



CHICAGO
LABORERS'
PENSION
FUND

CHICAGO LABORERS' WELFARE PLAN

Summary Plan Description | 2009 EDITION

Active Plan I



Chicago Laborers' Welfare Fund

11465 W. Cermak Road
Westchester, IL 60154

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Benefits Consultant	The Segal Company

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

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

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

IMPORTANT IMPORTANTE WAŻNE

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

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

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

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

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LABORERS'
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11465 W. Cermak Road
Westchester, IL 60154
Telephone: 708-562-0200 or 866-906-0200
Fax: 708-562-0716
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Website: www.chicagolaborersfunds.com

To All Active Plan 1 Participants:

We are pleased to provide you with this Summary Plan Description booklet, which outlines your health and welfare benefits in effect as of June 1, 2009. This booklet includes recent changes that have been made to the Plan.

Among the improvements described in this booklet are:

- A new provider for medical care (Blue Cross Blue Shield of Illinois (BCBSIL) BlueCard Preferred Provider Organization);
- Increased medical benefits;
- The addition of Smoking Cessation Benefits (including laser treatments);
- A new provider for the prescription drug program (CVS/Caremark) and the addition of a specialty drug program;
- Increased dental benefits;
- Increased vision care benefits, as well as the addition of vision correction benefits (through QualSight, Inc.); and
- A new Health Reimbursement Arrangement (HRA) Program.

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

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

Sincerely,

BOARD OF TRUSTEES

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INTRODUCTION

The Chicago Laborers' Welfare Plan offers comprehensive healthcare coverage to help you and your dependents stay healthy. This coverage can also help provide financial protection against catastrophic healthcare expenses. The Plan provides:

- Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Weekly Income Benefits (for Eligible Members only); and
- Death and Accidental Dismemberment Benefits.

The Plan also includes a Health Reimbursement Arrangement (HRA) Program designed to provide reimbursement of certain healthcare expenses on a tax-free basis.

The benefits described in this booklet, which are effective as of June 1, 2009, are for Active Plan 1 participants. This booklet includes the changes that have been made to the Plan since the last booklet was printed. This booklet replaces and supersedes any prior Summary Plan Description.

Life Events

At some point in our lives, each of us will experience—if we have not already—a life event that affects our healthcare coverage. Beginning a new job, having a child or adopting one, getting married or divorced, having a major illness, performing military duty, retiring from employment as a laborer, and losing a loved one, are all examples of life events. This booklet is designed to show you how your Chicago Laborers' Welfare Fund benefits fit into the different stages of your life.

These are some of the life events that may affect your benefits:

- Beginning a new job;
- Birth, adoption, or placement for adoption of a child;
- Marriage or divorce;
- Major illness;
- Military duty;
- Retirement; and
- Death of a loved one.

Network Providers

- **Medical Care.** The Plan offers you Medical Benefits through the **Blue Cross Blue Shield of Illinois (BCBSIL) BlueCard Preferred Provider Organization (PPO)**. Within this network, you have access to many participating Physicians and Hospitals throughout the area where you live. By using the services of network Providers—Physicians and Hospitals that participate in the BCBSIL network—you receive services at pre-negotiated discounted rates and you receive the higher network level of benefits.
- **Smoking Cessation.** The Plan offers Smoking Cessation Benefits, including laser treatments.
- **Prescription Drugs.** The Plan offers Prescription Drug Benefits through **CVS/Caremark**, a Pharmacy Benefit Manager (PBM). There are more than 50,000 Pharmacies that participate in the CVS/Caremark network nationwide, including almost all of the major drug chains. Visit the CVS/Caremark web site at www.caremark.com for a list of participating Pharmacies. You must show your prescription drug program ID card when you fill your prescription at a CVS/Caremark Pharmacy to receive your prescription drug medications at discounted prices. If you do not use a participating Pharmacy or do not show your ID card when you fill your prescription, you will be responsible for 50% of the cost of the prescription medication.
- **Dental Care.** Dental Benefits are provided through **Delta Dental of Illinois**, a dental Preferred Provider Organization. Your level of coverage will depend on whether or not your Dentist or orthodontist is a Delta Dental network Provider. To receive the most benefits and the highest level of discounts, your Provider must participate in the **Delta Dental PPO Network**. You should contact Delta Dental at 630-964-2400, 800-323-1743 (toll-free in Illinois) or 800-331-0538 (toll-free outside Illinois) before seeking dental care.

