Chicago Laborers' Welfare Fund

Summary Plan Description For
Retiree Medical Plan 3
And
Retiree Basic Medical Coverage Plan

Effective February 1, 2005

Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, Illinois 60154
Telephone: 708-562-0200
Fax: 708-562-0716
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Chicago, Illinois 60603

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The Segal Company
101 North Wacker Drive, Suite 500
Chicago, Illinois 60606

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

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

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

Chicago Laborers' Welfare Fund
11465 W. Cermak Road
Westchester, Illinois 60154
Telephone: 708-562-0200
Fax: 708-562-0716

To All Retiree Plan Participants:

We are pleased to provide you with this Summary Plan Description booklet describing your health and welfare benefits for eligible retirees in effect as of February 1, 2005.

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 are married, share the information with your spouse and let your spouse know where you file this booklet.

If you have questions about the information in this booklet or about the Retiree Plans, 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 these Retiree Plans. If you have difficulty understanding any part of this booklet, contact the Welfare Department of the Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154. Office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday. 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 Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154. Las horas de oficina son de 8:00 a.m. a 5:00 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 Welfare Department del Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154, USA. L'orario d'ufficio è dalle 8.00 alle 17.00, 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 Welfare Department, Laborers' Welfare Plan, 11465 W. Cermak Road, Westchester, Illinois 60154. Biuro czynne codziennie od poniedziałku do piątku od 8:00 do 5:00. Pomoc można uzyskać telefonicznie pod numerem 708-562-0200.

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Introduction

The retiree plans of benefits under the Chicago Laborers' Welfare Fund (referred to in this booklet as the "Retiree Plans") are the Chicago Laborers' Retiree Medical Plan 3 (the "Retiree Medical Plan 3") and the Chicago Laborers' Retiree Basic Medical Coverage Plan (the "Retiree Basic Medical Coverage Plan"). The Retiree Plans offer medical, prescription drug (not available under the Retiree Basic Medical Coverage Plan) and death benefits. If you elect to continue coverage under the Chicago Laborers' Active Plan 3 (the "Active Plan 3"), through COBRA continuation coverage (see below), those benefits are described in a separate booklet.

Your Choice

When you retire from active employment in your trade, you may continue coverage under the Active Plan 3 until you are no longer eligible. You may then choose coverage for yourself and your dependents under any of the three options that are offered by the Chicago Laborers' Welfare Fund, as outlined in this booklet, provided you meet the eligibility requirements described on page 4.

Retiree death benefits are also available under the Retiree Plans; however, you must meet certain requirements for these benefits (see page 34).

Benefits under the Retiree Plans do not include Weekly Income or Accidental Dismemberment Benefits.

Retiree Medical Plan 3

The Chicago Laborers' Retiree Medical Plan 3 is available to eligible retirees age 50 and over and, in addition to the benefits described above, includes comprehensive medical coverage and prescription drug benefits.

It's your choice at retirement:

- Pay for comprehensive medical coverage under the Retiree Medical Plan 3, including prescription drug benefits,
- Receive free limited medical coverage under the Retiree Basic Medical Coverage Plan, or
- Elect COBRA continuation coverage under the Active Plan 3.

If you are eligible for this coverage and you elect the Retiree Medical Plan 3, you must pay a monthly premium for your benefits. If you choose this coverage, you will not be allowed to change to COBRA continuation coverage under the Active Plan 3 until you return to work in covered employment and reestablish your eligibility for benefits under the Active Plan 3. ***Coverage under the Retiree Medical Plan 3 will only be offered to you once*** – when you first apply for pension benefits. If you elect not to enroll in this coverage at that time or discontinue coverage at any time, you may not enroll or attempt to reenroll in the Retiree Medical Plan 3 at a later date.

Participants receiving a pension from the Laborers' International Union of North America Industrial Pension Fund (the "LIUNA Industrial Pension Fund") must contact the Chicago Laborers' Claim Department for information regarding retiree coverage.

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

If you meet the eligibility requirements when you retire, you and your dependents will receive, at no cost to you from age 50 to 65, a limited level of medical coverage. Also, you may be eligible for the retiree death benefit (see page 34).

The benefits under the Retiree Basic Medical Coverage Plan are available at no cost to you if you are between age 50 and 65 when you retire, and if you meet the eligibility requirements on page 4 and:

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

- You do not enroll in the Retiree Medical Plan 3,
- You enroll in the Retiree Medical Plan 3, but stop making payments for the coverage, or
- You discontinue coverage under the Retiree Medical Plan 3 for you and/or your dependents for any reason.

If you discontinue coverage or fail to make the required premium payments under the Retiree Medical Plan 3, you then will be covered under the Retiree Basic Medical Coverage Plan (if you are eligible) and you will not be eligible to resume participation in the Retiree Medical Plan 3.

Active Plan 3 COBRA Continuation Coverage

You may choose to elect COBRA continuation coverage when your eligibility for coverage under the Active Plan 3 ends. You will be notified of your COBRA continuation rights when your eligibility under the Active Plan 3 ends. In the event of divorce, death or your dependent losing dependent status under the Active Plan 3, you or your dependents must notify the Fund Office within 60 days of the qualifying event to be eligible for continued coverage through COBRA.

If you elect COBRA continuation coverage under the Active Plan 3, you will not be allowed to change to the Retiree Medical Plan 3 or Retiree Basic Medical Coverage Plan before or after your COBRA continuation coverage terminates. You should review the Summary Plan Description for Active Plan 3 employees or contact the Fund Office for details about COBRA continuation coverage under the Active Plan 3.

Network Providers

Medical Care. The Retiree Plans offers you inpatient and outpatient hospital medical coverage through BlueCross BlueShield of Illinois (BCBSIL), a Preferred Provider Organization (PPO). The Retiree Plans 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 Retiree Plans have contracted with National Preferred Provider Network (NPPN), to provide you and the Retiree Plans 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

Caremark www.caremark.com
Group No.: T190

Fund Office
708-562-0200
Toll Free: 866-906-0200
8:00a.m. - 5:00p.m.
Monday - Friday

Prescription Drugs (Only available under the Retiree Medical Plan 3). The Retiree Medical Plan 3 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. Under the Retiree Medical Plan 3, the Plan will pay 80% of the cost of your eligible prescription drug expenses if you use a participating Caremark pharmacy. If you do not use your identification card when you fill your prescription or do not use a Caremark pharmacy, you will be responsible for 50% of the cost of the prescription medication. In addition, this coinsurance amount does not apply to your $10,000 out-of-pocket maximum.

Questions About Your Benefits

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 Claim Department who speaks Spanish.

