards purchased through non-network dentists are not covered under the Plan.
- 70% of charges up to approved amounts for fillings, root canals, and dental Surgery.
- 50% of charges for dental implants.

Delta Dental has a list of approved benefit amounts for specific procedures. If your Provider charges more than the approved amount, you will have to pay the difference. You may contact Delta Dental for information about the Plans' approved costs for specific procedures. Before you have any dental services, have your Dentist contact Delta Dental directly for a pre-service inquiry and an estimate of expenses the Plans will cover.

Payment to Delta Dental PPO Dentists is based on preset, reduced fees. Payment to a Delta Premier Dentist is based on Delta Dental's Maximum Plan Allowance (MPA). For both networks, you only have to pay your Coinsurance amount. You are not responsible for charges exceeding the reduced PPO fee, if you receive treatment from a Delta PPO Dentist, or the MPA, if you receive treatment from a Delta Premier Dentist. However, the coinsurance amounts between networks may vary. To maximize your benefits, use a Delta Dental PPO Dentist.

There is a supplement to this Summary Plan Description that provides you with specific information about Delta Dental services and covered dental procedures. Contact the Fund Office for a copy of the supplemental booklet.

Orthodontic Care

Orthodontic care is covered by the Plans up to a lifetime maximum. The lifetime maximum is higher when you use network Providers. The Schedule of Dental Benefits on the prior page of this section outlines orthodontic benefits and coverage limits.

VISION BENEFITS

Vision Benefits

To help you manage the cost of routine vision expenses, the Plans provide Vision Benefits for you and your family. Vision Benefits cover expenses such as eye exams, frames, lenses and contacts furnished by a qualified Optometrist or ophthalmologist. The dollar limits for these benefits are listed in the Schedule of Vision Benefits on page 46.

To find a network Provider, contact VSP at:
800-877-7195
7:00 AM – 9:00 PM
Monday – Friday
www.vsp.com

You may go to any Optometrist, eye specialty Physician (ophthalmologist) or optician for your examination and covered supplies. If you choose to use a Provider that is not a participating VSP facility, you must pay for the services in full and submit an itemized bill with proof of payment when filing the Claim with VSP. Please contact VSP for instructions on how to file your non-PPO claim with them. Covered expenses will be reimbursed directly to you.

Vision Covered Expenses

As explained on page 3, the Board of Trustees has contracted with VSP to provide you with Vision Benefits at discounted rates. When you use a VSP facility, the dollar limits shown in the Schedule of Vision Benefits on the next page generally cover your services in full. The following services may be covered in full when you use a VSP facility:

- Basic eye exam or contact lens eye exam when contact lenses are purchased during the same visit;
- Frames for single vision or bifocal lenses in specific styles (only in limited selection);
- Contact lenses;
- Jumbo lenses;
- Transitional lenses;
- Polycarbonate lenses;
- Scratch coating (scratch coating in connection with transitional lenses is not covered);
- Tinting; and
- Special lenses to correct serious vision problems (high power ranges, special base curves, and prism lenses).

Calendar year maximums for Eye and Contact Lens Exams do not apply to dependent children under the age of 16.

Calendar year exam limitations do apply to dependent children over the age of 15 but under the age of 18.

Schedule of Vision Benefits

The chart on the next page highlights the Plans' Vision Benefits. Benefits are paid on a calendar year basis. All covered expenses must be within the guidelines of Usual and Customary Charges. Additional limitations apply for certain services. These limitations are explained later in this section.

Routine Vision Benefits	When You See a VSP Network Provider, the Plan Pays	When You See a Non-Network Provider, the Plan Pays Up to the Allowances Listed Below
Eye exams	One per calendar year	One per calendar year
Standard Eye Exam	100%	$30
Contact Lens Exam	100%	$95[1]
Lenses[2]	One pair per calendar year	One pair per calendar year
Single vision	100%	$26
Lined Bifocal	100%	$39
Lined Trifocal	100%	$55
Standard progressive lens (No line Bifocal)	100%	$105
Premium progressive lens (No line Trifocal)	100%	$105
Lenticular	100%	$0
Lens Options		
UV Treatment	$0	$0
Tint	100%	$15
Transition	100%	$40
Standard Plastic Scratch Coating	100%	$25
Standard Polycarbonate—Adults	100%	$25
Standard Polycarbonate—Kids under 19	100%	$25
Standard Anti-Reflective Coating	100%	$0
Polarized	100%	$40
Oversized	100%	$0
High Index	100%	$0
Hyper High Index	100%	$0
High Sphere	100%	$0
High Cylinder	100%	$0
Base Curve	100%	$0
Bifocal Add High Power	100%	$0
Prism	100%	$0
Photochromatic	100%	$0
Other Add-Ons	No discounts	No discounts
Contact Lenses		
Contact Lenses (Conventional contact lenses for correction of vision)	100% up to $250, no discount off additional balance over $250	$175
Contact Lenses (Medically necessary after cataract Surgery)	100%	$175
Disposable Lenses	100% up to $250, no discount off additional balance over $250	$175
Frames Maximum	100% up to $75, 20% off balance over $75	$75
Additional Discounts	In the VSP network, Plan participants also receive a 20% discount on unlimited additional pairs of glasses and sunglasses (i.e., lenses and frames and any additional lens options selected) within 12 months of the last covered eye exam, once the full benefit for services covered by the Plan has been used by the participant.	

[1] Contact lens exams are only covered when contact lenses are purchased during the same visit.

[2] VSP also covers specialized lens options (i.e., progressive, anti-reflective, photochromic, etc.) at varying limits and copays.

Expenses Not Covered Under Routine Vision Benefits

Charges for the following vision care expenses are not covered by the Plans.

1. More than one exam (except for children younger than age 16), one set of frames, or one pair of lenses per person per calendar year (except where Medically Necessary due to a prescription change for a child who is younger than age 16).
2. Any charges or portion of charge(s) for services or supplies that are covered in whole or in part under any other portion of the Plan or under any other medical or vision benefits plan provided by an employer.
3. Any charge incurred when you do not use a PPO or other medical or vision plan with vision benefit coverage that is primary to this Plan.
4. Treatment that is solely for cosmetic purposes.
5. Treatment under another benefit provision of the Plan.
6. Treatment covered by workers' compensation benefits.
7. Eye exams required by an employer as a condition of employment.
8. Special procedures or supplies.
9. Visual analysis that does not include refraction.
10. Medical or surgical treatment of the eyes.
11. Non-prescription eyeglasses of any type.
12. Antireflective coating provided by a non-network Optometrist.
13. Claims for expenses from non-VSP providers that are submitted without a full, itemized receipt.
14. Any vision service not listed on the Schedule of Vision Benefits on the prior page, including orthoptic therapy.
15. Scratch coating in conjunction with transition lenses.
16. Contact lens eye exam when contact lenses are not purchased during the same visit.

RETIREE DEATH BENEFIT

The Plans provide a Retiree Death Benefit to help provide financial protection to your family in the event of your death. The Retiree Death Benefit is payable to your named beneficiary when you die. The amount of the benefit depends on when you retired. If you retired:

- Before June 1, 2002, the Retiree Death Benefit is $4,000; or
- On or after June 1, 2002, the Retiree Death Benefit is $6,500. To qualify for this benefit, you must:
  - Retire on or after June 1, 2002;
  - Meet the requirements for coverage under the Retiree Medical Plan (see page 5); although you do not need to elect coverage under this Plan; and
  - Not be covered under a plan of benefits for active employees on the date of your death.

You may name any person as a beneficiary and may change your beneficiary at any time by filling out and submitting the proper beneficiary designation card to the Fund Office (available from the Fund Office). A beneficiary designation is not effective until the Fund Office receives the completed and signed beneficiary designation card. If you name more than one beneficiary, any Death Benefit payable will be paid in equal shares to each named beneficiary unless you specify a different division of payment.

If you name your spouse as your beneficiary and subsequently divorce, the designation will be void on the date of your divorce. After the date of divorce, you may rename your former spouse as the designated beneficiary, if you wish, by filing a new designation of beneficiary card.

If you do not name a beneficiary or if your named beneficiary is deceased, your Death Benefit will be paid:

- To your spouse; or, if none,
- To your children in equal shares; or, if none,
- To your parents in equal shares; or
- If no spouse, children, or parents are living, no Death Benefit will be paid.

Your beneficiary may direct the Welfare Fund to assign benefits, up to the full amount of the Death Benefit, to be paid to the person who assumes responsibility for funeral expenses or to the funeral home directly.

You are not eligible for a Retiree Death Benefit if you retire on or after June 1, 2002 and you do not meet the eligibility requirements for coverage under the Retiree Medical Plan (whether or not you elect this Plan).

You may name any person as your beneficiary and may change your beneficiary at any time by filling out and submitting the proper beneficiary designation card to the Fund Office (available from the Fund Office). A beneficiary designation is not effective until the Fund Office receives the completed and signed beneficiary designation card.

