Chicago Laborers' Welfare Fund

Active Summary Plan Description

Plan 3

Effective October 1, 2004

Chicago Laborers' Welfare Fund

11465 W. Cermak Road
Westchester, Illinois 60154
Telephone: 708-562-0200
Fax: 708-562-0716

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Only the Board of Trustees is authorized to interpret the Plan described in this booklet. No Employer, Union or any representative of any Employer or Union, is authorized to interpret the Plan nor can any such person act as agent of the Trustees. You may only rely on information regarding the Plan 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.

The Trustees reserve the right and have been given the discretion to amend, modify or discontinue all or part of the Plan whenever, in their sole judgment, conditions so warrant.

Benefits under the Retiree Plan 3 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 Retiree Plans.

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11465 W. Cermak Road
Westchester, Illinois 60154
Telephone: 708-562-0200
Fax: 708-562-0716

To All Plan 3 Participants:

We are pleased to provide you with this revised Summary Plan Description booklet describing your health and welfare benefits in Plan 3 in effect as of October 1, 2004.

This booklet is a revision of the Chicago Laborers' Welfare Fund Summary Plan Description booklet printed and distributed in 2002. This is intended for use by participants and dependents who are eligible for benefits in Plan 3.

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 at 708-562-0200. If you would like, request to speak to someone in the Claims Department who speaks Spanish.

Sincerely,

BOARD OF TRUSTEES

IMPORTANT

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, Illinois 60154. Office hours are from 8:30 a.m. to 4:00 p.m., Monday through Friday. Customer Service Representatives can be reached by telephone from 8:00AM to 5:00PM. For assistance, you can call the Fund Office at 708-562-0200.

IMPORTANTE

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 a.m. a 4:00 p.m., de Lunes a Viernes. Para obtener asistencia también puede llamar a las oficinas al 708-562-0200.

IMPORTANTE

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, USA. 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.

WAŻNE

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.

Table of Contents

Introduction

The Plan of the Chicago Laborers' Welfare Fund offers comprehensive health care coverage to help you and your dependents stay healthy. Benefits are paid on a calendar year basis. This coverage can also help provide financial protection against catastrophic health care bills. In addition to comprehensive medical benefits, the Plan provides:

- Prescription drug coverage,
- Weekly Income benefits (for covered employees only), and
- Death and Accidental Dismemberment benefits.

Beginning a new job, having a child or adopting one, getting married or divorced, having a major illness, performing military duty, retirement and losing a loved one are all examples of life events.

Life Events

At some point in our lives, each of us will experience a life event that impacts our health care coverage. Many of us have experienced some of these life events already. Beginning a new job, having a child or adopting one, getting married or divorced, having a major illness, performing military duty, retiring from employment as a laborer, and losing a loved one are all examples of life events. This booklet is designed to show you how your Chicago Laborers' Welfare Fund benefits fit into the different stages of your life.

Network Providers

Medical Care. The Plan offers you inpatient and outpatient hospital medical coverage through BlueCross BlueShield of Illinois (BCBSIL), a Preferred Provider Organization (PPO). The Plan offers physician medical coverage through HFN, Inc., an Exclusive Provider Organization (EPO). Within these networks you have access to many participating doctors and hospitals throughout the area where you live. You can go to any doctor, whether network or non-network, and receive benefits for covered expenses. However, by using the services of your network providers, you receive services at pre-negotiated discounted rates and you also receive the higher network level of benefits.

If you live outside Illinois or Northwest Indiana, the Plan has contracted with National Preferred Provider Network (NPPN), to provide you and the Plan with discounted service rates.

To select a hospital, facility, physician or other provider in your area, refer to the contact list on this page.

Health care providers can be reached at:

BCBSIL (hospital)
800-571-1043
8:00 a.m. – 5:00 p.m.
Monday – Friday
www.bcbsil.com
Group No.: P15412

HFN (physician)
800-295-5444
8:30 a.m. – 4:30 p.m.
Monday – Friday
www.hfninc.com
Group No.: W 9752

NPPN (national hospital/physician)
800-557-1656
www.nppn.com
Group No.: 6047

Prescription Drugs. The Plan offers prescription drug benefits through Caremark Inc., (*formerly AdvancePCS*), a Pharmacy Benefit Manager (PBM). There are more than 50,000 pharmacies that participate in the Caremark network nationwide, including almost all of the major drug chains. You may contact the Fund Office at 1-708-562-0200 or visit the Caremark website at www.caremark.com for a list of participating pharmacies. You must show your prescription drug program identification card when you fill your prescription at a Caremark pharmacy to receive your prescription drug medications at discounted prices. If you do not use your identification card when you fill your prescription, you will be responsible for 50% of the cost of the prescription medication.

Questions About Your Benefits

Please take some time to review this booklet. If you're married, share the information with your spouse and let your spouse know where you file this information for future reference.

Questions? If you have any questions about the benefits described in this booklet, contact the Fund Office at 708-562-0200. If you would like, you may request to speak to someone in the Claims Department who speaks Spanish.

Schedule of Benefits

The chart below highlights your medical benefits. *All covered expenses must be within the guidelines of the usual and customary rates*. Contact the Fund Office for the most current usual and customary rates in effect at the time of service.

Additional limitations apply for certain services. These limitations are explained in the description of your benefits beginning on page 23.

Comprehensive Medical Benefits	
Benefit	**Benefit Amount/Special Limits**
Annual Deductible	$300 per person per calendar year $600 per family per calendar year
Coinsurance	After you pay your annual deductible, the Plan pays the applicable coinsurance rate of the next $7,500 per person of covered expenses each calendar year. The Plan then pays 100% of additional expenses up to the lifetime maximum for the remainder of the year.
Medical Coinsurance: Network Provider Non-network provider	Plan pays: 90% of covered expenses 80% of covered expenses
Lifetime Maximum	$875,000 per person
Contraceptive Benefits (Employee and Spouse Only)	$400 per person per calendar year
Chiropractic and Spinal Manipulation Annual Maximum	$2,000 per person per calendar year
Home Health Care Services	60 days at $650 per day *(combined with outpatient Skilled Nursing Expenses)*
Infertility Treatment Lifetime Maximum (Employee and Spouse Only)	$12,500 per person
Mental Illness Annual Maximum Inpatient Outpatient	 Up to 30 days per person per calendar year Up to 50 visits per person per calendar year
Skilled Nursing Facility Services Inpatient Maximum Outpatient Maximum	 60 days at $650 per day 60 days at $650 per day *(combined with Home Health Care Services)*
Speech Therapy for Dependents[1] Standard Developmental Therapy before age 5 Therapy for Special Diagnoses before age 9	 $5,000 lifetime benefit Additional $5,000 lifetime benefit (total of $10,000 combined with standard therapy benefit)

[1] *See explanation on page 27.*

Comprehensive Medical Benefits	
Benefit	**Benefit Amount/Special Limits**
Suicide Attempt Expenses	$10,000 maximum (one time only benefit)
Transplants	*Contact Fund Office to determine coverage*
Alcoholism and Substance Abuse Treatment (Includes Detoxification)	Plan pays: 90% of covered expenses in network 80% of covered expenses out of network
Inpatient Lifetime Maximum	Up to $300 per person per day $12,000
Outpatient Lifetime Maximum	Up to $150 per person per visit $11,000
Prescription Drug Benefits	
Benefit	**Benefit Amount/Special Limits**
Basic Prescription Drug Benefit[2]	$5,000 per person per calendar year (100% covered for covered expenses)
Annual Deductible[3]	After the Plan pays the first $5,000 of prescription drug expenses, you must pay: $200 per person per calendar year $400 per family per calendar year
Coinsurance	After you pay your annual deductible, the Plan pays 80% of covered expenses for the remainder of the calendar year

[2] *If you do not go to a participating pharmacy or you do not show your ID card or when you pick up your prescription, you will pay 50% of the cost for your prescription medication. This amount does not count toward your basic prescription drug benefit or your annual deductible.*

[3] *The Prescription Drug Benefit annual deductible is separate from the Comprehensive Major Medical Benefit annual deductible.*

Weekly Income Benefits (Employees Only)	
Benefits begin on the first day you are unable to work due to an injury or on the eighth day after you are unable to work or the eighth day after your doctor's first treatment for an illness.	
Weekly maximum benefit: non-occupational injury or illness	$200
Weekly maximum benefit: occupational injury or illness	$25
Maximum period benefits are payable	26 weeks
Extended Weekly Income Benefit	Up to 26 additional weeks (lifetime maximum)

Death Benefits	
Life Event	**Benefit Amount**
Your Death	$20,000 (payable to your beneficiary)
Death of Your Spouse or Child	$5,000 (payable to you)
Death of Your Child who is less than 6 months old	$200 (payable to you)

Accidental Dismemberment Benefits		
Type of Loss	**You**	**Your Covered Dependent**
Loss of one hand, one foot or sight in one eye	$5,500	$1,875
Loss of one hand and one foot, one hand and sight in one eye or one foot and sight in one eye	$11,000	$3,750
Loss of both hands, both feet or the sight in both eyes	$11,000	$3,750

Eligibility

The Board of Trustees, in establishing this alternate plan of benefits, Plan 3, expressly intend that this Plan shall cover only those employees who perform work in the jurisdiction of the Chicago Laborers' District Council, or under a Reciprocal Agreement, and who work for employers who are not engaged in the construction industry.