Eligibility

No duplicate coverage. You cannot be eligible for active and retiree benefits at the same time.

Once you decide to retire from covered employment, you should contact the Claim Department at the Fund Office. Depending on your age and prior work history, you may be eligible to elect coverage under the Retiree Medical Plan 3 or the Retiree Basic Medical Coverage Plan. If you qualify for the Retiree Medical Plan 3 but fail to enroll, decline coverage or terminate coverage, you will be covered under the Retiree Basic Medical Coverage Plan if you are eligible. ***Retiree medical coverage options will be offered to you only once*** at the time you contact the Fund Office and if you meet the criteria listed below.

Retiree Eligibility

You are eligible for retiree coverage under the Retiree Plans if you:

- Are at least age fifty (50), and
- Are receiving benefits from the Chicago Laborers' Pension Fund (the "Pension Fund") or from LIUNA Industrial Pension Fund, and
- Have at least fifteen (15) years of participation in the Chicago Laborers' Welfare Fund; and
  - A year of participation is defined as having at least 800 hours reported to the Chicago Laborers' Welfare Fund for each of fifteen (15) fiscal years. A fiscal year begins June 1 and ends May 31.
- Have at least 500 hours reported to the Chicago Laborers' Welfare Fund at least three (3) years of the last five (5) fiscal years immediately preceding your pension retirement effective date.

If you are retired on a Disability Pension from the Pension Fund or from the LIUNA Industrial Pension Fund before age 50 but you meet all of the other eligibility requirements outlined above, you are eligible for retiree coverage under the Retiree Medical Plan 3. However, you are not eligible for coverage under the Retiree Basic Medical Coverage Plan if you are not age 50 or older when you become eligible for a Disability Pension.

If you die after age 50 and before your retirement date, your surviving spouse may elect coverage under the Retiree Medical Plan 3 or Retiree Basic Medical Coverage Plan if:

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

Retiree Medical Plan 3 Eligibility

If you are eligible for retiree coverage, you will receive coverage under the Retiree Medical Plan 3 if you:

- Elect coverage under the Retiree Medical Plan 3, and
- Have the required monthly premiums deducted from your pension check from the Pension Fund, or
- Make the required monthly payments for such coverage if you are receiving a pension from the LIUNA Industrial Pension Fund.

When you are eligible for Medicare (due to attainment of age 65 or disability), you may continue your retiree coverage under the Retiree Medical Plan 3 as long as:

- The Retiree Medical Plan 3 has not been terminated or amended to exclude coverage for Medicare eligible participants, and
- You are receiving a pension from the Chicago Laborers' Pension Plan or the LIUNA Industrial Pension Fund, and
- You continue to deduct or pay the required monthly premium payments, and
- You enroll in Medicare Part B and supply proof of this coverage to the Fund Office.

Your benefits under the Retiree Medical Plan 3 will be coordinated with Medicare when you are eligible for Medicare.

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

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

- Are not yet age 65 when you retire from covered employment, and satisfy one of the following:
    - Fail to elect or decline coverage under the Retiree Medical Plan 3, or
    - Elect to terminate your Retiree Medical Plan 3 coverage, or
    - Do not make the required monthly premium payments for Retiree Medical Plan 3 coverage.

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

- On or after age 65, or
- Before age 50 on a Disability Pension.

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

Returning to Covered Employment After Retirement

If you return to covered employment after you retire, your coverage under the Retiree Medical Plan 3 or the Retiree Basic Medical Coverage Plan will end on the day you return to covered employment. You will not be eligible for COBRA continuation coverage under the Retiree Medical Plans. You will regain eligibility on the first day of the month following the completion of the required number of hours.

If you retire and return to covered employment three times, you will no longer be eligible to obtain coverage under the Retiree Medical Plan 3 or the Retiree Basic Medical Coverage Plan. Your only option to continue your medical coverage when your eligibility runs out will be to elect COBRA continuation coverage under the Active Plan 3.

Refer to the insert which accompanies this Summary Plan Description that describes the most current eligibility requirements for retirees who return to covered employment.

Dependent Eligibility

Your eligible dependents are covered when you are covered. The effective date of your pension will determine who qualifies as your dependent for coverage under the Retiree Plans. You may not add dependents once you begin coverage under the Retiree Plans. If your spouse no longer qualifies because of death or divorce, you may not add a new spouse.

In the event of your death while covered under the:

- ***Retiree Medical Plan 3***, your surviving spouse and dependents may continue coverage if they meet the Plan's definition of a dependent and the required monthly premium payments for coverage are made, or
- ***Retiree Basic Medical Coverage Plan,*** coverage for your spouse and dependents end upon your death.

Once your eligible dependents become entitled to Medicare, benefit payments from the Retiree Medical Plan 3 are coordinated with Medicare. See page 42 regarding Coordination of Benefits with Medicare.

Dependents. If your spouse and children are your dependents when you are first covered under the Retiree Plans, they can be covered under the Retiree Plans. You cannot add dependents once your retiree coverage begins.

You may be required to submit documentation (such as a marriage license, affidavits, tax returns, etc.) to the Fund Office as proof of your dependent's eligibility. Contact the Eligibility Department of the Fund Office for more information.

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

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

Dependent Defined

A person is your dependent if, on the date you become covered under the Retiree Plans, that person is:

- 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 support and maintain a permanent residence in your home.

Under the Retiree Plans your child is defined as:

- 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 ordered to support the child, and,
  - The natural parent has not been 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 signed a voluntary acknowledgement of paternity, if the child lives with you in the same household in a parent-child relationship,
- 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 within two months before coverage would otherwise end.

The term child **does not** include:

- A child who is not an eligible dependent on the date you retire, or
- 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, or
- A child who is in full-time armed forces service, or
- A child who is not otherwise defined as your child, except for a child who is the subject of a paternity order that calls for health insurance coverage, limited as follows:
  - If the child is the subject of a paternity order that calls for medical coverage, there will be no pre-existing conditions coverage before the date of the paternity order,
  - If the paternity order is entered because of knowledge of the child's sickness, all coverage will be excluded under the Retiree Plans, and
  - If the paternity order is entered into by consent or without contest, the Retiree Plans are entitled to and may require verification of paternity through a blood test or other scientifically recognized and commonly used examination to determine paternity. The Retiree Plans may exclude all coverage based on the results of such a test.

When Your Eligibility Ends

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

- When you enter the armed forces, or
- When you die, or
- When the Retiree Plan in which you are participating ends, or
- When you no longer meet the eligibility requirements, or
- When you lose the right to participate in the Retiree Plans after you have returned to covered employment three times after you initially retired (see page 6).