A beneficiary designation card will not be accepted after a participant's date of death.

In the event you name someone as your power of attorney, that person may change a beneficiary on your behalf only if the right to do so is explicitly contained in the executed Power of Attorney document.

Death Benefit Exclusions and Limitations

Death Benefits are not paid if the eligible participant's death occurs while the participant is committing a felony.

CLAIM AND APPEAL INFORMATION

Annual Claim Form

You are required to complete an Annual Claim Form, which provides the Fund Office with information about your spouse, dependents, and other medical insurance coverage. It is very important that you complete and return the Annual Claim Form when you are first eligible, regardless of whether or not you are submitting a Claim. If the Fund Office does not have your Annual Claim Form on file, processing and payment of any Claims will be delayed.

Please ensure that your information on file with the Fund Office is up-to-date by notifying the Fund Office of a change of address as soon as possible. The Fund Office will mail an Annual Claim Form to you each year, or more often as required, to process your Claims.

An Annual Claim Form is required by the Fund Office each year before benefits are payable to update general information on you, your dependents, and other medical insurance coverage you may have. In addition, you may be asked to complete a separate *Accident Claim Form* if your medical Claims provide a diagnosis that the Fund Office suspects may be an injury due to an accident (e.g., automobile accident).

You must complete your Annual Claim Form in full. If you are married, both you and your spouse must sign and date the form. Failure to complete the Annual Claim Form in full will delay processing of your Claim for benefits.

Filing Claims

A Claim may be submitted in paper form or through Electronic Data Interchange (EDI). All medical and professional Claims must be submitted to Blue Cross Blue Shield of Illinois (BCBSIL). If your Provider and services were obtained outside the BCBSIL network area, your Provider must file the Claim with their local Blue Cross Blue Shield Plan.

Be sure that each bill indicates the name of the patient, name of the participant, and participant's Social Security Number or alternate ID number that may be assigned to you by the Fund Office. Make certain that the date for each service appears on the invoice. The Provider's name and tax identification number must be on all Claims (invoices), except Pharmacy receipts. In addition, the Claim should indicate the appropriate ICD-9 code (diagnosis) and specific services provided, as defined by the appropriate CPT, HCPC, NDC, or other nationally recognized codes, including the expense charged for each service.

Submit:

Medical and professional Claims. Your Provider must file Claims directly with their local BCBS plan.

Dental Claims to:
Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

All other Claims to:
Laborers' Welfare Fund Claim Department
11465 W. Cermak Road
Westchester, IL 60154

The Fund Office does not accept handwritten bills.

You are responsible for any amounts not paid by the Fund, with the exception of PPO network discounts or discounts that may be negotiated between the Plan and the Provider on non-network Claims. PPO or other negotiated discounts do not apply to medical expenses that are not covered by the Plan.

Neither you nor any of your eligible dependents may assign your rights as a participant to a Provider or other third party (as described below) or in any way alienate your Claims for benefits. Any attempt to assign your rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund for that purpose. The Fund will treat any document attempting to assign rights as a participant or to alienate a Claim for benefits to a Provider to only be an authorization for direct payment by the Fund to the Provider. For example, the Fund will not allow you to assign to a Provider any of your rights as a participant under the Fund's plans of benefits, including but not limited to, the right to appeal a Claim denial or the right to receive documentation concerning your Claims. In the event that the Fund does receive a document claiming to be an assignment of benefits, the Fund will send payments for the Claims to the Provider, but will send all Claim documentation, such as an Explanation of Benefits, and any procedures for appealing a Claim denial directly to you. If the Fund should deny the Claim, only you will have the right to appeal.

The Fund will pay Claims only when covered under the terms of the Plan provisions under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from you, your eligible dependents, or any other entity or organization that was required to make the payment or that received an erroneous payment. Recovery of such erroneous payments may be made through, but is not limited to, an offset or reduction of any future benefits you or your eligible dependents may be entitled to receive from the Fund (see page 15 for more information).

Claim Types Covered by the Retiree Medical Plan include:

- Health Care Claims, which include medical, prescription drug, dental, and vision benefits; and
- Other benefit Claims, which include Death Benefits.

Claim Types Covered by the Retiree Basic Medical Coverage Plan include:

- Health Care Claims, which include medical, dental, and vision benefits; and
- Other benefit Claims, which include Death Benefits.

Pre-Medicare Retirees and Dependents Health Care Claims

Health Care Claims (medical, hearing, vision, prescription drug, and dental claims) for pre-Medicare Retirees and Dependents are divided into four basic types of claims:

- Urgent Care, which is a claim for care or treatment that would:
  - Seriously jeopardize your or your dependent's life, health or ability to regain maximum function if normal pre-service (see below) standards were applied; or
  - Subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.
- Pre-Service, which is a claim for benefits where pre-certification is required before you obtain care (see page 17 for information on when you are required to use the UR program). However, the Plan will not deny benefits for care if it is not possible to obtain pre-certification or if the process would jeopardize your or your dependent's life or health.
- Post-Service, this is a claim for benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim.
- Concurrent Care, which is a claim that is reconsidered after it has been initially approved (such as pre-certification of the number of days of a Hospital stay) and the reconsideration results in reduced benefits or a termination of benefits.

If the Plan receives a document or transmission that contains the first six items as stated in Benefit Claims, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, the Fund Office may request an extension of the time to make a benefit determination.

Benefit Pre-Certification

If you are a pre-Medicare Retiree, you and your dependents must use the Utilization Review (UR) program, which includes Utilization Management and Enhanced Case Management. The UR program provides assistance with maximizing and managing your and your family's medical coverage so that the right care is received at the right time and in the right setting. For more information, see page 17.

If you are a Medicare Retiree or dependent, the Plan does not require pre-certification for any type of medical treatment. You and your dependents are encouraged to seek Medical Care whenever necessary. However, if you are not sure whether a particular treatment or service will be covered, you may contact the Fund Office in advance of any non-urgent care.

Benefit Claims

Benefit Claims covered by the Plan include requests for benefits accompanied by:

- HCFA, Hospital, prescription, dental, or vision bills or other types of invoices that include:
  - Patient name and ID number;
  - Participant name and Social Security Number or other ID number assigned by the Fund Office;
  - Date of service or date of fill or refill for prescription drug Claims;
  - Specific services performed and expense charged for each service;
  - Type of device defined by HCPC, CPT code, ICD-9, NDC, or other nationally recognized codes, including individual charges for each;
  - Attending Physician's or care Provider's name and federal tax ID number (not required for prescription drug Claims);
  - Place of service;
  - Billing address; and
  - Previous balances paid.
- Copy of death certificate with a fully completed form for Death Benefits.

What is a Claim?

A Claim is a request for Plan Benefits made by a Claimant according to the Plan's procedures for filing Claims. Claims may be submitted in paper form or through Electronic Data Interchange (EDI). A Provider may submit a Claim on behalf of a Claimant when benefits are assigned to the Provider.

Who Is a Claimant?

A Claimant is usually the patient. However, a spouse can file a Claim or Appeal on behalf of the patient. In addition, a participant can file a Claim or Appeal for a legal dependent. A Claimant may authorize a representative to file a Claim or Appeal on their behalf. A Claimant must notify the Fund Office of a designation of representation in writing whenever possible. A Claimant's representative may present a power of attorney for health care. If a representative is designated, all Appeal correspondence will be sent directly to the representative, unless specified otherwise.

What is NOT a Claim

Any general inquiry about benefits or the circumstances under which benefits might be paid under Plan terms is not a Claim. Also, any document or EDI transmission that is submitted to the Fund Office that does not meet the criteria of a Claim, as described above in Benefit Claims, is not considered a Claim and is not covered by the Plan's Claim and Appeal procedures. Examples include:

- A cash register receipt;
- An Explanation of Benefits (EOB) form from another plan;
- Handwritten bills (invoices) or handwritten statements of services;
- A balance due statement;
- An inquiry from a participant, Physician, care Provider, other insurance carrier, participant's authorized representative, Hospital, or facility regarding:
  - Plan coverage (e.g., a question about whether the Plan covers Diagnostic Service);
  - Plan benefit amounts (e.g., a question as to whether the Plan would pay 100% of Surgery costs if the Surgery were tomorrow);
  - Plan eligibility (e.g., if you are scheduled for Physical Therapy at a facility twice a week and your Physician calls to ask if you are eligible for benefits); or
  - Consideration of additional payment on a Claim.

Any of the above offered in paper form, verbal inquiry, or EDI transmission is not considered a Claim. Although the Fund Office may respond to such submissions, the legal requirements for processing Claims do not apply.

If you have questions about filing a Claim, please contact the Fund Office by:

- Calling 708-562-0200 or 866-906-0200 between the hours of 8:00 AM and 5:00 PM, Monday through Friday;
- Writing to:
  Chicago Laborers' Welfare Fund
  11465 W. Cermak Road
  Westchester, IL 60154; or
- E-mail at claims@chilpwf.com.