Initial Eligibility

You first become eligible for benefits under the Plan after you have worked a minimum number of hours in covered employment either within a 6- or a 12-consecutive month period. Your coverage becomes effective on the first day of the month **following** your completion of the required hours.

Covered Employment means that you work for an Employer that is required to make contributions to the Fund on your behalf.

The chart below outlines the Plan's requirements for your initial eligibility.

*Minimum Covered Employment Hours Required**

Age Group	Hours during 6 consecutive months	Hours during 12 consecutive months
Under Age 50	500	800
Ages 50 to 54	400	700
Ages 55 and over	200	300

* *Any individuals covered by a Collective Bargaining Agreement that contains an Early Eligibility Provision will receive an addendum to these rules.*

Continuing Eligibility

Once you become eligible under the Plan, you continue to be eligible on a month-to-month basis. Your coverage continues as long as you work 500 hours in covered employment during the preceding 6 months or 800 hours during the preceding 12 months (or the appropriate minimum hours for your age group, see chart above).

You can check your eligibility 24 hours a day by calling 708-947-7260. Be sure to have your Social Security Number handy and follow the instructions given in the telephone prompts (available in English or Spanish).

If You Change Employers

On October 1, 2004, the minimum covered hours requirement listed above determines your eligibility status, while your employer's contribution rate determines in which plan you and your dependents may participate. In the future, if you change employers, you may

participate in a different plan of benefits. This is because employers remit contributions at varying rates.

Example: How your plan participation may change if you work for an employer who contributes to a different plan of benefits. John Smith, age 41, works for Employer ABC who contributes to Plan 3. John is currently eligible for benefits under Plan 3 through September. Employer ABC is sold in April and the Chicago operations are closed for the remainder of the year. In May, John goes to work for Employer Stone who contributes to Plan 5 benefits. Once John gains eligibility in the Plan 5, his eligibility in Plan 3 terminates.

Month	Hours	Eligibility Plan 3	Eligibility Plan 5
May	150	Yes	No
June	180	Yes	No
July	175	Yes	No
August	120	No	Yes

In July, John met the minimum hours requirement for 6-consecutive months under Plan 5. John becomes eligible for Plan 5 benefits on August 1, the first day of the month following the completion of required employment hours. **Hours worked for Employer ABC and Plan 3 benefit eligibility are not counted toward the minimum hours requirement for Plan 5 eligibility.** This is because the employer contribution rates vary by plan.

Few participants will experience any change in benefit plans if they change employers. However, if you do change employers in the future, you may wish to consult with your employer, Local Union or the Fund Office to determine to which plan of benefits your new employer remits contributions.

After Retirement

Your coverage under the Plan will continue after you retire from covered employment as long as you maintain a sufficient number of hours during the preceding 6- or 12- consecutive month period. When your hours eligibility expires and you no longer qualify for benefit coverage under the Plan, you will be offered the chance to elect COBRA Continuation Coverage. In addition, if you meet certain retiree eligibility requirements, you may be offered coverage under the Retiree Medical Plan 3.

Returning to Covered Employment After Retirement

If you return to covered employment after you retire, your pension benefits may be suspended. In addition, your coverage under the Retiree Medical Plan 3 will end on the day you return to covered employment. You will not be eligible for COBRA continuation. You will regain eligibility under this Plan on the first day of the month following the completion of the required number of hours, provided that your employer remits contributions to this Plan.

When you consider retiring from covered employment, contact the Claim Department of the Fund Office at 708-562-0200. A representative will advise you the welfare benefit options that are available to you.

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

If you retiree and return to covered employment three times, you will no longer be eligible for the Retiree Medical Plan 3 coverage. Your only option to continue your medical coverage when your eligibility under this Plan expires will be to elect COBRA continuation coverage.

Dependent Eligibility

If you have dependents and you are eligible for benefits under the Plan, then your dependents are eligible for dependent benefits under the Plan at the same time (see below for a definition of dependents eligible under the Plan).

You will be required to provide documentation to the Fund Office that verifies your dependent's status. Documentation may include a birth certificate, adoption papers, court orders, affidavits, tax returns, etc. Please contact the Eligibility Department of the Fund Office for more information.

If your spouse or child is eligible for benefits as an employee under the Plan, he or she cannot be covered as your dependent under the Plan.

If you add a dependent while you are eligible for benefits under the Plan, the dependent's eligibility for benefits begins on the date that he or she becomes your dependent. You should enroll a newborn child in the Plan within 31 days of birth. You must provide the Plan with a copy of the newborn's birth certificate within 90 days of the date of birth to continue your dependent's coverage under the Plan.

Dependent Defined

Your dependents are:

- Your spouse if you are not divorced.
- Your unmarried child:
  - Who is less than 19 years old.
  - Who is age 19, but less than 26, if enrolled at a state accredited secondary college, university or at a technical, vocational-technical or trade school or institute as a full-time student, as defined by the educational institution. The child must be dependent on you for the major portion of his or her support and maintain a permanent residence in your home.

If your dependent has coverage under another plan, Coordination of Benefits will apply. See page 51 for more information.

Under the Plan your child is defined as:

Your ***dependents*** are generally your spouse and your children up to age 19 or up to age 26 if they are full-time students.

- Your natural child,
- Your stepchild, provided:
  - You are financially responsible for the child,
  - Claim the child as a dependent on your tax returns,
  - The natural parent has not been court ordered to support the child and,

- The natural parent has not been court ordered to provide health coverage,

- Your adopted child or child placed with you for adoption,
- Your child who is entitled to coverage pursuant to a Qualified Medical Child Support Order (QMCSO),
- Your child for whom you have legal guardianship, provided:
  - The child resides in your home in a parent-child relationship,
  - The child depends on you for 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.
- Your unmarried child who is age 19 or older and is incapable of self-sustaining employment due to mental or physical handicap. The handicap must have occurred before reaching age 19, or age 26, if a full-time student. The child must depend on you for financial support and daily living. You must give the Fund Trustees written proof of the child's handicap at the Plan Administrator's request within two months before coverage would otherwise end.

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,
- 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. The

Plan may exclude all coverage based on the results of such a test.

When Coverage Ends

For You

Your coverage ends on the earliest of the following dates:

- On the first day of the month following the date you fail to meet the requirement of covered employment hours,
- On the first day of the month following initial eligibility in another Laborers' plan of benefits,
- The last day of the period for which the last contribution was paid for your coverage,
- 31 days after your eligibility ends, your Death and Accidental Dismemberment Benefit coverage terminates,
- The first day of the month that you fail to meet the requirements for continued eligibility for Weekly Income Benefits and Medical Benefits,
- The date you become eligible for other coverage due to other employment (outside of Laborers' jurisdiction),
- The date the Plan is terminated, or
- The date that your Employer ends coverage for its employees.

When coverage ends, you and your dependents may be eligible to continue your coverage under the federal law known as COBRA. See the section that explains COBRA continuation coverage on page 13.

For Your Dependents

Your dependent's eligibility for benefits under the Plan will end on the same day that your coverage ends. Your dependent's coverage under the Plan also ends:

- When your dependent no longer meets the Plan's definition of an eligible dependent (for example due to divorce or a child reaching age 19 or age 26 if a full-time student),
- At the end of the period for which the last COBRA contribution was paid for your dependent's coverage,
- The date the Plan is terminated,
- The date that your Employer ends coverage for its employees, or
- When your dependent enters the armed forces.

If you die while you are eligible for benefits, your dependents are eligible to continue coverage by electing COBRA continuation coverage for up to 36 months (see page 13). If your dependents elect

COBRA continuation coverage, the first 18 months are free; that is the Fund pays for the first 18 months of COBRA continuation coverage. After that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

Certificate of Creditable Coverage

When your coverage under the Plan ends, the Fund 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 you or your dependents elect COBRA continuation coverage or coverage under USERRA, another Certificate will be provided within 60 days after the COBRA continuation coverage or USERRA 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 later of the date coverage under the Plan ended or the date COBRA continuation coverage or USERRA coverage ended.

Reinstatement of Eligibility

If your coverage ends, you can reinstate your eligibility by satisfying the Plan's initial eligibility requirements again (see page 6). For information regarding your eligibility during and after your return from a leave of absence for military service (see page 12) or family and medical leave (see page 12).

Continuation of Coverage

Military Service

Health care coverage under the Plan will continue for you (or your dependent) if you (or your dependent) serve in the uniformed services of the United States (active duty or inactive duty training) for up to 31 days. If you serve in military service for more than 31 days, you may continue your coverage at your own expense for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Reemployment – Following your discharge from military service, you may be eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your Employer.