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

- ***Retiree Medical Plan 3*** when you terminate coverage or the required monthly premium payment for coverage is not made, or
- ***Retiree Basic Medical Coverage Plan*** when you reach age 65.

When Your Dependents' Eligibility Ends

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

- When your dependent no longer meets the Retiree Plans' definition of an eligible dependent (for example due to divorce or a child reaching age 19 or age 26 if a full-time student),
- When the Retiree Plan in which you are participating ends, or
- When your dependent enters the Armed Forces.

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

- ***Retiree Medical Plan 3*** when you terminate coverage or the required monthly premium payment for coverage is not made, or
- ***Retiree Basic Medical Coverage Plan*** when you die or your dependent is eligible for Medicare.

Certificate of Creditable Coverage

When your coverage under either Retiree Plan ends, the Fund will provide you and/or your covered dependents with a Certificate of Creditable Coverage (the "Certificate"). The Certificate indicates the period of time you and they were covered under the Retiree 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 your Plan 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 Retiree Plan ended or the date COBRA continuation coverage or USERRA coverage ended.

USERRA is the federal law that permits a participant in one of the Retiree Plans, who enters the uniformed services, to regain their eligibility if they return to covered employment shortly after their release from service.

Changes in Eligibility Rules

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

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

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 benefits 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 obtain information on how to change:

- Your beneficiary information,
- Your address, if you move, or
- Your dependents, in the case of birth, death or divorce.

Notify the Fund Office

You can help avoid delays in payment of benefits, by notifying the Fund Office of any change in your family status, such as when a dependent has other coverage or is no longer eligible for coverage.

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

If your dependent child reaches age 19, you must provide proof of full-time student status for your child to maintain coverage under the Retiree Plans. Your child may continue coverage until age 26, provided that he or she remains a full-time student and you provide the necessary documentation as requested by the Fund Office. Please contact the Fund Office to obtain a school certificate.

Your child must receive most of his or her support from you and maintain a permanent residence at your home. See page 7 for the definition of dependent child.

If Your Dependent Loses Eligibility for Coverage

If your dependent loses eligibility for coverage by reaching age 19 (or age 26 if a full-time student) or by losing status as a full-time student, your child's coverage under the Retiree Plans will end. However, your dependent may be entitled to COBRA continuation coverage. Contact the Fund Office for more information.

If You Divorce

If you obtain a divorce, you must notify the Fund Office immediately, but no later than 60 days from the date of the divorce and submit a complete copy of your divorce decree. In the event of a divorce, your ex-spouse's coverage under the Retiree Plan will end on the date of the divorce. However, your ex-spouse may be entitled to COBRA continuation coverage. Contact the Eligibility Department at the Fund Office for more information.

Qualified Medical Child Support Order (QMCSO)

The Retiree Plans recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs must be submitted to the Fund Office who will determine whether the order is qualified as a QMCSO under federal law. A copy of the procedures that the Retiree Plans follow to make this determination is available at the Fund Office. Remember that eligible dependent children under the Retiree Plans only include children that were eligible as dependents when you first became covered under the Retiree Plans.

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

In the Event of Your Death

If you die, your surviving spouse or dependents should contact the Fund Office. The Fund Office will assist them in determining whether they are eligible to receive the retiree death benefit.

If you were covered under the Retiree Medical Plan 3, your surviving dependents may elect to continue coverage under the Retiree Medical Plan 3. Your surviving dependents must make the required monthly premium payments for coverage. If you were covered under the Retiree Basic Medical Coverage Plan, your dependents' coverage will end on the date of your death.

In the Event of Military Service

Health care coverage 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, it will stop 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 Retiree Plans,
- 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 monthly premiums under USERRA, contact the Fund Office at 708-562-0200.

Retiree Medical Plan 3

When you retire you may choose to enroll in the Retiree Medical Plan 3 if you meet the eligibility requirements and you make your monthly premium payments. Medical coverage under the Retiree Medical Plan 3 includes prescription drug coverage. Your coverage begins on the first day of the month ***following*** the month your coverage under the Active Plan 3 ends. Your coverage under the Active Plan 3 may continue beyond your date of retirement until your eligibility runs out. After that you may elect coverage under the Retiree Medical Plan 3, Retiree Basic Medical Coverage Plan or COBRA continuation coverage under Active Plan 3.

Monthly Premium Payments

You must make monthly payments for coverage under the Retiree Medical Plan 3. The payment amount is automatically deducted from your monthly pension check from the Pension Fund. If you are receiving pension benefits from the LIUNA Industrial Pension Fund and you are eligible to participate in the Retiree Medical Plan 3, you must make payments directly to the Chicago Laborers' Welfare Fund Office.

Once you are eligible for retiree coverage under the Retiree Medical Plan 3, you will be notified of the current monthly premium rate for coverage. The amount of your monthly premiums is based on:

- Your years of service earned under the Chicago Laborers' Welfare Fund (see page 4 regarding eligibility), and
- Whether or not you elect dependent coverage (you may elect coverage for yourself only or for yourself and your dependents, which may include your spouse, spouse and children or children only).

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

Coverage for Your Survivors

In the event of your death, your surviving spouse and dependents may continue Retiree Medical Plan 3 coverage by making monthly premium payments. Your dependents must contact the Fund Office to obtain information regarding continuing medical coverage and the amount of required monthly premium payments for that coverage

How the Retiree Medical Plan 3 Works

Once you meet your deductible of $450 per person per calendar year, the Retiree Medical Plan 3 pays a percentage of covered expenses (known as "coinsurance"). After the amounts you pay for coinsurance reach your out-of-pocket maximum of $10,000 during a calendar

year, the Plan pays 100% of eligible covered medical expenses for the remainder of that calendar year up to the lifetime maximum.

Annual Medical Deductible

The annual medical deductible is the amount of covered medical expenses that you pay before the Plan begins paying medical benefits. The amount of the annual deductible is $450 per person each calendar year.

Annual Medical Deductible:
$450 per person per calendar year

Emergency Room Deductible:
$50 per visit

Prescription Drug Deductible:
$100 per person per calendar year
(see page 23)

Emergency Room Deductible

In addition to your annual deductible, you must pay a $50 deductible each time you or your dependent uses the emergency room for your medical care and treatment.

To find a network provider:

Refer to the listing on page 3,

or call
Fund Office 708-562-0200
Toll free: 866-906-0200
8:00 a.m. – 5:00 p.m.
Monday – Friday

Annual Prescription Drug Deductible

The annual prescription drug deductible is the amount of covered medical expenses that you pay before the Retiree Medical Plan 3 begins paying prescription drug benefits. The amount of the annual deductible is $100 per person each calendar year.