Claim Filing Procedures

When you submit a Claim to the Fund Office, the Fund Office will determine if you are eligible for benefits and will calculate the amount of any benefits payable.

You must file a Claim with the Fund Office within 12 months of the date the service was provided. If you do not file your Claim within 12 months, your Claim will be denied.

Claim Processing Deadlines for Pre-Medicare Retirees and Dependents

The deadlines for processing Claims vary, as follows:

- Health Care Claims: An initial determination regarding payment or denial of a Claim will be made for:
  - Urgent Care Claims, within 72 hours of receipt of the Claim. Notice of a decision on your urgent care Claims may be provided to you orally within 72 hours and then confirmed in writing within three days after the oral notice. If additional information is needed to process your Claim, you will be notified within 24 hours of receipt of your Claim. You will then have up to 48 hours to respond. The initial 72-hour deadline is suspended for up to 48 hours or until the information is received, if sooner.
  - Pre-Service Claims, within 15 days of receipt of the Claim. If additional time is necessary, up to 15 additional days, due to matters beyond the control of the Plan, you will be informed of the extension within this 15-day deadline. If additional information is needed to process your Claim, you will be notified within 15 days of receipt of your Claim and you will then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.
  - Post-Service Claims, within 30 days of receipt of the Claim. If additional time is necessary, due to matters beyond the control of the Plan, you will be informed of the extension within this 30-day deadline. If additional information is needed to process your Claim, you will be notified within 30 days of receipt of your Claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.
  - Concurrent Care Claims. While other Claims have certain deadlines throughout the Claims and Appeals process, there is no formal deadline to notify you of the reconsideration of a Concurrent Care Claim. However, you will be notified as soon as possible and in time to allow you to have an Appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your Claim is received at least 24 hours before the expiration of the approved treatment.

  If a Claim for Post-Service or Concurrent Care is approved, payment will be made and the payment will be considered notice that the Claim was approved. However, for Urgent Care and Pre-Service Claims, the Plan will give you written notice of its decision about your Claim within the timeframes described above.
- Death Benefit Claims, within 90 days of receipt of the Claim.

Claim Processing Deadlines for Medicare Retirees and Dependents

The deadlines for processing Claims vary, as follows:

- **Initial Determination.** An initial determination regarding payment or denial of a Claim will be made for:
  - Health Care Claims, within 30 days of receipt of the Claim.
  - Death Benefit Claims, within 90 days of receipt of the Claim.
- **Extension of Initial Determination Period.** In some instances, an extension of the initial determination period may be requested due to matters beyond the Plan's control. If an extension is necessary, you will be notified. The notice will include the special circumstances requiring the extension and the date the Plan expects to render a decision. You (or the Claimant) will be notified for:
  - Health Care Claims, within the 30-day initial determination period that one 15-day extension is necessary.
  - Death Benefit Claims, within the 90-day initial determination period that up to an additional 90 days may be necessary. The extension cannot be more than 90 days from the end of the initial 90-day period, or 180 days total.
- **Additional Information Needed to Process a Claim.** In some instances, the Plan may need additional information or require information that was not originally provided to process a Claim. If such information is needed, you (or the Claimant) will be notified for:
  - Health Care Claims, within the 30-day initial determination period of the information needed. You (or your Provider if your Provider is notified) have up to 45 days to provide the requested information. If the Fund Office receives the requested information in the 45-day period, the Claim will be processed within 15 days following the receipt of the additional information.
  - Death Benefit Claims, within the 90-day initial determination period of the information needed. The 90-day extension of initial determination period listed above includes any time needed by the Plan to obtain this information.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office. If a disagreement is not resolved, there is a formal procedure you can follow to have your Claim reconsidered.

Claim Denial

If for any reason your Claim is denied, in whole or in part, the Fund Office will send you a written notice. The notice will include:

- The specific reason or reasons your Claim was denied;
- Reference to the specific Plan provisions on which the denial was based;
- A description of any additional information you need to submit in support of your Claim;
- An explanation of why the additional information is needed;
- An explanation of the Plan's Claim review procedures and applicable time limits; and
- A statement of your rights under ERISA to bring a civil action.

You must follow the Plan's Claim and Appeal procedures completely before you can bring any legal action to obtain benefits. The Trustees, or their designated representative, have sole, discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Trustees.

You must follow and completely exhaust the Plan's Appeal procedures (including time limits) before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency. In the event you submit a denied Claim for review and the Claim Appeal is denied, any legal action must begin within 180 days of the date the Plan provides an adverse Appeal determination.

Claim Appeal

If your Claim is denied or you disagree with the amount of the benefit, you have the right to have the initial determination reviewed by appealing the denial to the Trustees of the Claim Committee of the Chicago Laborers' Welfare Fund. Your Appeal must be filed in writing at the Fund Office not more than 180 days (or 60 days for Death and Accidental Dismemberment Benefit Claims) after the date you received the letter denying your Claim.

Send your written Appeal to:

Claim Committee
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or

E-mail at claims@chilpwf.com.

When filing an Appeal (requesting a review of a denied Claim), note the following:

- Your Appeal must be submitted in writing within the applicable timeframe.
- Your Appeal must state the reasons you disagree with the Claim determination.
- You must attach all copies of evidence supporting your Appeal.
- You, or your designated representative, have the right to receive, upon written request, copies of all documents relevant to your Claim.
- Your designated representative may be an attorney.
- You have the right to challenge the denial of a Claim by filing a lawsuit in court, seeking review of the Fund's decision under Section 502(a) of ERISA. Such a lawsuit can only be filed after you have followed the Fund's Appeal procedures.
- If your Claim is denied based on an internal rule, guideline, protocol, or other similar criteria, you have the right to request a free copy of that information.
- If your Claim is denied based on a Medical Necessity, Experimental Treatment, or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.
- You have the right to be advised of the identity of any medical experts and you may:
  - Submit additional materials, including comments, statements, or documents; and
  - Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
    - Was relied upon by the Plan in making the decision;
    - Was submitted, considered, or generated (regardless of whether it was relied upon); or
    - Demonstrates compliance with Claim processing requirements.

Appeal Review

Once your Claim is received, if you filed your Appeal on time and followed the required procedures, the Claim Department's management staff reviews it first. If the management staff determines that additional benefits are payable under the terms of the Plan, your Appeal is responded to and payment is made within 30 days of the receipt of your Appeal.

In all other cases, the Claim Committee of the Chicago Laborers' Welfare Fund Board of Trustees will review your Appeal. The Committee currently meets on the first Tuesday of every month.

After the Claim Committee receives your written request. A determination on your Appeal, for:

- Health Care Claims for pre-Medicare Retirees and Dependents:
  - Urgent Care Claims will generally be made within 72 hours of receipt of the Appeal.
  - Pre-Service Claims will generally be made within 30 days from receipt of the Appeal.
  - Post-Service Claims will generally be within 30 days of receipt of the Appeal and the written decision will be mailed to your last known address no later than 60 days after your Appeal is received.
  - Concurrent Care Claims will generally be made before termination of your benefit.
- Health Care Claims for Medicare Retirees and Dependents will generally be made within 30 days of receipt of the Appeal and the written decision will be mailed to your last known address no later than 60 days after your Appeal is received.
- Death Benefit Claims will generally be made within 60 days of receipt of the Appeal. If an extension is necessary; the Claimant will be notified within the 60-day Appeal determination period that up to an additional 60 days (no more than 120 days total from receipt of the Appeal) may be necessary; The written decision will be mailed to the Claimant's last known address no later than 60 days (or 120 days if an extension is necessary) after receipt of the Appeal.

The Trustees will issue a written decision reaffirming, modifying, or setting aside the action you are appealing. The Trustees' decision will be based on all information used in the initial determination as well as any additional information submitted. If your Claim is not paid in full, the written decision will include:

- The specific reason or reasons for the decision;
- Reference to the specific Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records, and relevant information; and
- A statement that you may bring a civil action suit under Section 502(a) of ERISA.

Payment in Event of Incompetency

In the event the Fund determines that a Claimant is incompetent or incapable of managing Plan benefits and no guardian has been appointed, the Fund may pay any amount otherwise payable to that Claimant to the spouse, blood relative, or any other person or institution determined by the Fund to have provided benefits or agreed to provide care to the Claimant. Any payment in accordance with this provision discharges the Fund from any further obligation for such payment.

Rights to Information

You have the right to receive, upon written request, copies of all documents relevant to the decision made on your Appeal.

The Plan is also required to provide you with the identification of medical or vocational experts whose advice was obtained for reviewing your Appeal. However, the Plan is not required to supply this information automatically. The names of medical or vocational experts will only be disclosed upon receipt of a written request, signed by the participant, for this specific information.