To select a Physician, Hospital, or other Provider in your area, contact BCBSIL by calling 800-810-2583 or visiting www.bcbsil.com. Information about participating Providers is provided to you free of charge.

Delta Dental can help you select a network Dentist or orthodontist and answer specific questions relating to your Dental Benefits. You may also use Delta Dental's web site at www.deltadentalil.com to find a network Provider.

- **Routine Vision Care.** The Plan has contracted with **Mid-America Vision** to provide discounted vision care such as annual eye exams, glasses, and contact lenses. To locate a Mid-America Vision facility near you, call toll-free 888-760-1010.
- **Vision Correction Surgery.** The Plan has contracted with **QualSight, Inc.** to provide discounted vision correction Surgery; see page 37. To find out if you may be a candidate for vision correction Surgery, contact QualSight at 877-507-4448.

Be a Wise Healthcare Consumer

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

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

Questions About Your Benefits

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

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

Healthcare Providers Contact Information

- **Blue Cross Blue Shield (Medical)**
800-810-2583
www.bcbsil.com
Group No.: P15412
- **Laser Concepts of Chicago (Smoking Cessation)**
866-908-7848
www.laserconceptschicago.com
- **CVS/Caremark Inc. (Prescription)**
www.caremark.com
Group No.: T 190
- **Specialty Drug Program**
866-387-2573
Group No.: S 190
- **Delta Dental of Illinois (Dental)**
630-964-2400
In Illinois: 800-323-1743
Outside Illinois: 800-331-0538
8:30 AM–5:00 PM Monday–Friday
www.deltadentalil.com
Group No.: I133
- **Mid-America Vision (Routine Vision)**
888-760-1010
5:30 AM–3:30 PM Monday–Friday
- **QualSight, Inc. (Vision Correction Surgery)**
877-507-4448
www.qualsight.com
- **Fund Office**
708-562-0200 or
toll-free at 866-906-0200
Office hours
8:30 AM–4:00 PM Monday–Friday
Call Center
8:00 AM–5:00 PM Monday–Friday

ELIGIBILITY

Initial Eligibility

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

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

Covered Employment

Work for an Employer that is required to contribute to the Fund on your behalf.

MINIMUM COVERED EMPLOYMENT HOURS REQUIRED*

Age Group	Hours During 6 Consecutive Months	Hours During 12 Consecutive Months
Under Age 50	500	800
Ages 50 to 54	400	700
Ages 55 and over	200	300

* If you are covered by a collective bargaining agreement that includes an early eligibility provision, you will be provided with an addendum that may modify these initial eligibility rules.

Continuing Eligibility

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

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

Example: Initial and Continuing Eligibility

Jake, who is 30, begins working in covered employment on February 1st. By the end of June he has worked more than 500 hours during the six-consecutive month period. As a result, Jake is eligible for coverage as of July 1st, the first day of the month following completion of the required hours.

Jake continues to work in covered employment and works 90 hours in July, which means he will continue to be eligible since he still has more than 500 hours during the preceding 6 month period.

The Fund Office sends you statements every other month that list the number of hours reported by your Employer. If you have questions or concerns regarding your hours and eligibility, please contact the Fund Office.

Changing Employers

Benefits described in this booklet are for Active Plan 1 participants. The Fund has alternate plans (Plan 2, Plan 3, Plan 4, and Plan 5) that cover employees who perform work in the jurisdiction of the Chicago Laborers' District Council, but work for employers who are not engaged in the construction industry or who contribute at different hourly rates. Your Employer's contribution rate determines in which of the plans you and your dependents may participate. In the future if you change employers, you may participate in a different plan.

When you consider retiring from covered employment, contact the Pension Department of the Fund Office at 708-562-0200. A representative will advise you of your pension benefit options and discuss available welfare benefit options.

After Retirement

Your coverage under the Plan will continue after you retire from covered employment as long as you maintain a sufficient number of hours during the preceding 6- or 12-consecutive month period. When your hours eligibility expires and you no longer qualify for benefit coverage under the Plan, you will be offered the chance to elect COBRA Continuation Coverage. In addition, if you meet certain retiree eligibility requirements, you may be offered coverage under the Retiree Medical Plan 1 or the Retiree Basic Medical Coverage Plan.