Coinsurance

Each year, once you (or your dependent) have satisfied your annual medical deductible of $450 per person, and/or your Emergency Room deductible of $50 per visit, the Retiree Medical Plan 3 pays a percentage of covered expenses and you pay the rest, up to the annual out-of-pocket maximum. This is known as coinsurance.

The Retiree Medical Plan 3 offers benefits and care from a network of hospitals that participate in BlueCross BlueShield of Illinois (BCBSIL), a Preferred Provider Organization (PPO). The Retiree Medical Plan 3 offers physician benefits through HFN, Inc., an Exclusive Provider Organization (EPO).

EPO/PPO – 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 Retiree Medical Plan 3 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.

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 3 for more contact information for preferred providers.

Once you meet your annual medical deductible, the Retiree Medical Plan 3 pays:

- 80% of covered expenses when you use a network provider, or
- 50% of covered expenses when you use a non-network provider.

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

When you use a network provider, you save money for yourself and the Retiree Medical Plan 3 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 for his hospitalization when using a network hospital versus a non-network hospital. Joe is eligible for benefit coverage and when Joe has surgery, his share of the costs is determined as follows, assuming Joe has not met his annual medical deductible:

	*Network Hospital**	*Non-Network Hospital*
Expenses Charged for a 2-day Hospital Stay	*$3,200*	*$3,200*
Network Discount	*- $600*	*- $0*
Adjusted Charges	*$2,600*	*$3,200*
Joe's Annual Deductible	*- $450*	*- $450*
Balance of Charge	*$2,150*	*$2,750*
Plan Pays	*$1,720 (80%)*	*$1,375 (50%)*
Joe Pays	*$430 (20%)*	*$1,375 (50%)*
Joe's Total Out-of-Pocket Costs	*$880*	*$1,825*

Joe saves $945.00 by using a network hospital.

* *This example assumes a network savings rate of approximately 20%. The actual savings may vary.*

Retiree Medical Plan 3 benefits are in addition to the Retiree Basic Medical Coverage Plan benefits. This example of out-of-pocket expenses assumes Joe exhausted his limits under the Retiree Basic Medical Plan.

Usual and Customary Charge means:

- The charge that is no higher than the 90th percentile of the Retiree Plans' 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% of the U&C amount, no higher than the 90th percentile, for the primary procedure and for the secondary procedures, an amount determined after medical review,
- For surgical assistance by a doctor, 20% of the charge allowed for the surgery, and
- For EPO/PPO providers, usual and customary charges are amounts that do not exceed the negotiated fee.

If You are Eligible for Medicare

If you or your eligible dependents are eligible for Medicare, the Retiree Medical Plan 3 coordinates benefits under this Plan with your Medicare benefits. You must enroll in Medicare as soon as you are eligible. In addition, you must enroll in Medicare Part B and provide the Fund Office with proof of your eligibility.

The Retiree Medical Plan 3 pays covered expenses after Medicare pays benefits. Covered expenses include your Medicare Part A and B deductibles and copayments.

Coordination with Medicare. If you are eligible for Medicare, your benefits will be coordinated with Medicare.

Enroll in Medicare as soon as you are eligible. When you are eligible, the Retiree Medical Plan 3 treats you as if you were enrolled in Medicare Part B, so you should enroll in Part B or Part C to keep your expenses down.

Example: How the Retiree Medical Plan 3 Coordinates With Medicare

Pete incurs $1,100 in covered expenses from his doctor. Under the Retiree Medical Plan 3, since Pete is eligible for Medicare, Medicare will pay first and then the Retiree Medical Plan 3 will pay. However, the maximum amount the Retiree Medical Plan 3 will pay is calculated without considering what Medicare will pay. The following shows what Medicare, the Retiree Medical Plan 3 and Pete will pay. This example assumes Pete uses a network provider and has not satisfied his annual medical deductible.

What Medicare Will Pay	
Covered expenses	*$2,100*
Medicare deductible	*- $100*
Remaining covered expenses	*$2,000*
Medicare copayment	*x 75%*
Medicare pays	*$1,500*
Maximum Retiree Medical Plan 3 Will Pay	
Covered expenses	*$2,100*
Pete's Retiree Medical Plan 3 deductible amount	*-$450*
Remaining covered expenses	*$1,650*
Retiree Medical Plan 3 copayment	*x 80%*
Maximum Retiree Medical Plan 3 will pay	*$1,320*
What Pete Will Pay	
Covered expenses	*$2,100*
Medicare pays	*- 1.500*
Remaining amount not paid by Medicare	*$600*
Pete's Retiree Medical Plan 3 deductible amount	*-$450*
Remaining amount	*$150*
Amount Retiree Medical Plan 3 pays	*$150*

In this example, Pete pays the Retiree Medical Plan 3 deductible of $450.00.

Out-of-Pocket Maximum

Once the amount you pay toward covered medical expenses reaches your annual out-of-pocket maximum of $10,000 for the calendar year, the Retiree Medical Plan 3 pays 100% of eligible covered medical expenses for the remainder of that year up to the lifetime maximum.

Lifetime Maximum

The Retiree Medical Plan 3 pays up to a lifetime maximum of $500,000 per person in covered expenses.

Key Features of the Retiree Medical Plan 3

The following chart outlines the benefits payable under the Retiree Medical Plan 3 (the "Plan"). Benefits are paid on a calendar year basis. *All eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service.* Contact the Fund Office for the most current usual and customary rates in effect at the time of service.