Discretionary Authority

The Trustees have full discretionary authority to:

- Determine eligibility for benefits under the Plan;
- Interpret the Plan; and
- Interpret all of the documents, rules, procedures, and terms of the Plan.

The Trustees' decisions and interpretations are binding on you and will be honored by the courts, unless the Trustees acted arbitrarily.

COORDINATION OF BENEFITS

The Plan has been designed to help you meet health care costs, such as medical, prescription drug, dental, orthodontic, and vision care. It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of benefits payable under the Plan will take into account any coverage you or a covered dependent has under other plans. Benefits under the Plan will be coordinated with the benefits you or your dependents receive from other plans so that no more than 100% of covered expenses will be paid by the combination of plans.

Generally, a Plan that does not have Coordination of Benefits rules or a Plan that covers you as an employee pays first.

Specifically, in a calendar year, the Plan will always pay to you either:

- Its regular benefits in full; or
- A reduced amount that, if added to the amount received from another plan, will be equal to the total that the Plan would have paid if you were not covered by the other plan.

If you or your dependents are covered under another plan, you must report that health coverage when you make a Claim.

"Another plan" means any:

- Group, blanket, or franchise insurance coverage;
- Service plan contract, group practice, individual practice, and other prepayment coverage;
- Any coverage under a labor-management trusteed plan, union welfare plan, or employer or employee benefit organization plan; or
- Any coverage under a federal, state, or other governmental plan or program that is largely tax-supported or provided through act of government, including Medicare or Medicaid.

If both you and your spouse are Eligible Retirees in either Plan, benefits payable to an Eligible Retiree or dependent under either Plan will be reduced to the extent necessary so that the sum of the benefits payable under either Plan as both the primary and secondary Plan will not exceed 100% of the total allowable expense.

"Another plan" does not mean any:

- Accidental injury plan provided through a school;
- Hospital indemnity plan;
- Civilian Health and Medical Program of the Uniformed Services (TRICARE, formerly CHAMPUS); or
- Individual plan, except one that provides no-fault automobile insurance or that is issued on a franchise basis.

The expenses that are coordinated are any necessary, Usual and Customary Charges or expenses, at least part of which are covered under one of the plans covering you, your spouse, or your dependents. If a plan provides benefits in the form of services or supplies instead of cash, such as those provided by an HMO, the reasonable cash value of the service rendered and supplies furnished will be considered when benefits are coordinated.

If Your Dependent Has Employer-Sponsored Coverage

If your dependent is covered under an employer-sponsored plan that would be primary under this Plan's rules or the Association of Insurance Commissioners COB regulations, and the other plan denies or caps benefits to avoid the usual operation of coordination of benefits rules, this Plan will not provide benefits until the other plan provides the customary benefits of a primary plan.

Order of Payment

If you and/or your dependent are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its payment so that total benefits do not exceed 100% of the allowable expense incurred.

The following rules determine the order of payment:

- A plan that does not have a coordination of benefits rule is primary.
- A group health plan that covers the participant before and concurrent with coverage under this Plan is primary.
- A plan that covers an individual as an employee is primary.

A plan that covers you or your dependents as active employees pays benefits before a plan covering you or your dependents as retired or laid off employees. If a dependent child is covered under more than one plan, the following rules determine the order of payment:

- If the parents are not divorced or separated:
  - The plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule);
  - If the parents have the same birthday, then the plan covering the parent for the longest time is primary; or
  - If one plan uses a rule other than the birthday rule, the plan using the other rule is primary.
- If the parents are divorced or separated:
  - Where there is a court decree or order that establishes financial responsibility for medical expenses, the plan covering the dependent child(ren) of the parent who has financial responsibility is primary;
  - Where there is no court decree, or the decree does not establish who has responsibility for medical expenses or such responsibility is shared equally between the parents, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule);
  - Where there is no court decree and the parents have the same birthday, then benefits are coordinated in the following order:
    - The plan of the parent with custody; then
    - The plan of the custodial stepparent, if remarried; then
    - The plan of the non-custodial parent.

If none of the above rules apply, the plan covering the patient the longest period of time will be primary.

Exclusions from Coverage and Coordination of Benefits with Other Health Care Plans

A number of employers offer health care coverage to their employees and exclude or limit coverage to their employees if that employee has a spouse covered under another health care plan, such as the Chicago Laborers' Welfare Plan.

To prevent cost shifting from another health care plan to this Plan, this Plan includes the following provisions:

- Coverage will be excluded, or the amount of benefits your dependent may obtain from this Plan may be limited, if your spouse elects to opt out of an employer-sponsored plan.
- No benefits will be paid under the Chicago Laborers' Welfare Plan to a participant's dependent who has health coverage of any kind under another employer's health plan unless that plan provides the same maximum level of benefits to the dependent, after taking into account the coverage the dependent would be eligible to receive in that plan, as it does to other participants in that plan, without regard to any benefits the dependent may be eligible to receive from the Chicago Laborers' Welfare Plan.

Benefits will be coordinated as follows:

- If a plan's fee-for-service option is primary (pays first), it will pay its regular benefits.
- If it is secondary (pays after another plan covering the person), it will pay a reduced benefit that, when added to the benefit paid by the other plan, will not exceed the highest amount allowed among two plans for services rendered.

- If an employer of a participant's dependent has one or more other plans that would be primary under the Plans' rules or the model COB regulations of the Association of Insurance Commissioners, and any such other plan contains a provision denying or capping benefits for the participant's dependents (having the effect of shifting coverage liability to these Plans in a manner designed to avoid the usual operation of coordination of benefit rules), the Plans will not be liable to provide benefits until and unless the other plan(s) provides the customary benefits of a primary plan as determined without regard to such exclusion or cap.

Coverage for Orthodontic Appliances: *The Plans will cover treatment when an active appliance has been installed, provided the participant does not have other orthodontic coverage available to them. Coverage for such services will terminate under the Plans on the date the individual became eligible for the other orthodontia coverage through another employer.*

This provision does affect your dependents' coverage under the Chicago Laborers' Welfare Plan if the coordinating plan does not attempt to reduce or exclude benefits as a result of the dependent's coverage under the Chicago Laborers' Welfare Plan.

Coordination of Benefits with Medicare

If you or your eligible dependents are eligible for Medicare, your Retiree Medical Plan or Retiree Basic Medical Coverage Plan, as applicable, coordinates benefits with your or your dependents' Medicare benefits. Covered Services include Medicare Part A and B deductibles and copayments for services and supplies covered under the Plans. The Plans pay for Covered Services after Medicare pays benefits. Medicare is a multi-part program:

Medicare

The Health Insurance for the Aged Program under Title XVIII of the Social Security Act and the Social Security Amendments of 1965 (Public Law 89-87), as this Program is currently constituted and as it may later be amended.

- **Medicare Part A.** Officially called "Hospital Insurance Benefits for the Aged and Disabled," Medicare Part A primarily covers Hospital benefits, although it also provides other benefits.
- **Medicare Part B.** Officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," Medicare Part B primarily covers Physician's services, although it also covers a number of other items and services.

Medicare generally pays your Claim first when benefits are coordinated with the Retiree Medical Plan or Retiree Basic Medical Coverage Plan.

- **Medicare Part C.** Called Medicare Advantage, Medicare Part C is the managed care portion of Medicare; specific choices depend on where you live. If you are covered by an HMO, the Plans will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- **Medicare Part D.** Called "Medicare Prescription Drug Coverage," Medicare Part D is Medicare's prescription drug coverage that is offered through private companies to all Medicare-eligible individuals. See page 21 for details regarding the Plans' prohibitions regarding simultaneous prescription drug coverage.

The Plan treats you as having enrolled in both Medicare Part A and Part B when you are first eligible. If you fail to obtain Medicare coverage for the month you are first eligible, you will not receive benefits from the Plan that would have been paid by Medicare.

Typically, you become eligible for Medicare when you reach age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). If you are eligible for Medicare based solely on permanent kidney failure (ESRD), Medicare coverage will not start until the fourth month of Dialysis Treatment. Therefore, the Plans are generally your only coverage for the first three months of Dialysis Treatment. When you obtain Medicare because of ESRD, there is a period of time when the Plans are primary and will pay health care bills first. This is called the 30-Month Coordination Period. The 30-Month Coordination Period starts the first of the month you are able to get Medicare because of ESRD, even if you have not enrolled in Medicare yet.

EARLY RETIREMENT AND DISABILITY PENSIONS

If you retire early or you are a disabled worker, you may become eligible for Medicare before age 65. Coverage under the Plan must be coordinated with any payment of health care benefits under Medicare from the Social Security Administration or other insurance provider.

When you become eligible for Medicare, you must submit a copy of your Medicare Card showing enrollment in Medicare Part A (Hospital Insurance) and Part B (Supplemental Medicare Insurance). Failure to apply for Medicare benefits when eligible will result in a reduction of benefits under the Plan.