If you continue your coverage at your own expense, the coverage under the Plan will end at the *earliest* of the following:

- The date you or your dependents do not make the required payments within 30 days of the due date,
- The date the Fund no longer provides any group health benefits,
- The date you reinstate your eligibility for coverage under the Plan,
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA, or
- The last day of the month after 18 consecutive months.

For more information about self-payments under USERRA, contact the Fund Office at 708-562-0200.

Family and Medical Leave Act

If eligible, the Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child,
- The care of a seriously ill spouse, parent or child, or
- Your own serious illness.

You are generally eligible for a leave under the ***FMLA*** if you:

- Have worked for a covered employer for at least 12 months,
- Have worked at least 1,250 hours over the previous 12 months, and
- Work at a location where at least 50 employees are employed by your Employer within 75 miles.

During your leave, you will maintain all the coverage offered under the Plan. You will remain eligible until the end of the leave, provided your contributing Employer properly grants the leave under the federal law and your Employer makes the required notification and payment to the Fund. See your Employer to learn if this applies to you.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you or your dependents may continue health care coverage past the date coverage would normally end. Under certain circumstances, by making the required COBRA payments, you or your dependents may continue coverage under COBRA.

The COBRA continuation coverage will be identical to the coverage you had under Plan 3. You will *not* be eligible to continue coverage for Weekly Income or Accidental Dismemberment Benefits.

If you have a new child that meets the Plan's definition of an eligible dependent (for example, if you have a newborn child, adopt a child or have a child placed with you for adoption for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add that child to your coverage. You must give the Fund Office written notice of the birth, adoption or placement of a child with you for adoption in order to have the child added to your coverage.

Children born, adopted or placed for adoption as described above, have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, these children's continued coverage depends on timely and uninterrupted COBRA payments on their behalf.

Qualifying Events

You do not have to show that you are insurable for COBRA continuation coverage. It is offered to you if you or your dependents lose coverage under the Plan as a result of a qualifying event. Qualifying events include:

- Termination of your covered employment (for causes other than gross misconduct),
- Reduction in your hours reported for covered employment,
- Your death,

- Your attainment of Medicare health care coverage entitlement during the first 18 months of COBRA continuation coverage that causes your dependents to lose coverage,
- 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 beneficiary must inform the Fund Office of a legal separation, a divorce or a child losing dependent status under the Plan, within 60 days of the event. If you do not notify the Fund Office within 60 days of such an event, you lose your right to elect COBRA continuation coverage.

Notice. You must notify the Fund Office within 60 days of a:

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

Your Employer may notify the Fund Office of your termination of employment, reduction in hours, death or entitlement to Medicare coverage. However, because Employers contributing to multiemployer funds may not be aware of these events, the Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Fund Office of any qualifying events as soon as they occur.

When the Fund Office is notified that one of these events has occurred, you and your dependents will be notified of your right to elect COBRA continuation coverage. Once you receive a COBRA notice, you have 60 days to respond to the Fund Office if you wish to elect COBRA continuation coverage. Whether or not you elect coverage for yourself, your dependents have the opportunity to elect coverage independently from you.

Paying for COBRA Continuation Coverage

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

The Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The Trustees determine the cost for COBRA continuation coverage each year. It will not exceed 102% of the cost to provide this coverage. If you qualify for extended disability coverage under COBRA, the cost for the 19th through the 29th month is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your *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 you or 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.

Period of Coverage

Coverage Continues for 18 Months: You may elect to purchase COBRA continued coverage for yourself and your dependents for up to 18 months if coverage ends due to your termination of covered employment or your reduction in hours.

Coverage Continues for 29 Months (Extended Disability Coverage): Your coverage or your dependent's coverage may continue for a total of 29 months (an additional 11 months) after your covered employment is terminated or you have a reduction in your hours if you or one of your dependents is totally disabled, as determined by the Social Security Administration. The determination must be made either:

- At the time of your termination from covered employment or reduction in hours, or
- Within the next 60 days after your termination or reduction in hours.

You must notify the Fund Office of your determination of disability by the Social Security Administration before the end of the 18-month period of COBRA coverage.

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

- Death,
- Your attainment of Medicare health care coverage entitlement during the first 18 months of COBRA continuation coverage,
- Legal separation or divorce, or
- Your dependent child no longer meets the definition of child and does not qualify for dependent coverage under the terms of the Plan. See page 8 for the definition of child under the Plan.

When your COBRA continuation coverage ends, you will be provided with a Certificate of Creditable Coverage for your 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 you or your dependents may be cut short for any of the following reasons:

- You or 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 you or 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
- You or your eligible spouse become entitled to Medicare.

Changes in Your 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 in order 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.

Call the Fund Office at:

708-562-0200 to notify them of any change in your family status. You may also want to call the Fund Office for an update of:

- Your beneficiary information, or
- Your address, if you move.

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'll 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. Also, 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.

Getting Married

If you get married, you will need to submit a certified copy of your marriage license to the Fund Office. Common-law spouses are not eligible dependents under the Plan.

If Your Dependent Reaches Age 19 and is a Full-Time Student

If your dependent child reaches age 19 and is a full-time student, he or she may continue coverage under the Plan if you provide the Fund Office with proof of your child's full-time student status. Your child may be covered under the Plan until age 26 if your child maintains

full-time student status and you continue to provide the necessary documentation to the Fund Office. Please contact the Fund Office to obtain a copy of the school certification form.

Your child must receive most of his or her support from you and maintain a permanent residence at your home. See page 8 for the definition of dependent child.

If Your Dependent Loses Eligibility for Coverage

If your dependent loses eligibility for coverage under the Plan by reaching age 19 or by losing status as a full-time student, your child may continue coverage under COBRA. You or your child must notify the Fund Office of the loss of dependent status within 60 days from the date of loss in order to be eligible to elect COBRA continuation coverage. See page 13 for more information about COBRA continuation coverage.

If You Divorce

If you obtain a divorce, you must notify the Fund Office immediately and submit a complete copy of your divorce decree. If your ex-spouse was covered under the 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 page 13 for more information about COBRA continuation coverage.

Qualified Medical Child Support Order (QMCSO)

QMCSOs are official court orders that provide benefits for dependent children in the event of a divorce or other family law action.

The Plan recognizes 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 Plan follows to make this determination is available at the Fund Office.

In the Event of 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 Death Benefit.

If you are eligible for benefits under the Plan at the time of your death, your dependents are eligible for COBRA continuation coverage for a period of up to 36 months. The Plan provides the first 18 months of COBRA continuation coverage free of charge (see page 13). After

that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

In the event of one of your eligible dependent’s death, you should contact the Fund Office to submit a claim for Dependent Death Benefits. If your dependent was covered under the Plan, you will need to submit a certified copy of your dependent's death certificate.

Medical Benefits

Exclusive Provider Organization/Preferred Provider Organization

PPO/EPO – a network of doctors 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 doctor or hospital. It's your decision whether or not to use a network doctor or hospital. You always have the final say about the doctors and hospitals you and your family use.

The Plan offers benefits and care from a network of hospitals that participate in BlueCross BlueShield of Illinois (BCBSIL), a Preferred Provider Organization (PPO). The Plan offers physician benefits through HFN, Inc., an Exclusive Provider Organization (EPO).

In addition, if you live or travel outside of Illinois or Northwest Indiana, you have access to network providers through National Preferred Provider Network (NPPN). See page 2 for more contact information for preferred providers.

When you use a network provider, you save money for yourself and the Plan because network doctors 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 when using a network hospital versus a non-network hospital. Joe is eligible for benefit coverage and has already satisfied the $300 annual deductible. When Joe has additional surgery, his share of the cost is determined as follows:

	*Network Hospital**	*Non-network Hospital*
Expenses Charged for a 2-day Hospital Stay	*$3,200*	*$3,200*
Network Discount	*-$1,500*	*-$ 0*
Adjusted Charges	*$1,700*	*$3,200*
Plan Pays	*$1,530 (90%)*	*$2,560 (80%)*
Joe Pays	*$ 170 (10%)*	*$ 640 (20%)*

Joe saves $470 more by using a BCBSIL network hospital.

** This example assumes a network savings rate of approximately 47%. The actual savings may vary.*

To find a provider in your area, please refer to page 1 for the directory of PPO providers, contact numbers and web addresses.

How the Plan Works

Annual Medical Deductible

The annual deductible is the amount of covered medical expenses that you initially pay each calendar year. You are responsible for the payment of the annual medical deductible. The annual individual deductible is $300. The annual family deductible is $600. The family deductible will be satisfied when the combined deductibles of all family members reach $600 in a calendar year. However, no one family member can apply more than his or her individual deductible to the family deductible.

Any covered expenses that are applied to your individual deductible in the last three months of the calendar year may also be applied to the next calendar year's annual deductible.