Benefit	Amount Payable by the Retiree Medical Plan 3
Annual Medical Deductible	$450 per person per calendar year
Annual Prescription Drug Deductible	$100 per person per calendar year
Emergency Room Deductible	$50 per visit in addition to annual deductible
Coinsurance PPO Network Provider Non-Network Provider	After you pay your deductible, the Plan pays: 80% of eligible expenses 50% of eligible expenses[1]
Annual Out-of-Pocket Maximum	Once you pay $10,000 per person per calendar year the Plan pays 100% of additional expenses up to your lifetime maximum
Lifetime Maximum	$500,000 per person
Alcoholism and Substance Abuse[2] PPO Network Provider Non-Network Provider Inpatient Lifetime Maximum Outpatient Lifetime Maximum	 80% of eligible expenses 50% of eligible expenses Up to $300 per person per day $12,000 Up to $150 per person per visit $11,000
Chiropractic Care Annual Maximum	30 visits per person per calendar year
Hearing Aids[2]	$1,500 maximum benefit every three years
Mental or Nervous Disorders Annual Maximum Inpatient Outpatient	 Up to 30 days per calendar year Up to 50 visits per calendar year
Transplant Benefit	Contact Fund Office to determine coverage
Prescription Drug Benefits[3] Deductible Caremark Network Pharmacy Non-Network Pharmacy	 $100.00 per person per calendar year Plan pays 80% after your deductible Plan pays 50%, (your 50% coinsurance does not apply toward your out-of-pocket maximum)

[1] *Eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service. Contact the Fund Office for the most current U&C rates.*

[2] *Not subject to the Plan's annual deductible and coinsurance provisions.*

[3] *Prescription drug benefits are provided through Caremark and are subject to the Plan's annual deductible. When you have your prescription filled at a Caremark participating network pharmacy you will receive your prescription at discounted prices.*

Retiree Medical Plan 3 Covered Expenses

The Retiree Medical Plan 3 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 Key Features of the Retiree Medical Plan 3 chart on page 16.

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.

- ***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 16. The deductible and coinsurance provisions do not apply to these expenses. 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.

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.

- ***Ambulance service*** as deemed medically necessary and not for patient convenience**.**
- ***Anesthetics, oxygen and durable medical equipment*** up to the amount of their purchase price. Repairs to or replacements for DME are not covered by the Retiree Medical Plan 3.
- ***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 30 visits per calendar year. No other payment from any other portion of the Retiree Medical Plan 3 will be made.
- ***Cosmetic surgery*** that is necessary to repair damage caused by an accident if performed within two years of an accident.
- ***Diabetes education***.
- ***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.***
- ***Durable Medical Equipment (DME),*** see page 17 for definition. Repairs to or replacements of DME are not covered by the Retiree Medical Plan 3.
- ***Doctors' services*** may be provided either in or out of a hospital and include surgical procedures and other medical care and treatment.
- ***Erectile dysfunction treatment***, provided the dysfunction is physical, not psychological, in nature.
- ***Hearing aids*** are covered up to $1,500 over a three-year period. The deductible and coinsurance provisions do not apply to these expenses.
- ***Home health care*** following your hospital stay. These 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

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, licensed clinical professional counselors 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.

- Maintains clerical records of all patients.

- ***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.
- ***Mammography*** benefits include an annual mammogram for you or your spouse only.
- ***Mental or nervous disorders*** are treated like other medical illnesses and are subject to the limitations listed on page 16. *Note:* These expenses **are** applied to the calendar **coinsurance** expenses, unlike substance abuse benefits. 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.
- ***Naprapath*** services are covered only if given by a licensed naprapath.

- ***Orthotics*** are covered up to one pair per calendar year.
- ***Physical therapy*** as ordered by prescription by a physician to treat a specific condition.
- ***Pre-admission tests*** for hospital confinement, including x-rays, laboratory examinations, tests or analyses.
- ***Pregnancy*** expenses, for you or your spouse only, are covered the same as any other medical condition. The Retiree Medical Plan 3 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. However, health care providers are not required to obtain authorization from the Retiree Medical Plan 3 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.
- ***Prostheses,*** initial artificial limbs or eyes required to replace natural ones lost while covered under the Retiree Medical Plan 3. Repairs or replacements are not covered.
- ***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 Retiree Medical Plan 3 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 Retiree Medical Plan 3.
- ***Second surgical opinion*** includes services and supplies necessary to obtain the opinion.
- ***Skilled Nursing Facility*** services are covered based on medical necessity.
- ***Social Worker services*** by a licensed clinical social worker.
- ***Sterilization procedures*** such as tubal ligation, hysterectomy and vasectomy are covered. Reversals of such procedures are not covered.
- ***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

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. The nurse will work directly with you to obtain transplant benefits if you are eligible for them.

to eligible participants.

- ***Vision correction surgery***, including corrective procedures such as lasik surgery, is covered by the Retiree Medical Plan 3 up to one procedure per eye per lifetime.
- ***Wig*** in association with chemotherapy.

Exclusions and Limitations on Payment of Retiree Medical Plan 3 Expenses

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

Expenses that are *not* covered as medical expense benefits under the Retiree Medical Plan 3 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 Retiree Medical Plan 3.
- Any expenses incurred by a dependent who does not meet the Retiree Medical Plan 3'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 Retiree Medical Plan 3'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 Retiree Medical Plan 3.
- Any and all dental services.
- All vision services such as eye exams, lenses, contact lenses and frames.
- 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 their medical consultants.
- Nutritional counseling.
- Gastric stapling or gastroplasty or any other surgeries related to weight reduction or obesity.
- Hair removal or hair implants.
- Home health aid.
- Infertility expenses, including, but not limited to:

Exclusions. Not all of your medical expenses are covered by the Retiree Medical Plan 3. Read these items carefully to see what is excluded from or limited in coverage.

In rare instances, an item excluded under the Retiree Medical Plan 3 may be covered for a specific diagnosis. If you have any questions regarding coverage, please contact the Fund Office.

  - Expenses relating to the diagnosis of infertility and attempts to cause pregnancy, such as artificial insemination or in vitro fertilization,
  - Any medical expenses related to the services of a surrogate mother or harvesting of or storage of eggs or semen, and
  - Any other related treatment such as blood tests, medications, lab charges, testing and hormone therapy.
- Liposuction.
- Routine health examinations (i.e. physical examinations).
- 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,
  - 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 covered by the Retiree Medical Plan 3 and for which the Retiree Medical Plan 3 paid benefits.
- Sex transformation surgery or treatment.
- Investigative, experimental or inappropriate drugs, devices, treatments or procedures. These include services and treatments that are:
  - Not yet officially accepted by the medical community,
  - Not recognized as having proven beneficial outcomes to the patient,
  - Not yet approved by the Federal Drug Administration,
  - 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.
- Repairs to or replacement of prostheses, artificial limbs or eyes.
- Expenses excluded under coordination of benefits clauses.
- Expenses that result from you, your spouse's, or your dependent's failure to use his or her HMO, PPO or EPO provider.
- Charges for the reversal of previous elective sterilization.
- Premarital examinations.
- Speech therapy, except in the case of illness, accident or injury.
- Chelation therapy.
- Marriage counseling.
- 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.

Retiree Medical Plan 3 Prescription Drug Benefits

The Chicago Laborers' Welfare Fund has an agreement with Caremark Inc. to provide prescription drug coverage at a substantial savings to Retiree Medical Plan 3 participants. To receive the discounts on your eligible prescription drug expenses, you must purchase your prescription drugs at a participating Caremark pharmacy, and ***you must show your prescription drug identification card to the pharmacist.*** There are more than 50,000 pharmacies participating in the Caremark network, including almost all of the major pharmacy chains.