The Plan requires you to submit a copy of your Social Security Award Letter if you have been approved for disability benefits by the Social Security Administration. The Social Security Administration automatically enrolls you in Medicare Part A and Part B after you receive disability benefits for two years. While the coverage for Medicare Part A is free, you will need to pay a monthly premium to Medicare for Medicare Part B coverage. If you are enrolled under the Retiree Medical Plan, you cannot decline Medicare Part B coverage when entitled. You must submit a copy of your Medicare Card showing enrollment in Medicare Part A and Part B coverage when received.

The Plan treats you as having enrolled in both Medicare Part A and Part B when you are first eligible. If you fail to obtain Medicare coverage for the month you are first eligible, you will not receive benefits from the Plan that would have been paid by Medicare.

The Retiree Medical Plan is secondary when you are not actively working.

You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since the Plans treat you as having enrolled in both Medicare Part A and Part B when you are first eligible, if you do not obtain Medicare Part B coverage for the month you are first eligible, you will not receive benefits from the Plans that would have been paid by Medicare. While, in general, you are not required to file an application for enrollment in Medicare Part A, you are required to file an application for enrollment in Medicare Part B. To be entitled to receive Medicare Part B benefits in the month in which you first become eligible, you must file an application for Part B in the three-month period before the month in which you first become eligible.

For example, if you turn age 65 on April 15, you must file your Part B application during the preceding January, February, or March to become entitled to receive Part B benefits on April 1. If you file your application in April, you would not be entitled to receive Part B benefits until May 1 and you will be responsible for the payment of medical expenses incurred during April that Medicare Part B would have paid had you enrolled. After you have enrolled in Medicare Part B, you must provide the Fund Office with proof of your eligibility. Medicare will require you to pay a premium for Part B coverage.

Any benefits payable to you or your dependents under any portion of the Plans will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your dependents are above age 65 and Medicare is the primary plan over the Plans for the same injury or illness, regardless of whether or not you have received or made application for such benefits or compensation.

Enroll in Medicare Part B before you become eligible

When you are eligible for Medicare, the Plans treat you as if you were enrolled in both Medicare Part A and Part B. So, you should enroll in Part B (or, alternatively, Part C) in the three-month period prior to the month in which your initial eligibility date occurs to avoid paying for expenses that Medicare Part B would have otherwise covered.

For all purposes of this provision, if you or your dependents are entitled to benefits or other compensation under Medicare and Medicare is your primary coverage, the Plans will reduce your benefit by the amount Medicare would have paid, even if you are not enrolled or participating in Medicare.

If you or your dependents are entitled to benefits or other compensation under Medicare, the Plans will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

SUBROGATION AND REIMBURSEMENT

If you become ill or are injured by the actions of a third party, the costs associated with your illness or injury should be paid by the responsible third party. For example, if you are injured in a vehicle collision caused by another driver, the driver or his or her insurance company may be liable for payment of your medical expenses. However, the wait for payment in these situations can be long, uncertain, and stressful. As a service to you, the Fund may agree to pay benefits for the illness or injury, with the understanding that these benefits will be repaid to the Fund from any recovery you receive from the third party.

Subrogation

If another person or entity is responsible for your medical expenses, you must help the Plans recover from that person or entity the benefits that the Plan paid to you.

Definitions

Throughout this section, these words have the following meaning:

You or Your eligible Dependents. All Plan participants, including eligible Dependents.

Third Party. Any person, corporation, government, or insurance coverage, including underinsured, uninsured, and medpay provisions, and workers' compensation coverage.

Benefits. All payments related to the injury or illness, including, but not limited to, medical expenses and income replacement or lost time benefits.

Recovery. Any and all payments from another source as a result of an injury or illness, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless or whether any amount is specifically included or excluded as medical expenses.

Fund's Rights

The Fund has the following rights:

- The Fund is entitled to reimbursement for any payments it makes to you or on your behalf for expenses related to an injury or illness resulting from the actions of a third party. The reimbursement is made from the third party or from you out of the funds received from the third party if you have been paid by the third party.
- The Fund must be reimbursed in full, out of any recovery paid by any third party, without any amounts deducted from that reimbursement for attorney's fees, costs, or future medical expenses.
- The Fund's right to reimbursement must be satisfied first before any other claims on the recovery can be satisfied and this right applies even if the recovery is not sufficient to fully compensate you for your illness or injury and even if liability is not admitted or found. Any amount left over, after the Fund has been reimbursed, will be paid to you.
- The Fund has the right to pursue a claim against the third party if you do not do so within a reasonable period of time.
- The Fund has the right to join in any suit or claim against a third party brought by you on your behalf.
- The Fund has the right to information about any claims you may be pursuing.

Your Responsibilities

You have certain responsibilities, as follows:

- You must comply with all Claim and records procedures and cooperate fully with the Fund in the recovery of the benefits paid by the Fund and the Fund's exercise of its reimbursement and subrogation rights.
- You will be required to complete and submit an Accident Claim Form, Statement of Injured Party Form, Subrogation and Reimbursement Agreement, and perhaps other documents. The Agreement must also be reviewed and signed by your attorney, confirming your and your attorney's understanding that the Fund is entitled to reimbursement.
- You must provide other information about your illness or injury as requested by the Fund.

- You must keep the Fund advised of any changes in the status of your claim against the third party.
- You must refrain from doing anything to compromise the Fund's subrogation and reimbursement rights without agreement by the Fund. The Fund must be notified before any settlements are concluded or before any trial or other hearing is held.
- You are solely responsible for your attorney fees; the Fund is not liable for any costs or fees incurred by you in pursuing your claim, regardless of any common fund doctrine.
- You must inform the Fund as to whether you have received a recovery related to your illness or injury before signing the *Subrogation and Reimbursement Agreement*. If you receive a recovery before the Agreement is signed, the Fund will not be responsible for any further Claims related to the illness or injury and you will still be obligated to reimburse the Fund for the Claims that it has paid.

Any Claims for your illness and/or injury will not be paid until the Fund has received a signed copy of the Subrogation and Reimbursement Agreement. If the Fund inadvertently pays Claims before receiving the signed agreement, the Fund is not obligated to pay any further Claims under the agreement until it is signed and the Fund is still entitled to reimbursement for the Claims that it has paid.

Procedures

You must immediately notify the Fund Office whenever you make a claim against a third party. If you do not meet this responsibility, the Fund may withhold payment of benefits. You are also responsible for compliance by your agents and attorneys with these procedures. If you receive payment from a third party, you or your attorney must hold that money separately from other assets until the Fund's rights have been satisfied.

The Fund has a claim, lien, or constructive trust on that money and it must remain segregated and under your control. Once the Fund's reimbursement rights have been determined, you must make immediate payment to the Fund out of the recovery proceeds. If you do not pursue a claim against the third party, and the Fund, at its discretion, elects to do so, you must allow the Fund to assert the claim in your name or on your behalf in the Fund's name and cooperate with the Fund's prosecution of the claim.

Noncompliance

If you receive payment from a third party but do not promptly segregate the money and reimburse the Fund in full, the Fund may take action to recover the benefit paid. Such action includes, but is not limited to:

- Initiating an action against you and/or your attorneys to compel compliance with these terms, the terms of the Plans, and the Subrogation and Reimbursement Agreement;
- Withholding benefits payable to or for you or your dependents until you comply or until the reimbursement amount has been offset;
- Seeking a penalty payment for delay in tendering reimbursement without Fund agreement; or
- Initiating other appropriate equitable or legal actions.

If you do not reimburse the Fund within 60 days of the date the claim is settled or the judgment is entered, you will be responsible for paying the Fund 1% interest per month on the amounts owed. The Fund is also entitled to reimbursement of any costs or fees it incurs in efforts to enforce its rights against you.

Conclusion of Claim

Once you have settled or received an award or judgment on your claim against the third party, your Claim for benefits from the Fund for the illness or injury is concluded. No further expenses associated with that injury or illness may be submitted to, or paid by, the Fund. Therefore, it is very important that you and your attorney scrutinize the status of all expenses before finalizing your third party Claim.

PRIVACY POLICY

The rules described below apply to each individual covered under the Fund; whether the individual is the participant, spouse, or covered dependent child. The information contained in this section describes how certain health information may be used and disclosed and how you may obtain access to this information.

The Chicago Laborers' Welfare Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your rights to privacy with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and with the Secretary of the Department of Health and Human Services (HHS); and
- The person or office you should contact for further information about the Fund's privacy practices. PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164.

This Privacy Policy attempts to summarize these regulations. The regulations will supersede any conflicting provisions contained here if there is any discrepancy between the information here and the regulations.

Your Protected Health Information

Protected Health Information (PHI) includes all information maintained by the Fund related to your past, present, or future physical or mental health condition or for payment of health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

PHI refers to your health information maintained by the Fund.