Medically Necessary means those services, treatments or supplies ordered by your doctor that are:

- Required to identify or treat an injury or sickness,
- Appropriate and consistent with the symptoms, diagnosis or treatment of the condition, disease, sickness 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.

Coinsurance

If a covered person, during any calendar year in which his/her deductible amount has been satisfied, incurs covered expenses, payable at less than 100%, totaling $7,500 (known as the copayment limit), the percentage payable on covered expenses during the remainder of the year will be 100%.

This means that each calendar year, after you meet your deductible, the Plan pays a percentage (90% for network providers and 80% for non-network providers) of the next $7,500 in covered expenses. After that, the Plan pays 100% of covered expenses, subject to usual and customary rates, for the rest of the year.

Your expenses must be medically necessary to be eligible for coverage.

All charges for your care are subject to usual and customary rates. If you do not use a network provider, the Plan may pay less than the stated percentage reimbursement of covered expenses because the charged amount exceeds usual and customary rates. You are responsible for all charges over usual and customary rates.

Any covered expenses that were incurred during the last three months of the preceding calendar year for which medical benefits were paid at less than 100%, will be counted toward the copayment limit.

Usual and Customary Charge means:

- The charge that is no higher than the 90th percentile of the Plan's most currently available health care charge data, or
- Where there is insufficient data, a value or amount established by the Fund,
- 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, and
- For surgical assistance by a doctor, 20% of the charge allowed for the surgery.

Example: How You and the Plan Cover Your Annual Medical Costs

John and his wife Joan and their daughter Julia are covered by Plan 3. John had medical expenses of $10,000, Joan had medical expenses of $9,600 and Julia's medical expenses reached $8,100. The family deductible of $600 is applied to the family's expenses before the Plan pays a percentage of the family's additional medical expenses. Assuming the family used PPO providers, their expenses for the year would be:

	John's Expenses	***Joan's Expenses***	***Julia's Expenses***	***Family Expenses***
Total Medical Expenses	*$10,000*	*$9,600*	*$8,100*	*$27,700*
Less Deductible	***-$ 300***	***-$ 300***	***-$ 0***	***-$ 600***
Balance	*$9,700*	*$9,300*	*$8,100*	*$27,100*
Plan pays 90% of first $7,500	***-$6,750***	***-$6,750***	***-$6,750***	***-$20,250***
Plan pays 100% of remaining charges over $7,500	***-$2,950***	***-$2,550***	***-$1,350***	***-$6,850***
Balance due	*$ 750*	*$ 750*	*$ 750*	*$2,250*
Member pays (Deductible & Copay)	***$ 1,050***	***$1,050***	***$ 750***	***$2,850***

So, out of a total of $27,700 in medical expenses (after PPO discount), John and his family pay only $2,850.

Lifetime Maximum

All active coverage plans provided for by the Chicago Laborers' Welfare Fund pay up to a lifetime maximum of $875,000 (in aggregate) for covered expenses per individual covered under the Comprehensive Medical Benefit Plan. This means if you incur covered claims expenses as a participant in Plan 3, as a participant of Plan 3, and through COBRA coverage under Plan 3, your total claim expenses for all active coverage are combined so your lifetime maximum cannot exceed $875,000.

Comprehensive Medical Benefits

Your 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 the Schedule of Benefits on page 3.

- ***Acupuncture*** if treatment is by a licensed acupuncturist for the treatment of pain management only.
- ***Alcoholism and substance abuse treatments*** are treated like other medical illnesses, subject to the limitations listed on page 4. An inpatient treatment center must meet the following criteria:
  - Be approved by the Joint Commission on the Accreditation of Hospitals,
  - Have full-time permanent bed care facilities for five or more resident patients,
  - Have the regular services of a doctor,
  - 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.
- ***Anesthetics, oxygen and durable medical equipment (DME)*** up to the amount of their purchase price. Repairs to or replacements for DME are not covered by the plan.
- ***Anesthetists' services.***
- ***Assistant Surgeon*** charges may be covered, subject to medical review of the surgery performed. Please contact the Fund Office for more information.
- ***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 prior to surgery.
- ***Chemotherapy.***
- ***Chiropractic and spinal manipulation*** if treatment is *for back-related care only* up to $2,000 per calendar year. No other payment from any other portion of the Plan will be made.

To find a network provider, contact:

BCBSIL (hospital)
800-571-1043
8:00 a.m. – 5:00 p.m.
Monday – Friday
www.bcbsil.com
Group No.: P15412

HFN (physician)
800-295-5444
8:30 a.m. – 4:30 p.m.
Monday – Friday
www.hfninc.com
Group No.: W 9752

NPPN (national hospital/physician)
800-557-1656
www.nppn.com
Group No.: 6047

Durable Medical Equipment is

- Equipment that can withstand repeated use, and
- Is primarily and customarily used to serve a medical purpose, and
- Generally is not useful to a person in the absence of illness or injury, and
- Is appropriate for use at home.

- ***Contraceptive devices*** such as Norplant implants, Intrauterine Devices (IUDs) and diaphragms, including medical charges associated with the devices up to $400 per calendar year for you and your spouse only.
- ***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 calendar year for participation of you and your family in a diabetes instruction program.
- ***Diagnostic testing*** as ordered by a doctor to determine treatment of a medical or psychological diagnosis. Procedures may include x-rays, blood tests and other laboratory tests.
- ***Dialysis.***
- ***Doctors' services*** may be provided either in or out of a hospital and include surgical procedures and other medical care and treatment.
- ***Durable Medical Equipment (DME),*** see page 23 for definition. Repairs to or replacements of DME are not covered by the Plan.
- ***Erectile dysfunction treatment***, provided the dysfunction is physical, not psychological, in nature.
- ***Home health care*** following your hospital stay, up to a maximum of 60 days per calendar year at a rate of $650 per day. *These expenses are combined with outpatient Skilled Nursing Expenses for a total benefit of 60 days at a maximum of $650 per day.*

  Covered expenses include: care by a nurse (RN or LPN), evaluation and development of a plan of home care by a registered nurse, licensed clinical social worker, physical therapist or occupational therapist and medical supplies, drugs and medications prescribed by your doctor 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 skilled nursing and therapeutic services,
  - Has its policies governing services set by a professional group,
  - Provides for supervision of its services by a doctor or registered nurse,
  - Provides mainly skilled nursing and therapeutic services, and
  - Maintains clerical records of all patients.

Doctor or ***Physician*** means a legally qualified doctor practicing within the scope of his or her license.

Doctor also includes clinical psychologists, licensed clinical social workers, licensed physical and occupational therapists and licensed chiropractors.

When you need to see a Doctor:

- Call to make an appointment.
- Write down any questions that you want to review with your doctor 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.
- File your claim with the Fund Office.

It's a good idea to make and keep a copy of your claim and any supporting materials for your records before you submit it.

- ***Hospice care*** is covered for medical prognosis of six-month or less life expectancy only. A hospice is a health care facility or program that provides medical care and support services, such as counseling, to terminally ill persons and their families.
- ***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, doctors' fees or specialized or private duty nursing fees.

  A ***Hospital*** must:
  - Be approved by the Joint Commission on the Accreditation of Hospitals,
  - Have full-time permanent bed care facilities for five or more resident patients,
  - Have the regular services of a doctor,
  - 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 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.
- ***Infertility treatment*** includes expenses relating to the diagnosis of infertility and attempts to cause pregnancy of you or your eligible spouse *only* up to the limit listed on the Schedule of Benefits. Treatment may include, but is not limited to, blood tests, medications, lab charges, testing, hormone therapy, artificial insemination, invitro fertilization and harvesting of eggs or semen.
- ***Mammography:*** An annual mammogram is covered for employees and spouses.
- ***Mental or nervous disorders*** are treated like other medical illnesses and are subject to the limitations listed on page 3. *Note:*

Family counseling *may* be covered with appropriate diagnosis. An inpatient treatment center must meet the following criteria:

- Be approved by the Joint Commission on the Accreditation of Hospitals,
- Have full-time permanent bed care facilities for five or more resident patients,
- Have the regular services of a doctor,
- 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 place for the aged, and
- Be licensed to operate where it is located.

- ***Midwife*** services are covered for the delivery of a newborn child only. 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.
- ***Nursery care*** for newborn dependents, including doctor's charges for circumcision or medical treatment, if the newborn dependent is covered under the Plan.
- ***Orthotics*** are covered up to one pair per calendar year.
- ***Occupational therapy*** as ordered by prescription by a physician to treat a specific covered condition.
- ***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 doctor'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.

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.