To find a network pharmacy, contact:

Caremark
www.caremark.com
Group No.: T 190

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

After you meet the $100 annual prescription drug benefit deductible, prescription drug expenses are treated like other medical expenses under the Retiree Medical Plan 3. The Retiree Medical Plan 3 pays 80% of your prescription drug cost if you use a participating Caremark pharmacy. You may have your prescriptions filled at any participating retail pharmacy. To receive the maximum benefits available from the Retiree Medical Plan 3, you must have your prescription filled at a participating pharmacy and show your ID card.

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 network pharmacy, the Retiree Medical Plan 3 will only pay 50% of your covered expenses. Any additional payments for which you are responsible when you do not use a participating pharmacy or do not show your ID card does not apply toward your annual deductible or out-of-pocket maximum of $10,000 per person per year.

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 out-of-pocket maximum. So, always be sure you use a participating pharmacy and have your identification card handy to present to your pharmacist when you have a prescription filled.

Prescription Drug Card

To receive the negotiated rates with participating Caremark network pharmacies and to have your prescription drug expenses apply to your annual deductible, you must show your prescription drug ID card at the time you fill your prescription.

When you pick up your prescription, you must pay for your medication in full at the pharmacy. To receive reimbursement from the Retiree Medical Plan 3, 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

Contact the Fund Office if you need to have a prescription refilled early.

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.

It's Smart to Use Generics

You can make your prescription drug benefit go a long way and help save the Retiree Medical Plan 3 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: John takes a maintenance medication. John's prescription costs $200 per month. In February, John meets his $100 Retiree Medical Plan 3 prescription drug deductible for the year. The Retiree Medical Plan 3 will then pay 80% of John's prescription drug costs for the remainder of the year – that's $160 a month for his maintenance medication ($200 prescription cost minus $40 for the 20% coinsurance paid by John).

If another covered member of John's family has prescription drug expenses, that family member must also meet the $100 per person prescription drug deductible before the Retiree Medical Plan 3 pays 80% of the prescription costs.

Covered Prescription Drugs

The Retiree Medical Plan 3 covers the following:

- Legend drugs that are not listed as exclusions.
- Insulin.
- Disposable insulin needles/syringes.
- Immunization agents, blood or blood plasma.
- Compound medications in which at least one ingredient is a legend drug.
- Medications obtained in a foreign country; however the Retiree Medical Plan 3 will reimburse 50% 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 10 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).

Exclusions and Limitations on Payment of Prescription Drug Expenses

Charges for the following drugs and medications are not covered by the Retiree Medical Plan 3:

In rare instances, an item excluded under the Retiree Medical Plan 3 may be payable for a specific diagnosis. If you have questions regarding coverage, contact the Fund Office.

- 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.
- Infertility medications.
- Non-legend drugs except those specifically listed as covered.

- Pigmenting/depigmenting agents.
- Smoking deterrent or cessation drugs (including patches and nicorette).
- Vitamins and 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 Retiree Medical Plan 3.
- Levonorgestrel (Norplant).
- Legend contraceptives.

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

Important. Prescription drugs are *not* included in the Retiree Basic Medical Coverage Plan.

You may choose not to enroll and pay the monthly premiums for more comprehensive coverage under the Retiree Medical Plan 3. If so, and if you are an eligible retiree between the ages of 50 and 65, you and your eligible dependents will receive a limited level of coverage from the Retiree Basic Medical Coverage Plan (Basic Plan) at no cost to you. You will also receive a death benefit if you retired before June 1, 2002 as described in this booklet. Please note that prescription drug coverage is not included in the Retiree Basic Medical Coverage Plan.

Key Features of the Retiree Basic Medical Coverage Plan

The following chart outlines the benefits payable under the Retiree Basic Medical Coverage Plan. Benefits are paid on a calendar year basis. *All eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service.* Contact the Fund Office for the most current usual and customary rates in effect at the time of service.

Benefit	Amount Payable by the Retiree Basic Medical Coverage Plan
Outpatient doctor office visits (retiree only)	$10 per visit (maximum 50 visits per year)
Outpatient medical services (hospital services and supplies received as outpatient, therapeutic treatments, laboratory tests and x-rays)	$3,200 per person per year
Hospitalizations	Covered up to 120 days per incident
Room and Board	$200 per day
Intensive Care	U&C Semi-private room
Hospital services	$3,000
Doctor visits (retiree only)	$10 per visit, up to 1 visit per day
Surgery	$750
Alcoholism and Substance Abuse[1]	
PPO Network Provider	80% of eligible expenses
Non-Network Provider	50% of eligible expenses
Inpatient	Up to $300 per person per day
Lifetime Maximum	$12,000
Outpatient	Up to $150 per person per visit
Lifetime Maximum	$11,000
Emergency Room Treatment:	After a $50 deductible per incident, the Retiree Basic Medical Coverage Plan pays:
For Accident	Up to $3,000 per person per year in combination with hospital services
For Illness	Up to $3,200 per person per year in combination with outpatient medical services
Ambulance	$50 per trip up to a maximum of 2 trips per incident

Additional Accident Benefit (for medical services needed as a result of an accident, you must be treated within 90 days of the accident)	$300 per person per incident
Mental or Nervous Disorders[2]	
PPO Network Provider	80% of eligible expenses covered
Non-Network Provider	50% of eligible expenses covered
Inpatient	Up to 30 days per calendar year
Outpatient	Up to 50 visits per calendar year
Hearing Aid Benefit	No benefits are payable.
Prescription Drug Benefits	No benefits are payable.

[1] *Eligible expenses are covered at the usual and customary (U&C) rates in effect at the time of service.*

[2] *Outpatient mental or nervous disorder treatment is considered a doctor's visit and is paid after the $10 per visit copayment.*

Retiree Basic Medical Coverage Plan Covered Expenses

The Retiree Basic Medical Coverage Plan covers the actual usual and customary charges for the medically necessary services and supplies that are listed below. Limitations on the number of treatments and the dollar amount for the treatment are contained in the Key Features of the Retiree Basic Medical Coverage Plan chart on page 27.

- ***Alcoholism and substance abuse treatments*** are treated like other medical illnesses, subject to the limitations listed on page 27. The deductible and coinsurance provisions do not apply to these expenses. 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.

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.

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.