When the Fund May Disclose PHI

Under the law, the Fund may disclose your PHI without your consent authorization, or the opportunity to object:

- **At your request.** If you make a request under the Fund's procedures, the Fund is required to give you access to certain PHI to allow you to inspect it and/or copy it.
- **As required by an agency of the government.** The Secretary of the U.S. Department of Health and Human Services (HHS) may require the disclosure of your PHI to investigate or determine the Fund's compliance with federal law.
- **To the Fund's Trustees.** The Fund may disclose PHI to the Fund's Sponsor, the Board of Trustees of the Chicago Laborers' Welfare Fund, for the purposes related to treatment, payment, and health care operations. (For example, the Fund may disclose information to the Board of Trustees in order for them to make a determination on an Appeal or review a subrogation Claim.) The Fund's Plan documents have been amended to protect your PHI as required by federal law.
- **For treatment, payment, or health care operations.** The Fund and its Business Associates will use PHI without your consent, authorization, or opportunity to agree or object to carry out:
  - Treatment, which is health care treatment. Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your Providers.

To safeguard your health information, we request that all visitors show a valid photo ID when requesting benefit assistance. Acceptable forms of identification include a:

- Driver's license;
- State issued photo ID;
- Consular ID; or
- Passport.

The Fund does not need your consent or authorization to release your PHI when:

- You request it;
- A government agency requires it;
- Trustees are required to review it; or
- The Fund uses it for treatment, payment, or health care operations.

EXAMPLE

The Fund may disclose to a treating orthodontist the name of your treating Dentist so that the orthodontist may ask for your dental X-rays from the treating Dentist.

– Payment, which is paying Claims for health care and related activities. Payment includes, but is not limited to, making coverage determinations and payment. These actions include billing, Claim management, subrogation, Fund reimbursement, reviews for Medical Necessity, and appropriateness of care.

EXAMPLE

The Fund may tell your Physician whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

– Health Care Operations, which is involved with keeping the Fund operating soundly. Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities.

EXAMPLE

The Fund may use information about your medical Claims to refer you to a disease management program, to project future benefit costs, or to audit the accuracy of its Claims processing functions.

When Disclosure of PHI Requires Written Authorization

In general, the Plans must obtain your written authorization if it uses or discloses your PHI for purposes other than treatment, payment, or health care operations.

Generally, the Fund must obtain your written authorization before the Fund uses or discloses psychotherapy notes about you from your psychotherapist. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

In addition, the Fund must obtain your written authorization before it can disclose your PHI to your employer. In some cases, the Fund will require your written authorization before any disclosure is made to a family member (other than a spouse) or a close personal friend, as described later.

Psychotherapy Notes

Separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

When Use or Disclosure of PHI Requires an Opportunity to Agree or Disagree

Disclosure of your PHI to family members, other relatives, and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

In general, the Fund does not need your consent to release your PHI if required by law or for public health and safety purposes.

When Use or Disclosure of PHI Does Not Require Authorization

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization, or request:

- **When required by law.**

- **For public health purposes** to an authorized public health official if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **In domestic violence or abuse situations** when authorized by law, to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- **For oversight activities** to a public health oversight agency when authorized by law. These activities include civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions (e.g., to investigate complaints against Providers), and other activities necessary for appropriate oversight of government benefit programs (e.g., to the Department of Labor).
- **For legal proceedings** when required for judicial or administrative proceedings, provided:
  - The requesting party gives the Fund satisfactory assurances a good faith attempt has been made to provide you with written notice;
  - The notice provided sufficient information about the proceeding to permit you to raise an objection; and
  - No objections were raised or were resolved in favor of disclosure by the court or tribunal.

EXAMPLE

Your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

- **For law enforcement health purposes** (e.g., to report certain types of wounds).
- **For law enforcement emergency purposes**, including:
  - Identifying or locating a suspect, fugitive, material witness, or missing person; and
  - Disclosing information about an individual who is, or is suspected to be, a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
- **For determining cause of death and organ donation** when required by law, to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death, or other authorized duties. The Fund may also disclose PHI for cadaveric organ, eye, or tissue donation purposes.
- **For funeral purposes** when required to be given to funeral directors to carry out their duties with respect to the decedent.
- **For research purposes**, subject to certain conditions.
  - **For health or safety threats** when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
  - **For workers' compensation programs** when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in the Plans' Privacy Policy, uses and disclosures will be made only with written authorization subject to your right to revoke your authorization.

Designated Record Set includes your medical records and billing records that are maintained by or for the Fund. Records include enrollment, payment, billing, Claim adjudication, and case or medical management record systems maintained by or for a health fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose PHI to the Plan Sponsor for reviewing your Appeal of a Claim denial or for other reasons regarding the administration of the Fund.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Fund, regardless of the form of the PHI.

Individual Privacy Rights

Right to Request Restrictions on PHI Uses, Disclosures, and Receipt

In writing, you may request the Fund to restrict uses and disclosures of your PHI to:

- Carry out treatment, payment, or health care operations; or
- Family members, relatives, friends, or other persons identified by you who are involved in your care.

However, the Fund is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable. For example, if your request would interfere with the Fund's ability to pay a Claim, the Fund would consider your request unreasonable.

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI. Forms are available for these purposes.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI or to receive communications of PHI by alternative means or at alternative locations. Requests should be sent to:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a designated record set for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained at the Fund Office or within 60 days if the information is not maintained at the Fund Office. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your Personal Representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be sent to:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

If access is denied, you or your Personal Representative will be provided with a written denial setting forth the basis for why access was denied, a description of how you may exercise your review rights, and a description of how you may file a complaint with the Fund and the Secretary of the Department of Health and Human Services.

Right to Amend PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your written request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your written request in whole or part, the Fund will provide you with a written denial that explains the basis for the decision. You or your Personal Representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

Your written request to amend PHI should be sent to:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

You or your Personal Representative will be required to complete a form to request amendment of the PHI.

Right to Receive an Accounting of Fund's PHI Disclosures

At your request, the Fund will provide you with an accounting of disclosures by the Fund of your PHI made after this Policy became effective. The Fund does not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations or disclosures made to you or authorized by you in writing. See the Fund's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

The Fund has 60 days from the date it receives your request to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive a Paper Copy of Fund's Privacy Notice

To obtain a paper copy of the Fund's Privacy Notice, contact:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

Personal Representative

You may exercise your rights through a Personal Representative. Your Personal Representative will be required to produce evidence of authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed, and approved Appointment of Personal Representative Form. You may obtain this form by calling the Fund Office.

You may designate a Personal Representative by completing a form that is available from the Fund Office.

The Fund retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as Personal Representatives without you having to complete an Appointment of Personal Representative Form. For example, the Fund will automatically consider a spouse to be the Personal Representative of an individual covered by the Fund. In addition, the Fund will consider a parent or guardian as the Personal Representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. However, spouses and unemancipated minors may request that the Fund restrict information that goes to family members, as described at the beginning of this section.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a Personal Representative.

Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This Privacy Policy was effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this Policy. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund before that date. If the Fund changes any of its privacy practices, a revised version of this Privacy Policy will be provided, by mail, to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

Any revised version of this Privacy Policy will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI;
- Your individual rights;
- The duties of the Fund; or
- Other privacy practices stated in this Policy.

This Privacy Policy is to inform you of the Fund's obligation to maintain the privacy of your PHI.

Disclosing Only the Minimum Necessary PHI

When using or disclosing PHI, or when requesting PHI from another covered entity (e.g., a health care Provider or another health plan), the Fund will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

The Fund must limit its uses and disclosures of PHI or requests for PHI to the *minimum necessary* amount to accomplish its purposes.

However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care Provider for treatment;
- Uses or disclosures made by the Fund to you;
- Disclosures made by the Fund to the Secretary of the HHS;
- Uses or disclosures required by law; and
- Uses or disclosures required for the Fund's compliance with federal law.

Summary health information summarizes the Claim histories, expenses, or types of Claims experienced by individuals for whom the Plan Sponsor has provided health benefits under its Plan.

This Policy does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you; and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose summary health information to the Plan Sponsor to premium bids or modifying, amending, or terminating the Fund's benefits. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Right to File a Complaint with the Fund or HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Fund's Privacy official:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

You have the right to file a complaint if you feel your privacy rights have been violated.

The Fund will not retaliate against you for filing a complaint.

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

The Fund will not retaliate against you for filing such a complaint.

If You Need More Information

If you have any questions regarding the Fund's Privacy Policy or the subjects addressed in it, you may contact the Privacy Official at:

Privacy Official
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

PLAN ADMINISTRATIVE INFORMATION

Fund Name

The Fund's legal name is the Health & Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity. It is commonly referred to as the Chicago Laborers' Welfare Fund.

Plan or Benefit Plan

A program of benefits described in this booklet and any other written documents that the Plan Trustees designate to be part of the program of benefits under the terms of the Trust Agreement.