- ***Prosthesis*** is initial artificial limb(s) or eye(s) required to replace natural ones lost while covered under the Plan**.** Repairs and replacements are not covered under the Plan.
- ***Reconstructive breast 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 copayments, deductibles and coinsurance applicable to other physical conditions covered under the Plan.
- ***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 60 days per calendar year at a rate of $650 per day. *Outpatient skilled nursing expenses are combined with Home Health Care expenses* for a total of 60 days per calendar year at a maximum of $650 per day.
- ***Social Worker*** services by a licensed clinical social worker.
- ***Speech therapy*** provided by a licensed speech therapist under the supervision of a physician for treatment of your dependent child from birth up to their fifth birthday. This benefit is provided in conjunction with any state or federally mandated speech therapy programs. There is a $5,000 per dependent lifetime limit for treatment of speech conditions resulting from standard developmental or learning disabilities or personality disorders.

  An additional $5,000 lifetime benefit is available for dependents from age 5 up to their ninth birthday for special diagnoses.

  Special diagnoses are limited to:

  - Vocal nodules,

- Severe articulation disorder with a history of ear infections,
- Child psychosis non-active/conduct disturbances, speech language disorders, autism, and
- Focal dytonia, severe dysarthria, dysphonia secondary to neurologic impairment.

To receive the additional $5,000 in benefits, there must be demonstrable evidence that the dependent has benefited from prior therapy and would benefit from additional therapy.

Speech therapy may also be covered for needs resulting from an injury or accident. You may contact the Fund Office for more information.

- ***Sterilization*** procedures such as tubal ligation, hysterectomy and vasectomy are covered. Reversals of such procedures are not covered by the Plan. Coverage for such procedures are limited to the eligible participant and spouse.
- ***Suicide Attempt.*** Medical expenses relating to a suicide attempt are covered once, up to $10,000.
- ***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.
- ***Transplants.*** The Plan provides organ and tissue transplant benefits to eligible participants. If you need information about organ and tissue transplants, you should contact the Fund Office at 708-562-0200 and ask to speak to the on-site Registered Nurse. She will work directly with you to obtain transplant benefits if you are eligible for them.
- ***Vision correction surgery*** including corrective procedures such as lasik surgery, is covered by the Plan up to one procedure per eye per lifetime.
- ***Wig.*** One after chemotherapy.

Exclusions and Limitations on Payment of Medical Expenses

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

Expenses that are *not* covered as medical expense benefits under the Plan include but are not limited to, the following:

- Any expenses incurred during a period in which you or your dependents are not eligible for benefits under the Plan.
- Any expenses incurred by a dependent who does not meet the Plan's definition of dependent.
- Services or supplies that are not medically necessary or that exceed the usual and customary charge.
- Personal items received while confined to a hospital.
- Services or supplies while you are not under a doctor's care, or you are under the care of a person who does not meet the Plan's definition of doctor or physician.
- Services or supplies that are not recommended or approved by your doctor.
- Services for conditions other than ones specifically identified as being covered under the Plan.
- Any and all dental services.
- All vision services such as eye exams, lenses, contact lenses & frames.
- All vision therapy, such as orthopic therapy.
- 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.
- Nutritional counseling, except diabetes education.
- Colonoscopy and flexible sigmoidoscopy.
- Gastric stapling or gastroplasty or any other surgeries related to weight reduction or obesity.
- Hair removal or hair implants.
- Home health aid.
- Infertility expenses beyond the Plan's specific maximum, medical expenses related to the services of a surrogate mother, harvesting of eggs or semen from a donor other than you or your covered

Exclusions: Not all of your expenses are covered under 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.

spouse, storage of eggs or semen for you, your spouse or a donor and any similar treatments.

- Liposuction.
- All medications, medical supplies or medical equipment that may be purchased over the counter.
- Smoking cessation therapy, devices or medication.
- Baby formula and breast pumps.
- Breast reduction surgery that is cosmetic in nature.
- Expenses of an elective abortion, except:
  - When the mother's life is in danger, or
  - When there are medical complications from an abortion procedure, or
  - When the abortion is spontaneous.
- 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.
- Custodial care - Services or supplies; regardless of where or by whom they are provided, that: 1) a person without medical skills or background could provide or be trained to provide; or 2) 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 or tube or gastronomy, cleaning or preparation of meals, acting as a companion or sitter, or administering or supervising the administration of medication, or as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, sickness, injury or functional ability.
- Developmental care - Services or supplies, regardless of where or by whom they are provided, that are: 1) 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 and independent living or economic self-sufficiency; or 2) not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or sickness); or 3) educational in nature.
- Cosmetic surgery, except when it is performed:
  - To correct injuries that occurred as the result of an accident within two years of the accident, or

- To repair defects that result from a surgery for which the covered individual was paid benefits under the Plan.

- Sex transformation surgery or treatment.
- Investigative, experimental or inappropriate drugs, devices, treatment or procedures. These include services and treatments that are:
  - Not yet officially accepted by the medical community, or
  - Not recognized as having proven beneficial outcomes to the patient, or
  - Not yet approved by the Federal Drug Administration, or
  - Still primarily confined to a research setting, or
  - Are not recommended for an advanced state of an illness or disease.
- Services provided by a government hospital where governmental coverage is primary.
- Physical therapy and occupational therapy are not covered for developmental delays.
- Repairs to or replacement of durable medical equipment.
- Expenses excluded under coordination of benefits clauses.
- Expenses that may result from failure to use an HMO, PPO or EPO provider when covered under another plan that so requires.
- Charges for the reversal of previous elective sterilization.
- Premarital examinations.
- Marriage counseling.
- Chelation therapy.
- Well care and wellness benefits.
- Court mandated counseling or therapy.
- Charges incurred by organ donors that are not related to the transplant procedure or complications that may result from the transplant procedure.

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 service through Caremark Inc. (formerly AdvancePCS), explained on page 2.

To find a network pharmacy, contact:

Caremark Inc.
http://www.caremark.com/
Group No.: T 190

Fund Office 708-562-0200
8:00 a.m. – 5:00 p.m.
Monday - Friday

How the Prescription Drug Program Works

Prescription Drug Card. To receive the negotiated rates with participating Caremark 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 you do not show your ID card when you have your prescription filled at a participating pharmacy, the Plan will only pay 50% of your covered expenses and you will need to submit a claim to the Fund Office for reimbursement. In addition, this amount will not count toward your annual deductible or toward the basic benefit.

Basic Prescription Drug benefit. The Plan covers your eligible prescription drug expenses at 100% up to $5,000 for you and each of your dependents each calendar year. The Plan will cover up to $400 per calendar year of birth control pills for you and your spouse. You may have your prescriptions filled at any participating retail pharmacy. To receive the maximum benefits available from the Plan, you must have your prescription filled at a participating pharmacy and show your ID card.

USE YOUR PRESCRIPTION DRUG ID CARD!

If you do not show your identification card *when your prescription is filled and you do not use a participating pharmacy,* ***you are responsible for 50% of the cost of your prescription medication.*** *This amount does not apply to your annual deductible or toward your basic benefit. So, always be sure you use a participating pharmacy and have your ID card handy to present to your pharmacist when you have a 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 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 travelling or are on vacation, you should contact the Fund Office *before* ordering your refill. The Fund Office will contact the pharmacy so that your prescription refill can occur earlier.

Deductible and coinsurance. Once you have reached $5,000 in prescription drug expenses, you are responsible for an annual deductible of $200 per person per calendar year or $400 per family per calendar year. This deductible is separate and apart from the comprehensive medical program deductible. After you have satisfied your annual deductible, the Plan will cover 80% of any additional prescription drug charges (50% if you do not show your identification card when you have your prescription filled) for the remainder of the calendar year.

It's Smart to Use Generics

You can make your prescription drug benefit go a long way and help save the Fund some money by asking your doctor or pharmacist if there is a generic drug available whenever possible. The Food and Drug Administration tests the most commonly prescribed generic drugs to ensure their quality is high. So, the next time you or someone in your family needs a prescription drug, ask your doctor if there is a less expensive generic drug available.

Example: How the Prescription Drug Program works when you use a Network Pharmacy

John and his wife Joan both need maintenance prescriptions that are covered by the Plan. John's prescription costs $600 per month and Joan's costs $500 per month. In September, when John's prescription costs exceed $5,000, John must pay the next $200 of his prescription drug costs. The Plan then pays 80% of John's prescription drug costs.

Joan's prescription costs will exceed $5,000 after October. In November, Joan must pay $200 toward her prescription drug costs. The Plan then pays 80% of Joan's prescription drug costs.

If another covered member of John and Joan's family have prescription drug expenses that exceed $5,000 in the same year, that family member will not have to pay a deductible because John and Joan have satisfied the family deductible for the year.

The coinsurance percentage shown in this example assumes that John and Joan show their ID card when they have their prescriptions filled at a participating pharmacy.

Covered Prescription Drugs

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. Please contact the Fund Office for more information.
- Immunization agents, blood or blood plasma.
- Levonorgestrel (Norplant).
- Compound medications in which at least one ingredient is a legend drug.
- Legend contraceptives.
- Medications obtained in a foreign country; however, the Plan will reimburse only 50% of the cost of a legend prescription medication that can be prescribed by a physician and obtained in the United States.
- Medications, like Viagra and similar oral medications, for a diagnosis of impotence, limited to ten tablets per month.
- Medications to treat attention deficit disorder and narcolepsy.
- Topical tretinoin, such as Retin-A (restricted to covered individuals age 26 and younger).