- ***Ambulance service*** as deemed medically necessary and not for patient convenience**.**
- ***Anesthetics.***
- ***Anesthetists' services.***
- ***Chemotherapy.***
- ***Diabetes education.***
- ***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*** (retiree only) may be provided either in or out of a hospital and include surgical procedures and other medical care and treatment.
- ***Hospital room and board and charges for services and supplies*** include:
  - Charges for a semi-private room with general nursing services,
  - Charges for a private room if medically necessary (such as for contagious or communicable diseases),
  - Intensive care units,
  - Nursery charges for newborns,
  - Emergency room treatment, and
  - Charges made by the hospital for services and supplies for care received while an inpatient or outpatient. They do not include room and board, 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.
- ***Mammography*** benefits include an annual mammogram for you or your spouse only.
- ***Mental or nervous disorders*** are treated like other medical illnesses and are subject to the limitations listed on page 28. Family counseling *may* be covered with appropriate diagnosis. An inpatient treatment center must meet the following criteria:

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.

- 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.

- ***Pre-admission tests*** for hospital confinement, including x-rays, laboratory examinations, tests or analyses.

- ***Pregnancy*** expenses, for you or your spouse only, are covered the same as any other medical condition. The Retiree Basic Medical Coverage 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. However, health care providers are not required to obtain authorization from the Retiree Basic Medical Coverage 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.

- ***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 Retiree Basic Medical Coverage 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 Retiree Basic Medical Coverage Plan.

- ***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.

Exclusions and Limitations on Payment of Retiree Basic Medical Coverage Plan

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

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

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

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

- Any expenses incurred during a period in which you or your dependents are not eligible for benefits under the Retiree Basic Medical Coverage Plan.
- Any expenses incurred by a dependent who does not meet the Retiree Basic Medical Coverage 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 Retiree Basic Medical Coverage 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 and frames.
- 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 their medical consultants.
- Nutritional counseling.
- Gastric stapling, gastroplasty or any other surgeries related to weight reduction or obesity.
- Hair removal or hair implants.
- Home health aid.
- Infertility expenses, including, but not limited to:
  - Expenses relating to the diagnosis of infertility and attempts to cause pregnancy, such as artificial insemination or in vitro fertilization,
  - Any medical expenses related to the services of a surrogate mother or harvesting of or storage of eggs or semen, and

- Any other related treatment such as blood tests, medications, lab charges, testing and hormone therapy.

- Liposuction.
- Routine health examinations (i.e. physical examinations).
- 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,
  - 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.
- Developmental care.
- 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 covered by the Plan and for which the Plan paid benefits.
- 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,
  - Not recognized as having proven beneficial outcomes to the patient,
  - Not yet approved by the Federal Drug Administration,
  - 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.
- Expenses excluded under coordination of benefits clauses.
- Expenses that result from you, your spouse's, or your dependent's failure to use his or her HMO, PPO or EPO provider.
- Charges for the reversal of previous elective sterilization.

- Premarital examinations.
- Speech therapy.
- Chelation therapy.
- Marriage counseling.
- Court mandated counseling or therapy.
- Organ transplants including all charges incurred by organ donors, charges related to a transplant or charges resulting from complications due to a transplant procedure. (Participants covered under the Retiree Medical Plan 3, receiving an organ, qualify for a maximum coverage amount of $750. See "Surgery" benefit on page 27.)
- Oxygen and durable medical equipment.
- Repairs to durable medical equipment.
- Assistant Surgeon charges.
- Acupuncture, chiropractic, naprapath and spinal manipulation for dependents and amounts in excess of $10 per visit for such procedures for retired employees.
- Cosmetic surgery.
- Erectile dysfunction treatment.
- Hearing aids.
- Home health care.
- Hospice care.
- Orthotics.
- Physical therapy for dependents and amounts in excess of $10 per visit for physical therapy for retired employees.
- Prostheses, including artificial limbs or eyes.
- Repairs to prostheses, including artificial limbs or eyes.
- Second surgical opinions.
- Skilled Nursing Facility services.
- Social Worker services.
- Sterilization procedures in excess of $750 when covered under the Plan’s surgical benefits.
- Transplants in excess of $750 when covered under the Plan's surgical benefits.
- Vision correction surgery in excess of $750 when covered under the Plan's surgical benefits.
- Wig.
- Prescription drugs.

Retiree Death Benefit

If you retired before June 1, 2002, the Retiree Plans provide a retiree death benefit of $2,500 payable to your spouse or other named beneficiary when you die. If you are eligible for coverage under the Retiree Plans due to your Total and Permanent Disability, you are not eligible for the retiree death benefit. If you are covered under the Active Plan 3 for active employees at the time of your death, you are not eligible for the retiree death benefit.

If you retire on or after June 1, 2002, the Retiree Plans provide a retiree death benefit of $5,000, payable to your spouse or other named beneficiary when you die. To qualify for this benefit:

You are not eligible for a retiree death benefit if you retire on or after June 1, 2002 and you do not meet the eligibility requirements for coverage under the Retiree Medical Plan 3 (whether or not you elect this Plan).

- You must retire on or after June 1, 2002, and
- You must meet the requirements for coverage under the Retiree Medical Plan 3 (see page 4,); although you do not need to elect coverage under this Retiree Medical Plan 3.

If you do not name a beneficiary, 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 Retiree Plans to assign benefits up to $2,500 to the person who assumes responsibilities for funeral expenses or to the funeral home directly.

Exclusions and Limitations on Payment of Death Benefit

The Retiree Plans do 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.

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 additional 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.

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).

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.

Filing a Claim for Benefits

Submit claims to:

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

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 you authorize your provider to receive payment from the Fund directly. 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.

You must pay any amounts not paid by the Fund, with the exception of PPO network discounts or discounts that may be negotiated between the Retiree Plans and the provider on non-network claims.

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

Explanation of Benefits, and any procedures for appealing a claim denial directly to you. If the Fund should deny the claim, only you will have the right to appeal.

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

See the Claim for Benefits section (on page 37) for specific details on what is considered a claim by the Fund Office.

Types of Claims Covered by the Retiree Medical Plan 3

- Group health plan claims, including medical and prescription drug benefits, and
- Benefits other than health plan claims, including death benefits.

Types of Claims Covered by the Retiree Basic Medical Coverage Plan

- Group health plan claims, including medical, and
- Benefits other than health plan claims, including death benefits.

Pre-Certification of Benefits

The Retiree Plans do not require pre-certification for any type of medical treatment. The Trustees, Administrator and Plan Employers encourage participants and their dependents covered under the Retiree Plans 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.

What is a Claim?