Summary Plan Description

This booklet provides you with a simplified summary of the Plans. This booklet replaces and supersedes any prior Summary Plan Description.

Plan Sponsor and Plan Administrator

A Board of Trustees is responsible for the operation of the Plans. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for Employer contributions, answer participant inquiries, process Claims and benefit payments, and handle other routine administrative functions. The Administrator contracts with various providers for services, as indicated on pages 2 and 3. The Fund's Certified Public Accountant prepares required government reports.

Trustee

A Trustee is an individual or the individual's successor, who is appointed and designated according to the terms of the Trust Agreement to administer the Fund. Trustees designated by the Employer Association are Employer Trustees. Trustees designated by the Union are Union Trustees.

Fund, Trust Fund, or Welfare Fund

The entire Trust of the Chicago Laborers' Welfare Fund, established and administered according to the Trust Agreement.

Board of Trustees

The Board of Trustees consists of Employer and Union Trustees selected by the Employer Associations and Unions that have entered into collective bargaining agreements related to the Chicago Laborers' Welfare Fund. You may contact the Board of Trustees by using the following address and phone number:

Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154; or
E-mail at claims@chilpwf.com
708-562-0200 or 866-906-0200

The Trustees of the Plans are:

Union Trustees	Employer Trustees
Antonio S. Castro Laborers' Local Union No. 1 9726 Franklin Avenue Franklin Park, IL 60131-1702	**Julie Chamberlin** Berger Excavating Contractors, Inc. 1205 Garland Road Wauconda, IL 60084-1011
James P. Connolly Chicago District Council of Laborers 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527-0844	**Charles J. Gallagher** Gallagher Asphalt Paving Co. 18100 S. Indiana Avenue Thornton, IL 60476-1276
Martin T. Flanagan Laborers' Local Union No. 118 2430 E. Rand Road Arlington Heights, IL 60004-5877	**Richard E. Grabowski** Prinmar Corporation 8601 W. Bryn Mawr Avenue, Suite 110 Chicago IL 60631-3580
Richard Kuczkowski Laborers' Local Union No. 2 8842 W. Ogden Avenue Brookfield, IL 60513-2147	**Clifton M. Horn** A. Horn, Inc. 125 Harrison Street Barrington, IL 60010-3006
Charles V. Loverde, III Laborers' District Council of Laborers 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527-0844	**David H. Lorig** Lorig Construction Co. 250 E. Touhy Avenue Des Plaines, IL 60018-2653
Scott Pavlis Laborers' Local Union No. 75 1923 Donmaur Drive Crest Hill, IL 60403-1904	**Dennis P. Martin** Martin Cement Company 25 Forestwood Drive Romeoville, IL 60446-1343

Plan Interpretation and Continuation

Only the Board of Trustees is authorized and has the broad discretion to:

- Interpret the Plans' rules and procedures;
- Decide all questions about the Plans, including questions about eligibility for benefits and the amount of benefits payable;
- Determine the facts of any Claim for Plan benefits; and
- Change the eligibility rules and other Plan terms to amend, increase, decrease, or eliminate benefits or terminate the Plans, partially or totally.

Benefits under the Plans will only be paid when the Trustees or persons delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Plans.

Collective Bargaining Agreement
The negotiated Labor Agreement between the Union and your Employer that requires contributions to the Fund.

The Trustees intend to continue the Plans indefinitely for your benefit and the benefit of all Plan participants. However, the Trustees have been given the power to amend or terminate the Plans, as they deem necessary. The Plans may be amended or terminated by majority vote of the Board of Trustees at a meeting of the Trustees. If this occurs, the Fund Office will send you a written notice explaining the change. Please be sure to read all Fund and Plan communications and keep them with this summary booklet.

The Trustees also decide any factual question related to eligibility for and the type and amount of benefits. The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plans on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plans. You may only rely on information regarding the Plans that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

You are not vested in any of the benefits described in this booklet. The Trustees reserve the right to amend, modify, or terminate the Plans or any of their benefits at any time, and from time to time, in their sole and unrestricted discretion.

Collective Bargaining Agreements

You and your dependents may obtain, upon written request to the Fund Office, information as to the address of a particular employer and whether that employer is required to pay contributions to the Plans. You may also request a list (including addresses) of all contributing employers and unions maintaining the Plans.

Identification Numbers

The identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-2151212. The number assigned to the Plans by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501.

Contributions

Employer and Retiree contributions finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the Union and Employer Associations and those Employers that are not members of, or represented by, such Employer Associations but that enter into an individual collective bargaining agreement with the Union.

The collective bargaining agreements specify the amount of contributions, due date of Employer contributions, type of work for which contributions are payable, and the geographic area covered by these agreements. The amount of monthly premium payments due for your coverage is determined by the Trustees.

Trust Fund

The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. All benefits and administrative expenses are paid from the Fund's assets. The Trust Agreement consists of all the documents, including all amendments that establish the Trust Fund and its rules of operation.

Plan Year

The accounting records of the Plans are kept on a fiscal Plan Year basis beginning each June 1 and ending the following May 31.

Purpose

These Plans are employee welfare benefits plans maintained to provide medical, prescription drug (the Retiree Medical Plan only), dental, vision, and death benefits for you and your dependents who meet the eligibility requirements described in this booklet.

Plan Inspection

If you wish to inspect or receive copies of additional documents relating to the Plans, contact the Administrator at the Fund Office. You will be charged a reasonable fee to cover the cost of copying any document you request.

Legal Process

For disputes arising under the Plans, service of legal process may be made on:

James S. Jorgensen
Administrator
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154, or
708-562-0200 or 866-906-0200

Service of any legal process may also be made on any individual Trustee at the address for the Fund Office.

YOUR ERISA RIGHTS

As a participant in the Chicago Laborers' Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the following rights.

Receive Information about Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to:

- Continue 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. The Fund Office will provide you with the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the Plans when:
  - You lose coverage under the Plans;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ceases.

You must request the Certificate of Creditable Coverage before losing coverage or within 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plans 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 Plan Administrator.

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

Assistance with Questions

If you have any questions about the Plans, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office

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

Nearest Regional Office

Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
312-353-0900

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

DEFINITIONS

Throughout this booklet, many words are used that have a specific meaning when applied to your Plan coverage. When you come across these terms while reading this booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order and are initially capitalized when used in the booklet.

Ambulance Service	Local Transportation in a specially equipped certified vehicle from your home, scene of the accident or medical emergency to a Hospital, between Hospitals, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Service is then defined as the transportation to the closest facility that can provide the necessary service. Ambulance Service does not include transportation to a medical facility for patient convenience (i.e., transportation from you home to a Physician's appointment or therapy session).
Ambulatory Surgery Center	A facility (other than a Hospital): • Whose primary function is the provision of surgical procedures on an ambulatory basis; and • That is duly licensed by the appropriate state and local authority to provide such services.
Anesthesia Services	The administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.
Appeal	A Claimant has filed a written request within the specified timeline to have an initial Claim benefit determination reviewed by the Trustees of the Claim Committee of the Chicago Laborers' Welfare Fund.
Certificate of Creditable Coverage	A certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any pre-existing condition exclusion imposed by any group health plan coverage.
Certified Nurse Midwife (CNM)	An individual who: • Practices according to the standards of the American College of Nurse-Midwives; • Has an arrangement (or agreement with a Physician) for obtaining medical consultation, collaboration, and Hospital referral; • Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and • Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.
Certified Registered Nurse Anesthetist (CRNA)	An individual who is: • A graduate of an approved school of nursing; • Duly licensed as a registered nurse; • A graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; • Certified by the Council of Certification of Nurse Anesthetists or its predecessors; and • Recertified every two years by the Council on Recertification of Nurse Anesthetists.
Certified Surgical Assistant (CSA)	An individual specializing in surgical assistance who performs functions such as scrubbing for an operative session, assisting in the positioning of a patient, draping the operative site, retracting and exposing the operative site during a surgical procedure, and providing homeostasis (clamping or tying off bleeders and suture). A CSA must: • Have completed a specialized course of training, including classroom instruction and clinical application regarding the skills and requirements of a surgical assistant; • Bill for services as a CSA; • Be licensed if such licensure is required by the state in which he or she practices; • Practice under the direct supervision of a Physician or surgeon who is working within the scope of his or her own license; • Have a Physician or surgeon physically present while the CSA is providing billed services. A bachelor's degree from an accredited college or university is not required to be a CSA.