Use of generics. You can make your basic $5,000 prescription drug benefit go a long way and help save the Fund some money by asking your doctor or pharmacist for a generic substitute if there is one available. The Food and Drug Administration tests the most commonly prescribed generic drugs to ensure that their quality is high. So the next time you or your family member needs a prescription drug, ask your doctor if there is a less expensive generic drug available.

Exclusions and Limitations on Payment of Prescription Drug Expenses

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

- Anti-wrinkle agents such as Renova.
- Dermatologicals, hair growth stimulants.
- Drugs that are considered experimental or are determined by the Federal Drug Administration as lacking substantial evidence of effectiveness.
- Drugs that require a prescription by state law, but not by federal law.
- Fluoride supplements.

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.

- Infertility medications (however, infertility medications are covered under the infertility medical benefit and are subject to those exclusions and limitations).
- Non-legend drugs except those specifically listed as covered.
- Pigmenting/depigmenting agents.
- Smoking deterrent or cessation drugs (including patches and Nicorette).
- Vitamins/mineral supplements except legend pediatric multi-vitamins with fluoride and pre-natal vitamins.
- Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs.
- 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.
- Medications to promote weight loss or suppress appetite.
- Medications that can be purchased without a prescription.
- Medications or services that are covered under any other portion of the Plan.

In the Event of Your Disability or Death

In the event of your disability or death, the Plan may provide benefits to you or your designated Beneficiary. Your Weekly Income Benefit, Extended Weekly Income Benefit, Death Benefit and Accidental Dismemberment Benefit help provide financial protection to you and/or your family in the event you are injured, become disabled or die. This section describes these benefits.

Weekly Income Benefit (Covered Employees Only)

The Plan provides you with a Weekly Income Benefit, (also called Loss of Time Benefit), if you cannot work in your own occupation due to an injury or sickness, whether it is work-related or not. Your period of disability must be certified by your physician.

You are eligible for the Weekly Income Benefit if you:

- Were covered by the Plan at the time the injury or illness occurs,
- Are under the care of a physician,
- The injury or illness was not self-inflicted, and
- You are not receiving benefits from the Laborers' Pension Fund or the Laborers' International Union of North America (LIUNA) Pension Fund.

Your weekly income benefits will begin when the Fund Office receives proof of your disability. Partial weeks of disability will be paid at a daily rate of one-seventh of the weekly amount (listed below). Benefits are payable for a maximum of 26 weeks according to the following schedule:

If you are unable to work due to:	*Weekly Benefit Amount*
Non-occupational accident/sickness	$200
Occupational accident	$25

Your Weekly Income Benefits generally begin on the first day of your disability that is due to an accident. If your disability is due to sickness, your benefits begin on the eighth day after the first day you are unable to work or the eighth day after your physician first treats you for the sickness.

You are *not* eligible for weekly income benefits if you are continuing coverage under COBRA.

Extension of Benefits in the Event You are Totally Disabled

If you become totally disabled and you remain disabled until you receive these Plan benefits, your benefits may be extended after your coverage ends.

Totally Disabled means that due to a disabling condition that is non-occupational, you are (and continue to be) totally disabled from performing the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement. 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.

Once your coverage under the Plan ends, you will be offered COBRA continuation coverage. (See page 13.) If you elect COBRA, you and your dependents may receive coverage under the Plan. If you do not elect COBRA coverage, you will receive these extended benefits that relate to medical expenses for your disability only. Your dependents will not be covered. If you elect COBRA coverage, you are not entitled to any extension of medical benefits under this Plan provision.

Medical benefits. Eligible medical benefits include:

- Hospital confinement,
- Surgical operations and medical treatments, and
- Medical expenses.

On the day your coverage would normally end, you must be completely unable to perform your job as a result of an injury or sickness that is not related to your work. Your total disability must have occurred while you were covered under the Plan.

The extension of your medical benefits under the Plan is limited to expenses that are incurred as the result of the sickness or injury that caused your disability. They must also be incurred before the earliest of:

- The date you are covered by another plan,
- 12 months from the end of your coverage under the Plan, or
- 3 months after the Plan ends.

Extended Weekly Income Benefit

Under certain circumstances, the Plan allows you to extend the Weekly Income Benefit for up to an additional 26 weeks. You are eligible for this extension if:

- Your disability is due to a non-occupational accident or sickness,
- You were an active covered employee eligible for benefits when the disability began and for at least five years before the disability began, including the six consecutive month period immediately before your disability began, and

- After 26 weeks of disability covered under the Weekly Income Benefit you continue to be totally disabled and unable to perform your normal work as a laborer (or if you are employed in a position other than a laborer, the type of work you normally perform).

You must apply for Extended Weekly Income Benefits at least three months before your Weekly Income Benefits would otherwise end.

If you are eligible, Extended Weekly Income Benefits will begin after you have been totally and continuously disabled for 26 weeks (six months). Benefits will continue as long as you remain disabled, up to a maximum of 52 weeks (26 weeks of Weekly Income Benefits plus an additional 26 weeks of Extended Weekly Income Benefits). The 26 weeks of Extended Weekly Income Benefits is a lifetime maximum.

Example: How Extended Weekly Income Benefits Work

After ten consecutive years of employment covered under the Plan, John becomes disabled due to a non-occupational accident. John is eligible for up to 26 weeks of Weekly Income Benefits. After 26 continuous weeks of disability, John is not able to return to work and is eligible for Extended Weekly Income Benefits for up to 26 additional weeks. After 52 weeks of continuous disability, John is able to return to work.

Unfortunately, two years later, John becomes disabled once again in an unrelated accident. This time, John is still eligible for up to 26 weeks of Weekly Income Benefits. However, since John has already received 26 weeks of Extended Weekly Income Benefits, he is not eligible for any further extension of benefits.

Once you are no longer totally disabled or you reach the maximum number of weeks of disability, weekly benefits will end. If you return to work on a trial basis, the Weekly Income Benefit will be suspended for up to four weeks. If you continue to work for more than four weeks, you will no longer be considered disabled and you will no longer receive Weekly Income Benefits. However, if you present medical evidence that you can not continue to work, the weekly benefit will continue (up to the maximum period).

If your total and continuous disability prevents you from returning to gainful employment, you may be eligible for disability pension benefits from the Laborers' Pension Fund. Once benefits begin under the Pension Fund, Extended Weekly Income Benefits will end as of the first day of the month in which the disability pension benefits begin. However, since disability benefits under the Pension Fund may not begin right away, you must sign an agreement to reimburse the

Plan in the event benefits are later paid retroactively by the Laborers' Pension Fund. The amount of the reimbursement is based on the amount of benefits paid by the Pension Fund. If the Pension Fund disability benefits are less than the Weekly Income Benefit amount, you will only need to reimburse the amount you are paid by the Pension Fund.

Death Benefit

In the event of your death, your beneficiary will receive a death benefit in the amount of $20,000. A death benefit of $5,000 is payable to you if your dependent dies as the result of an accident or illness. In addition, there is a death benefit of $200 payable to you in the event of the death of a dependent infant less than 6 months old.

If you do not name a beneficiary, or your beneficiary is deceased, your death benefit will be paid:

- To your spouse, if living,
- If your spouse is not living, then to your children in equal shares,
- If your spouse or children are not living, then to your parents in equal shares, or to the survivor of your parents if only one is living,
- If no spouse, children or parents are living, no death benefit will be paid.

The named beneficiary may direct the Welfare Fund to assign benefits up to $5,000 to the person who assumes responsibilities for funeral expenses or to the funeral home directly.

Exclusions and Limitations on Payment of Death Benefit

The Plan does not cover losses that:

- Result from injuries you receive while you are operating or riding in any aircraft (except when you are a passenger on a regular commercial flight).
- Result from self-inflicted injuries or sickness, suicide or a suicide attempt.
- Occur while you are committing a felony or taking part in a riot.
- Result from an act of war.
- Occur while you are on active duty or training in the armed forces, National Guard or reserves of any state or country.

Extension of Death Benefits in the Event of Your Total Disability

If you become Totally Disabled due to a non-occupational injury, you can receive up to a three-year extension on the Plan's Death Benefit, which is payable to your beneficiary in the event of your death, at no cost to you or your family. The extension does not include Death Benefits for your dependents. To qualify for the extension:

- You must be eligible for benefits under the Plan through hours worked in covered employment at the time your disability begins;
- Your disability must begin before you reach age 60; and
- You must provide proof of the disability to the Fund Office.

You must notify the Fund Office of your disability no later than 12 months form the initial date of your disability. The Fund Office will provide you with a *Statement of Claim for Total and Permanent Disability* form and an *Estimated Functional Capacities* form to be completed by you and your physician. If you are collecting a Weekly Income Benefit (Loss of Time Benefit) as a result of this disability, the Fund Office will send you the forms following 26 weekly Loss of Time Benefit payments. In addition to the completed forms, you must supply the pertinent medical records supporting your disability.