A "claim for benefits" is a request for a plan benefit made by a claimant according to the Retiree 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 but such provider is not considered a claimant for purposes of appealing an adverse benefit determination.

Claims for Benefits

Claims for benefits covered by the Retiree Plans include request for benefits accompanied by the following:

- HCFA, hospital bill, prescription receipt or other provider bill or other type of invoice that includes:
  1. Patient name and patient ID,
  2. Member name and member ID,
  3. Member'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 service 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.

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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

Any general inquiry about benefits or the circumstances under which benefits might be paid under the terms of the Retiree Plans 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 Retiree Plans' claims and appeals procedures (see page 40). Examples include:

- A cash register receipt,
- An Explanation of Benefits (EOB) from another plan for a participant in one of these Retiree Plans.
- Balance due statement,
- An inquiry from a participant, physician, care provider, other insurance carrier, participant's authorized representative, hospital or facility regarding:
  - Coverage under one of the Retiree Plans (for example, a question about whether or not your Plan covers diagnostic testing),

If either Retiree Plan receives a document or transmission that contains items 1 through 6 as stated in "Claims 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.

- Benefit amounts payable under one of the Retiree Plans (for example, a question as to whether or not your Plan would pay 100% of surgery costs if the surgery was tomorrow), or

- Eligibility under one of the Retiree Plans (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, dentist, other provider, 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 toll-free 866-906-0200,
- 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, as issued by the Department of Labor, were adopted and are effective on and after 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, or
  - *For death 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 Retiree Plans. If an extension is necessary, you will be notified. The notice will include the special circumstances requiring the extension and the date the Retiree Plans expect 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 death 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 Retiree Plans 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 death 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 Retiree Plans to obtain such information.

Denial of 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.

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 Retiree 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 Retiree Plans' 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. Within 180 days after you receive notice of a claim denial (60 days for death benefit claims), or if you are otherwise dissatisfied with a determination under the Plan, you may file a written appeal.

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 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.

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 Retiree 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 Claim 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 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.

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, or
- *For death 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 Retiree 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 Retiree Plans are 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 Retiree Plans are 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 Retiree Plans,
- Interpret the Retiree Plans, and
- Interpret all of the documents, rules, procedures and terms of the Retiree Plans.

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

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

Coordination of Benefits

The Retiree Plans have 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 Retiree Plans will take into account any coverage you or a covered dependent has under other plans. Benefits under the Retiree Plans 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 Retiree Plans 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 Retiree Plans 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 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

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.

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

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 will be primary.

Coordination of Benefits with Medicare

If you or your eligible dependents are eligible for Medicare, the Retiree Medical Plan 3 or Retiree Basic Medical Coverage Plan, as applicable coordinates benefits with your Medicare benefits. You must enroll in Medicare as soon as you are eligible. In addition, you must enroll in Medicare Part B and provide the Fund Office with proof of your eligibility.

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.

Medicare generally pays your claims first when benefits are coordinated with the Retiree Medical Plan 3 or Retiree Basic Medical Coverage Plan.

Covered expenses include your Medicare Part A and B deductibles and copayments. The Retiree Plans pays covered expenses after Medicare pays benefits.

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 Retiree Plans will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.

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 Retiree 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 Retiree 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.

You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B of Medicare.

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

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 Retiree Plans will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating.

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

Subrogation

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

The Retiree Plans 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. 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 Retiree 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 it 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. If you (or your dependents) retain an attorney with respect to a claim against a third party, the attorney must also sign the Subrogation and Reimbursement Agreement.

By signing the Subrogation and Reimbursement Agreement, you accept benefits from the Retiree Plan on account of such an injury, sickness or death. However, 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 Retiree 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 your Plan or the Fund may offset future benefits you may be entitled to receive from the Retiree Plans.

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

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

Administrative Information about the Retiree Plans

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

Summary Plan Description

This booklet provides you with summaries of two Plans of retiree benefits. 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 these Retiree Plans. 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 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 Employers 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 numbers below:

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

Board of Trustees

The Trustees of the Retiree Plans are:

Union Trustees	***Employer Trustees***
James P. Connolly	Charles Gallagher
Randy Dalton	David H. 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 Retiree Plans' rules and procedures,
- Decide all questions about the Retiree Plans, including questions about your eligibility for benefits and the amount of benefits payable to you,
- Determine the facts of any claim you make for Retiree Plan benefits, and
- Change the eligibility rules and other Retiree Plan terms to amend, increase, decrease or eliminate benefits or terminate the Retiree Plans, partially or totally.
- Benefits under the Retiree Plans will only be paid when the Trustees or person delegated by them decide, in their discretion, that the participant or beneficiary is entitled to benefits in accordance with terms of the Retiree Plans.

The Trustees intend to continue the Retiree Plans 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 Retiree Plans, as they deem necessary, in their sole and unrestricted discretion. The Retiree Plans may be amended or terminated by majority vote of the Board of Trustees at a meeting of the Trustees. If this occurs, the Fund Office will send you a written notice explaining the change. Please be sure to read all Fund communications and keep them with this booklet.

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 Retiree Plans on behalf of the Board or to act as agents of the Board with respect to interpretation of the Retiree Plans. You may only rely on information regarding the Retiree Plans that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by the Administrator.

Parties to the Collective Bargaining Agreement

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

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 Retiree Plans.

Identification Numbers

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

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 collective bargaining agreements. The amount of monthly premiums due for your coverage under the Retiree Medical Plan 3 is determined by the Trustees.

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

The accounting records of the Retiree Plans are kept on a plan year basis beginning each June 1 and ending the following May 31.

Purpose

The Retiree Plans are employee welfare benefits plans maintained to provide medical, prescription drug and death benefits for you and your dependents who meet the eligibility requirements described in this booklet.

Inspection of the Plan

If you wish to inspect or receive copies of additional documents relating to the Retiree Plans, 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 Retiree Plans, 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 one of the Retiree Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (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 Retiree Plans. These include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Retiree Plans. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the 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 Active Plan 3 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 preexisting 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 Retiree Plans when:
  - You lose coverage under the Retiree 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 preexisting 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 Retiree Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Retiree Plans, called "fiduciaries" of the Retiree Plans, have a duty to do so prudently and in the interest of you and other Retiree 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 Retiree Plan documents or the latest annual report from the Retiree 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 Retiree 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 Retiree 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 the Retiree Plans, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration (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 publications 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 Retiree 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 Retiree Plans. The Trustees reserve the right and have been given the discretion to amend, modify or discontinue all or any part of the Retiree Plans whenever, in their sole judgment, conditions so warrant.