Chemotherapy	The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.
Chiropractor	An individual who is licensed to practice as a chiropractor in the state in which services are being provided.
Claim	A request for Plan benefits made by a Claimant according to the Plans' Claim filing procedures. Claims may be submitted in paper form or through Electronic Data Interchange (EDI). A Provider may submit a Claim on behalf of a Claimant to receive direct payment, but in no case will the Fund treat the Provider as the assignee of such Claim (assignment of Claims is prohibited).
Claimant	A patient, who can be the Retiree, spouse, or natural parent of an underage child who files a Claim for benefits.
Clinical Psychologist	A Psychologist who: • Specializes in the evaluation and treatment of mental health; • Has a doctoral degree from a regionally accredited university, college, or professional school; • Has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program or is a registered Clinical Psychologist with a graduate degree from a regionally accredited university or college; and • Has not less than six years as a Psychologist, with at least two years of supervised experience in health services.
COBRA	Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, that regulate the conditions and manner under which an employer can offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate.
Coinsurance	A percentage of an eligible expense that an eligible individual is required to pay toward a Covered Service.
Convenient Care Clinics	Health care clinics located in retail stores, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventative health care services.
Creditable Coverage	Coverage under any of the following: • A group health plan; • Health insurance coverage for Medical Care under any Hospital or medical service policy plan, Hospital or medical service plan contract, or HMO contract offered by a health insurance issuer; • Medicare (Parts A or B of Title XVIII of the Social Security Act); • Medicaid (Title XIX of the Social Security Act); • Medical Care for members and certain former members of the uniformed services and their dependents; • Medical Care program of the Indian Health Service or of a tribal organization; • State health benefits risk pool; • Health plan offered under the Federal Employees Health Benefits Program; • Public health plan established or maintained by a state or any political subdivision of a state, the U.S. government, or a foreign country; • Health plan under Section 5(e) of the Peace Corps Act; or • State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care	Any services or supplies provided primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed. Custodial Care services: • Can be safely provided by trained or capable non-professional personnel; • Are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.); and • Are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial Care also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement.
Dentist	A duly licensed dentist (DDS or DMD).
Diagnostic Service	Tests rendered for the diagnosis of symptoms and are directed toward evaluation or progress of a condition, disease, or injury. Tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.
Dialysis Facility	A facility (other than a Hospital): • Whose primary function is the treatment and/or provision of maintenance dialysis on an ambulatory basis for hemodialysis or peritoneal dialysis patients; and • Is duly licensed by the appropriate governmental authority to provide such services.
Dialysis Treatment	One unit of service, including the equipment, supplies, and administrative service that are customarily considered as necessary to perform the dialysis process.
Eligible Charge	• In the case of a Provider that has a written agreement with the Fund to provide care at the time Covered Services are rendered, the Provider's Claim charge for Covered Services; • In the case of a Provider that does not have a written agreement with the Fund to provide care at the time Covered Services are rendered, the amount for Covered Services as determined by the Fund Office based on the following order: – The charge that is within the range of charges other similar Hospitals or facilities in similar geographic areas charge patients for the same or similar services, as reasonably determined by the Fund Office, if available; – The amount that the Centers for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to those in the Medicare program; or – The charge that the particular Hospital or facility usually charges its patients for Covered Services.
Eligible Retiree	A retiree of an Employer who meets the eligibility requirements for this Plan's coverage, as described in the eligibility section of this booklet.
Employer	The company with which you were employed.
Hospice Care	Palliative and supportive care designed to provide for the physical and psychological well being of dying persons and their families. The goal of Hospice Care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and quality of life. Hospice Care is available in the home, Skilled Nursing Facility, or special Hospice Care unit.

Hospital	An institution that: • Is duly licensed for the care of the sick or injured to provide services under the care of a Physician, including the regular provision of bedside nursing by registered nurses; • Is accredited by a nationally recognized accrediting agency; • Has full-time permanent bed care facilities for five or more patients; • Has the regular services of a Physician; • Provides 24-hour-a-day nursing services by registered nurses; • Performs mainly diagnostic and therapeutic medical and surgical care of patients or provides care and treatment for Substance Abuse; and • Is licensed to operate in the state where it is located. A Hospital does not include health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes of the aged, or similar institutions.
Inpatient	A registered bed patient being treated in a Hospital or other health care facility.
Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures	Procedures, drugs, devices, services, and/or supplies that: • Are provided or performed in special settings for research purposes or under a controlled environment that are being studied for safety, efficiency, and effectiveness; • Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the patient; • Specifically with regard to drugs, combination of drugs, and/or devices are not finally approved by the Food and Drug Administration at the time used or administered to the patient; • Are not officially accepted by the medical community; • Are not recognized as having proven beneficial outcomes to the patient; and/or • Are not recommended for an advanced state of an illness or disease.
Licensed Clinical Professional Counselor	A duly licensed clinical professional counselor.
Licensed Clinical Social Worker (LCSW)	A duly licensed clinical social worker.
Maintenance or Developmental Care	Those services that are: • Administered to a patient to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.
Maintenance Occupational Therapy or Maintenance Physical Therapy	Therapy that is: • Administered to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.

Marriage and Family Therapist (LMFT)	A duly licensed marriage and family therapist. Marriage counseling is not covered under the Plans.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.
Medically Necessary or Medical Necessity	Services, treatments, or supplies ordered by your Physician that are: • Required to identify or treat an injury or illness; • Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, illness, or injury; • In keeping with acceptable National Standards of Good Medical Practice; and • The most appropriate that can be safely provided under the circumstances on a cost-effective basis.
Medicare	The program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).
Mental Health Disorder	Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) Manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health disorders include, but are not limited to, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.
Naprapath	A duly licensed Naprapath.
Naprapathy	The performance of naprapathic practice by a Naprapath that may legally render such services.
Nurse Practitioner	See Physician Assistant (PA) or Nurse Practitioner (NP) for definition.
Occupational Therapist	A duly licensed occupational therapist.
Occupational Therapy	Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.
Optometrist	A duly licensed optometrist.
Outpatient	Treatment received while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room, diagnostic laboratory tests and X-rays, medications, and supplies.
Participating Provider Option	A program of health care benefits designed to provide economic incentives for using designated Providers of health care services.
Pharmacy	Any licensed establishment in which the profession of pharmacy is practiced.
Physical Therapist	A duly licensed physical therapist.
Physical Therapy	The treatment of a disease, injury, or condition by physical means by a Physician or registered professional Physical Therapist under the supervision of a Physician that is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician	A legally qualified physician duly licensed to practice medicine in all of its branches.
Physician Assistant (PA) or Nurse Practitioner (NP)	A duly licensed physician assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider. A NP or PA is a health professional, qualified by academic and clinical training, who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a qualified licensed Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plans do not cover NP or PA assistance during Surgery.
Podiatrist (DPM)	A duly licensed podiatrist.
Private Duty Nursing Service	Skilled Nursing Service provided on a one-to-one basis by an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN). Private Duty Nursing Service is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private Duty Nursing Service is not covered under the Plans except to the extent that it can be covered under the Plans' home health care benefits when provided by a home health agency.
Prosthetic Device	A prosthetic appliance or device that is a type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and artificial eyes.
Provider	Any health care facility (for example, a Hospital or Skilled Nursing Facility), person (for example, a Physician or Chiropractor), or entity duly licensed to render Covered Services.
Psychologist	A Clinical Psychologist registered in a state where statutory licensure exists. The Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, must meet the qualifications specified in the definition of a Clinical Psychologist.
Reconstructive Surgery	A surgical procedure that is intended to improve bodily function and/or correct deformity resulting from congenital anomaly that causes a functional effect or results from a prior covered therapeutic procedure. Call the Fund Office for further information.
Respite Care Service	Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services. Respite Care Service is not covered under the Plans.
Skilled Nursing Service	An institution or a distinct part of an institution that is: • Primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care; and • Duly licensed by the appropriate governmental authority to provide such services.
Skilled Nursing Facility	Those services provided by a registered nurse (RN) or Licensed Practical Nurse (LPN) that require the clinical skill and professional training of an RN or LPN and that cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care service.
Speech Therapist	A duly licensed speech therapist.
Speech Therapy	The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy for developmental delay is limited to children under the age of five or children under the age of nine for specific diagnosis. Speech Therapy for older children and adults does not include therapy for developmental delay, educational training, or services designed and adapted to develop a physical function.

Substance Abuse	The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, including the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.
Substance Abuse Treatment Facility	A facility (other than a Hospital) whose primary function is the treatment of Substance Abuse that is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.
Surgery	The performance of any medically recognized, non-Investigational surgical procedure, including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures.
Temporomandibular Joint Dysfunction (TMJ) and related disorders	Jaw joint conditions, including temporomandibular joint disorders, craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves, and other tissues relating to that joint.
Totally Disabled or Total Disability	With respect to an Eligible Retiree, you are (and continue to be) unable to perform the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement due to a disabling condition that is non-occupational. If you are employed in a position that does not require work as a laborer, you must be disabled from performing the work that you are normally assigned.
Usual and Customary (U&C) Charge	• The charge that is no higher than 400% of what Medicare would pay for that service; • For multiple or bilateral surgeries performed at the same time, 100% for the primary procedure, an amount determined after medical review for additional procedures; • For surgical assistance by a Physician, up to a maximum of 20% of the charge allowed for the surgery; and • For PPO Providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

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