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

Returning to Employment after Retirement

If you engage in disqualifying employment (as defined by the Rules and Regulations of the Laborers' Pension Fund) after you retire, your pension benefits will be suspended. In addition, your coverage under the Retiree Medical Plan 1 or Retiree Basic Medical Coverage Plan will end on the day that you begin working in disqualifying employment. You will not be eligible for COBRA Continuation Coverage. You will regain eligibility for coverage under Active Plan 1 (or another Active Plan) on the first day of the month following the completion of the required number of hours if you return to work in covered employment. When returning to work in covered employment after receiving a pension benefit, you will regain eligibility following the completion of 500 hours in a six-consecutive month period or 800 hours in a 12-consecutive month period. These requirements apply regardless of your age.

If you retire and return to disqualifying employment three times, you will no longer be eligible to obtain Retiree Medical Plan 1 or Retiree Basic Medical Coverage Plan coverage. Your only option to continue medical coverage, when your eligibility under one of these Plans ends, will be to elect COBRA Continuation Coverage under the Active Plan 1.

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

Dependent Eligibility

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

If your child is eligible for benefits as a working laborer under the Plan, he or she cannot be covered as your dependent under the Plan.

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

If you do not provide a copy of your newborn's birth certificate within 90 days of the date of birth, benefit coverage will be suspended. In addition, if the birth certificate is received by the Fund Office more than one year after the child's birth, eligibility will resume on the date the birth certificate is received, if you, the Eligible Member, are eligible for benefits.

If Your Spouse Has Employer-Sponsored Benefits

If your Spouse has employer-sponsored medical coverage that he or she does not elect, your Spouse may not be eligible for coverage under the Plan or benefits may be limited. No benefits will be payable under the Chicago Laborers' Welfare Plan if your Spouse's employer-sponsored medical plan does not provide your dependent with the same level of benefits provided to other participants in that plan. *To ensure that your Spouse receives the maximum level of benefits payable under this Plan, your Spouse should elect coverage under any available employer-sponsored medical coverage your Spouse is eligible to receive.*

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

Dependent Defined

Your dependents are:

- Your Spouse if you are not divorced.
 - Your unmarried child:
 - Who is less than 19 years old. The child must be dependent on you for more than half of his or her financial support and maintain a principal residence with you for more than one-half of the calendar year.
 - Who is age 19, but less than 26, if enrolled and attending a state accredited secondary college or 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 more than half of his or her financial support and maintain a principal residence with you for more than one-half of the calendar year (except temporary absences). If the dependent is age 19 when between high school and further education, as outlined above, the dependent will be eligible to continue coverage by electing COBRA. Upon receipt of proof of enrollment in continuing education after high school, coverage will be retroactive to the date of high school graduation and any COBRA premiums paid will be refunded.
- If, at any time during the school year, your child loses full-time student status (i.e., dropping a class) and is no longer considered a full-time student, as defined by the educational institution, coverage will end on the date your child stopped being a full-time student.

Under the Plan, your child is defined as:

- Your natural child;
- Your stepchild if you provide over one-half of his or her financial support, Claim the child as a dependent on your tax returns, and **the natural parent has not been ordered to support the child or provide health coverage;**
- Your adopted child or child placed with you, the Eligible Member, for adoption;
- Your child who is entitled to coverage pursuant to a Qualified Medical Child Support Order (QMCSO);
- Your child for whom you have legal guardianship, provided:
 - You, the Eligible Member, are named legal guardian;
 - The child resides in your home in a parent-child relationship;
 - The child depends on you for more than half of his or her financial support;
 - You have taken full parental responsibility and control for the child;
 - The child is not temporarily living in your home;
 - The child is not still under the control of the social service agency that placed the child with you; and
 - The natural parents do not share parental responsibility and control of the child with you. Parental responsibility includes monetary support of any kind, maintenance of health coverage, and other supportive functions.
- 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 more than half of his or her financial support and daily living and maintain a principal residence with you for more than one-half of the calendar year. You must give the Fund Trustees written proof of the child's handicap. Please contact the Fund Office at least two months before coverage would otherwise end and request a *Proof of Incapacitated Child Form* for completion. You must provide the Fund Office with this completed form and copies of your child's medical records to support your Claim.

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

You are required to provide documentation to the Fund Office that verifies your dependent's status. Documentation may include a certified birth certificate, adoption papers, court orders, affidavits, tax returns, or other proof of financial support.

Financial support documents may include monetary payments to a natural parent or guardian, daycare expenses, education expenses, or other financial responsibilities.

Please contact the Eligibility Department of the Fund Office for more information.

If your child does not have his or her principal place of residence with you, he or she will be a dependent child, provided he or she meets the other (non-residence-related) requirements for dependents above and either of the following conditions is met:

- a. If you are divorced/separated:
 - i. You and the other parent are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times;
 - ii. You and the other parent provide over one-half of the child's support; and
 - iii. The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; or
- b. You provide over half the child's support and the child is not a "qualifying child" (within the meaning of Internal Revenue Code section 152) of any other person.