In determining Total Disability, the Plan has a right to require an examination by a physician designated by the Plan, Fund Office or Administrator.

If the Fund Office determines that you are Totally Disabled in accordance with the Plan's definition of Total Disability, your Death Benefit will be extended for three years, beginning on the date you lose coverage under the Plan due to a reduction in hours required to maintain coverage, see page 6. (Election of COBRA continuation coverage will not delay the three-year extension of Death Benefits.) To continue the extension of coverage, you must provide the Fund Office with proof of your continued disability once a year. The Fund Office will notify you when the information is due. This coverage will end the earliest of:

- The date you are no longer Totally Disabled; or
- Three consecutive years following the date you lost coverage under the Plan.

In the event of your death before you request an extension of the Death Benefit, or before the Fund Office receives your completed forms, benefits are still payable provided:

- You were eligible for benefits under the Plan through hours worked in covered employment at the time of your disability,
- Your injury was not work- related,
- Your death was within 12 months form the day your coverage under the Plan ended, and
- The Fund Office receives proof that your Total Disability was uninterrupted from the date your coverage under the Plan ended until the date of your death.

Accidental Dismemberment Benefit

The Accidental Dismemberment Benefit is available to you if you or any of your eligible dependents suffers the loss of limbs or eyesight due to an accident. For the Accidental Dismemberment program, your eligible dependents are your spouse and any children age 6 months or older. Your dependents must meet the Plan's definition of dependents as outlined on page 8.

Type of Loss	*Your Benefit*	*Your Dependent's Benefit*
Loss of one hand, one foot or sight in one eye	$5,500	$1,875
Loss of one hand and one foot, one hand and sight in one eye or one foot and sight in one eye	$11,000	$3,750
Loss of both hands, both feet or the sight in both eyes	$11,000	$3,750

Exclusions and Limitations on Payment of Accidental Dismemberment Benefit

The Plan does not cover losses that:

- Are not permanent.
- Occur more than 90 days after the injury.
- Result from injuries you receive while you are operating or riding in any aircraft (except when you are a passenger on a regular commercial flight).
- Result from self-inflicted injuries or sickness, suicide or a suicide attempt.
- Occur while you are committing a felony or taking part in a riot.
- Result from an act of war.
- Occur while you are on active duty or training in the armed forces, National Guard or reserves or any state or country.

Claims and Appeals 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 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 may 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 you an annual claim form each year or more often as required to process your claims.

An Annual Claim Form is required by the Fund Office each year to update general information on you, your dependents and other insurance coverage you may have. In addition, you may be asked to complete a separate **Accident Claim Form** if your injury or illness is a result of an accident (i.e. automobile accident).

Filing A Claim for Benefits

A claim may be submitted in paper form or through Electronic Data Interchange (EDI). Your provider may submit a claim for benefits for you when benefits are assigned to the provider. If your provider does not submit your medical claims directly to the Fund Office, you will need to submit them for reimbursement. Be sure that each bill indicates the name of the patient, the name of the participant and participant's social security number or other 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 specific services performed and the expense charged for each service.

Submit claims to:

Chicago Laborers' Welfare Fund
11465 W. Cermak Rd.
Westchester, IL 60154

You are responsible for any amounts not paid by the Fund, with the exception of network discounts or discounts that may be negotiated between the Plan and the Provider on non-network claims.

See the Claim for Benefits section (on page 43) for specific details on what is considered a claim by the Fund Office.

Types of Claims Covered by the Plan

- Group health plan claims, including medical, and prescription drug benefits,
- Disability claims, including Weekly Income and Extended Weekly Income Benefits, and

- Benefits other than health plan claims, including death and accidental dismemberment benefits.

Pre-Certification of Benefits

The Plan does not require pre-certification for any type of medical treatment. The Trustees, Administrator and Plan Employers encourage members and their dependents covered under the Plan to seek medical care when necessary.

However, if you are not sure whether a particular treatment or service will be covered, or if you want to know how much may be covered, you may contact the Fund Office in advance of such non-urgent care.

Claims for Benefits

Claims for benefits covered by the Plan include request for benefits accompanied by the following:

- HCFA, hospital bill, prescription receipt, or provider bill or other type of invoice that includes:
  1. Patient name and patient ID,
  2. Participant name and participant ID,
  3. Participant's social security number or other identification number assigned by the Fund Office,
  4. Date of service (or date of fill or refill for prescription drug claims),
  5. Type of device defined by HCPC, CPT code, ICD-9, NDC or other nationally recognized codes, including individual charges for each,
  6. Attending physician's or care provider's name and identification number (not required for prescription drug claims),
  7. Place of service,
  8. Billing address,
  9. Total charges, and
  10. Previous balances paid.
- Copy of Death Certificate with completed form for death benefit.
- Loss of Time/Accident Claim Form completed by you, your employer and your physician.

What is a Claim?

A "claim for benefits" is a request for a plan benefit made by a claimant according to the plans' procedures for filing benefit claims. The claim may be submitted in paper form or through Electronic Data Interchange (EDI). A provider may submit a claim for benefits 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 an appeal on behalf of the patient. In addition, a participant can file a claim or appeal for any 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 representative on behalf of the claimant may present a Power of Attorney for Health Care. If a claimant designates a representative, all correspondence regarding appeals will be sent directly to the representative unless specified otherwise.

What is NOT a Claim for Benefits

If the Plan receives a document or transmission that contains items 1 through 6 as stated in "Claim for Benefits," 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 time to make a benefit determination.

Any general inquiry about benefits or the circumstances under which benefits might be paid under the terms of the Plan is not a claim for benefits. Also, any document or EDI transmission that is submitted to the Fund Office that does not meet the criteria of "claim for benefits" as defined above, is not considered a claim for benefits and is not covered by the Plan's claims and appeals procedures (see page 47). Examples include:

- A cash register receipt,
- An Explanation of Benefits (EOB) from another plan for a participant in the Plan,
- Balance due statement,
- An inquiry from a participant, physician, care provider, other insurance carrier, participant's authorized representative, hospital or facility regarding:
  - Coverage under the Plan (for example, a question about whether or not your Plan covers diagnostic testing).
  - Benefit amounts payable under the Plan (for example, a question as to whether or not your Plan would pay 100% of surgery costs if the surgery was tomorrow).
- Eligibility under the Plan (for example, if you are scheduled for physical therapy at a facility twice a week and your doctor calls to ask if you are eligible for benefits), or
- A request by a physician, hospital, facility or other care provider to the Fund to consider additional payment on a claim.

Any of the above offered in paper form, verbal inquiry or EDI transmission is not considered a claim for benefits. 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, or
- In writing at Chicago Laborers' Welfare Fund, 11465 W. Cermak Road, Westchester, IL 60154, or
- By e-mail at claims@chilpwf.com.

Claims Filing Procedures

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

You must file your claim within 12 months of the date the service was provided. If you do not file your claim within a year, your claims for benefits will be denied.

Deadlines for Processing Benefit Claims

New claims and appeals procedures were adopted and effective on August 1, 2002. The deadlines for processing benefit claims vary and are described in the following information.

- ***Initial Determination.*** An initial determination regarding payment or denial of a claim will be made:
  - *For medical or prescription drug claims,* within 30 days of receipt of the claim,
  - *For disability claims,* within 45 days of receipt of the claim, or
  - *For death or accidental dismemberment benefit claims,* within 90 days of receipt of the claim.
- ***Extension of Initial Determination Period.*** In some instances, an extension of this initial determination period may be requested due to matters beyond the control of the Plan. 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.
  - *For medical or prescription drug claims,* you will be notified within the 30-day initial determination period that one 15-day extension is necessary.
  - *For disability claims,* you will be notified within the 45-day initial determination period that up to an additional 60 days maximum is necessary. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.
  - *For death or accidental dismemberment benefit claims,* the claimant will be notified within the 90-day initial determination period that up to an additional 90 days may be necessary. The extension can not 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 will be notified.

- *For medical or prescription drug claims*, the Fund Office will notify you and, in certain circumstances, your provider within the 30-day initial determination period and specify the information required. You (or your provider) have an additional 45 days to respond. 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.
- *For disability claims*, the Fund Office will notify you within the 45-day initial determination period and specify the information required. You have an additional 45 days to respond.
- *For death or accidental dismemberment benefit claims*, the Fund Office will notify the claimant within the 90-day initial determination period and specify the information required. The 90-day extension of initial determination period listed above includes any time needed by the Plan to obtain such information.

Denial of Claim

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,
- A 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.

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial determination reviewed. Your appeal must be filed in writing within 180 days (60 days in the event of death or accidental dismemberment claims) after the date you receive your letter or explanation of benefits denying your claim.

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.

Appeal of Claim

You will have the right to appeal the denial of your claim 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 of the
Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, IL 60154

When filing an appeal (requesting a review of a denied claim), remember the following:

- Your appeal must be submitted in writing within the applicable timeframe.
- You appeal must state the reasons you disagree with the denial of benefits.
- 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 for benefits 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 procedure.

In addition, when filing an appeal, 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,
- 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 the claims processing requirements.

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 such information. In addition, 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.

Review of Appeal

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 your 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 claim appeal. The Committee currently meets on the first Tuesday of every month.

A determination on your appeal will be made within 30 days of receipt of the appeal. However, for a death or accidental dismemberment benefit claim, an extension of this appeal determination period may be requested. If an extension is necessary, you will be notified within the 60-day appeal determination period that up to an additional 60 days (no more than 120 days total) may be necessary.

Generally, for Weekly Income and Extended Weekly Income Benefits claims, a decision will be made within 45 days of submission of your written appeal and the Plan will notify you within five days after the decision is made. If special circumstances require an extension of time, a decision will be made no later than 90 days after the date the Plan receives your request for review.

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.

After the Claims Committee receives your request, a written decision will be mailed to you at your last known address no later than:

- *For medical or prescription drug claims*, 60 days after your appeal is received,

- *For disability claims*, 45 days after your appeal is received, or
- *For death or accidental dismemberment benefit claims*, 60 days (or 120 days if an extension is necessary) after your appeal is received.

If your claim is not paid in full, the written decision will include:

- The specific reasons for the decision,
- References to the Plan provisions on which the decision is based,
- A statement notifying you:
  - That you have the right to request a free copy of all documents, records and relevant information, and
  - That you may bring a civil action suit under ERISA.

Your 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 the purpose of reviewing your medical claim appeal.

However, the Plan is not required to automatically supply this information. The names of medical or vocational experts will only be disclosed upon receipt of a written request for this specific information.

Discretionary Authority

The Trustees have full discretionary authority to:

- Determine your 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.

Benefits under this Plan 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 Plan.

Coordination of Benefits

The Plan has been designed to help you meet the cost of medical, and prescription drug care. It is not intended, however, that you receive

greater benefits than your actual healthcare 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 your covered expenses will be paid by the combination of plans.

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

- Its regular benefits in full, or
- A reduced amount that if you add the reduced amount to the amount you receive 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 for benefits.

"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 an act of government, including Medicare.

But "another plan" does not mean:

- An accidental injury plan provided through a school,
- A hospital indemnity plan,
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), or
- An individual plan, except one that provides no-fault automobile insurance, or one 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 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.

Order of Payment

Generally, a plan that does not have a coordination of benefits rule or a plan that covers you as an employee pays first.

If you are covered or your dependent is 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 benefit payment so that the 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 plan that covers an individual as an employee is primary.

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, the plan of the parent with custody is primary, or
  - If there is no court decree and the parent with custody is remarried, benefits are coordinated in the following order: the plan of the custodial parent, the plan of the custodial stepparent, the plan of the non-custodial parent.

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

Coordination of Benefits with Medicare

Medicare is a three-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers physician's services, although it, too, covers a number of other items and services. Part C of Medicare is called Medicare+Choice and covers Medicare HMO offerings. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.

Medicare means 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.

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 (ERD). If you are eligible for Medicare based solely on permanent kidney failure (ERD), Medicare coverage will not start until the fourth month of dialysis. Therefore, the Plan is generally your only coverage for the first three months of dialysis. When you obtain Medicare because of ERD, there is a period of time when the Plan is 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 ERD, even if you have not enrolled in Medicare yet.

The Plan is primary while you are actively working, even if you are over age 65. The Plan is secondary when you are not actively working.

Enroll in Medicare when you are eligible for coverage. For all purposes of this provision, if you or your dependents are entitled to benefits or other compensation under Medicare, the Plan will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

Any benefits payable to you or your dependents under any portion of the Plan 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 Plan for the same injury or sickness, regardless of whether or not you have received or made application for such benefits or compensation.

Subrogation

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

The Plan may provide benefits for an injury, sickness or death that is caused by a third party. In that case, the Fund may make a claim or take legal action against the third party to recover benefits on your behalf. For example, if you were injured in an automobile accident caused by someone else, the Fund may take legal action against the person who caused the accident to recover the expenses the Plan paid for your medical treatment.

The **Subrogation and Reimbursement Agreement** must be witnessed and signed by a Notary Public.

If information on a claim for benefits indicates that medical services were rendered and expenses incurred as a result of injuries due to an accident, you will be required to complete an Accident Claim Form. When the completed form is received, the Fund's Subrogation Coordinator will review the form and the claims submitted. If it is determined that any injury, sickness or death was caused by a third party, each claimant (you and/or your dependents) must complete a Statement of Injured Party form and a Subrogation and Reimbursement Agreement.

By signing the Subrogation and Reimbursement Agreement, you accept benefits from the Plan on account of such an injury, sickness or death, and, you or your dependents automatically give the Fund the right to make a claim against the liable third party to the extent of the amount of the benefits you received from the Plan. You must protect the Fund's right to reimbursement for the benefits it pays on your behalf, and assist and cooperate with the Fund's representatives as they pursue such a claim.

If you do not bring an action against the liable third party, the Fund may do so in your name or your dependent's name, and the Fund may recover its costs and expenses of that action from any settlement or recovery received as a result of that action. The Fund has the right to its share of funds you receive in your action, no matter how they are awarded to you by the court or by settlement.

If you bring an action and receive a settlement or recovery, but you do not reimburse the Fund according to the subrogation provision, then the Fund may bring an action against you to recover the expenses it paid under the Plan and/or suspend future benefits.

The Fund will pay your benefits if you cannot recover from a liable third party.

This subrogation provision does not apply if the claim is for a death or dismemberment benefit.

Administrative Information about the Plan

Fund Name

This Fund is called the "Health & Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity," and is commonly referred to as the "Chicago Laborers' Welfare Fund."

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

Plan 3, the Plan, this Plan or benefit plan means a plan of benefits described in this booklet and any other written documents that the Plan Trustees designate to be part of the plan of benefits under the terms of the Trust Agreement.

Summary Plan Description

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

Plan Sponsor and Fund Administrator

A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the "Fund Administrator," they have delegated certain administrative responsibilities to the 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 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.

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
Phone: 708-562-0200

Board of Trustees

The Trustees of Plan 3 are:

Union Trustees	***Employer Trustees***
James P. Connolly	Charles Gallagher
Randy Dalton	David Lorig
Martin Flanagan	Dennis P. Martin
Liberato Naimoli	Tim J. Scully
Scott Pavlis	Roger T. Vignocchi
Frank Riley	Sam Vinci

Rules about Plan Interpretation and Continuation

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

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

The Trustees intend to continue the Plan indefinitely for your benefit and the benefit of all the Plan participants. However, the Trustees have been given the power to amend or terminate the Plan, as they deem necessary. The Plan 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.

Benefits under the Plan 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 Plan.

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 Plan on behalf of the Board or to act as agents of the Board of Trustees with respect to interpretation of the Plan. You may only rely on information regarding the Plan 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.

Parties to the Collective Bargaining Agreement

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 Plan.

Collective Bargaining Agreement means the negotiated labor agreement between the Union and your Employer that requires contributions to the Fund.

Identification Numbers

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

Source of Contributions

Employer 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 Associations but that enter into an individual collective bargaining agreement with the Union.

Eligible Contributing Employers

The Board of Trustees, in establishing this alternate plan of benefits, Plan 3, expressly intend that the alternate plan shall only cover those employees who perform work in the jurisdiction of the Chicago Laborers' District Council, or under a Reciprocal Agreement, and who work for employers who are not engaged in the construction industry.

Amount of Contributions

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.

Trust Fund

The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. 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 Plan are kept on a Plan year basis beginning each June 1 and ending the following May 31.

The ***plan year*** is June 1 through the following May 31.

Purpose

The Plan is an employee welfare benefits plan maintained to provide comprehensive medical, prescription drug, disability and death benefits for you and your dependents who meet the eligibility requirements described in this booklet.

Your coverage by the Plan does not constitute a guarantee of your continued employment.

Your coverage by the Plan is *not* a guarantee of continuing employment.

Inspection of the Plan

If you wish to inspect or receive copies of additional documents relating to the Plan, contact the Administrator at the address or telephone number listed below. You will be charged a reasonable fee to cover the cost of copying any document you request.

Agent for Service of Legal Process

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

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

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

Your Rights Under ERISA

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

Receive Information about Your 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 Plan. 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 (ESBA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. 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 Plan when:
  - You lose coverage under the Plan,
  - 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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the 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 (ESBA), U.S. Department of Labor, listed in your telephone directory or:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration. For single copies of publications, contact the Employee Benefits Security Administration Brochure Request Line at 1-800-998-7542 or contact the ESBA field office nearest you.

You may also find answers to your Plan questions or a list of (ESBA) field offices at the website of the (ESBA) at http://www.dol.gov/dol/esba/

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