The term child **does not** include:

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

When Coverage Ends

For You

Your coverage ends on the earliest of:

- The first day of the month following the date you fail to meet the requirement of covered employment hours;
- The last day of the period for which the last contribution was paid for your coverage;
- 31 days after your eligibility ends and Death and/or Accidental Dismemberment Benefit coverage ends;
- The first day of the month that you do not meet the requirements for continued eligibility for Medical Benefits and Weekly Income Benefits;
- The date you become eligible for other coverage due to other employment;
- The date the Plan is terminated; or
- The date that your Employer ends coverage for its Eligible Members.

For Your Dependents

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

- When your dependent no longer meets the Plan's definition of an eligible dependent (e.g., due to divorce, legal separation, or a child reaching age 19 or age 26 if a full-time student);
- At the end of the period for which the last contribution was paid for your dependent's coverage;

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 children must depend on you for more than half of their financial support and live in your home for more than half the calendar year (except temporary absences). Children who are away at school are considered to share your principal residence, as long as it is reasonable to assume that they return to your home when school is not in session.

If the dependent is a stepchild, you are required to provide an annual copy of your federal tax return to show proof that you Claimed the dependent on your tax return.

A court order stating that you are required to provide health coverage for a dependent child is not sufficient to grant coverage. You will be required to submit all forms and documents requested before coverage is extended.

When coverage ends, you and your dependents may be eligible to continue your coverage under the federal law known as COBRA. See page 8 for more information.

- The date the Plan is terminated;
- The date that your Employer ends coverage for its Eligible Members;
- When your dependent enters the armed forces; or
- The date your dependent marries.

If you die while you are eligible for benefits, your dependents are eligible to continue coverage by electing COBRA Continuation Coverage for up to 36 months (see page 8). If your dependents elect COBRA Continuation Coverage, the first 18 months are free; that is the Fund pays for the first 18 months of COBRA Continuation Coverage. After that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

Certificate of Creditable Coverage

When your coverage under the Plan ends, the Fund Office will provide you and/or your covered dependents with a Certificate of Creditable Coverage. The Certificate indicates the period of time you and they were covered under the Plan and certain additional information that is required by federal law. The Fund Office will send you the Certificate by first class mail within 45 days after coverage under the Plan ends. If you or your dependents elect COBRA Continuation Coverage or coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), another Certificate will be provided within 60 days after the COBRA Continuation Coverage or USERRA coverage ends.

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

Reinstatement of Eligibility

If your coverage ends, you can reinstate your eligibility by satisfying the Plan's initial eligibility requirements again (see page 3). For information regarding your eligibility during and after your return from a leave of absence for military service or family and medical leave (see page 8).

Extension of Benefits

If you are an Inpatient at the time your coverage under the Plan ends, the Plan will provide an extension of benefits limited to the Covered Services of this Plan that are rendered by and regularly charged by the Hospital, Skilled Nursing Facility, or Substance Abuse Treatment Facility in which you are an Inpatient. Benefits will be provided under the terms of the Plan until you are discharged. No benefits are payable following discharge.

Changes in Eligibility Rules

The Trustees reserve the right, at their sole and unrestricted discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Plan at any time. The Trustees have the authority to establish contribution rates and self-payment rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

Changes in Social Security Numbers

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

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

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

CONTINUATION OF COVERAGE

Military Service

Healthcare coverage under the Plan will continue for you (or your dependents) if you serve in the uniformed services of the United States (active duty or inactive duty training) for up to 31 days provided you were eligible for benefits at the time of your deployment. If you serve in military service for more than 31 days, you may continue your coverage for your dependents at your own expense for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Coverage continued under the provisions of USERRA runs concurrently with COBRA Continuation Coverage.

If you continue coverage at your own expense, the coverage will end at the earliest of the:

- Date you or your dependents do not make the required payments within 30 days of the due date;
- Date the Fund no longer provides any group health benefits;
- Date you reinstate your eligibility for Plan coverage;
- End of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- Last day of the month after 24-consecutive months.

While you are deployed for military service, your eligibility will be “frozen.” Once your military service ends, your eligibility will be reinstated upon your return to covered work as a laborer, provided you meet USERRA reemployment provisions. For more information about self-payments under USERRA, contact the Fund Office.

Family and Medical Leave Act

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

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

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

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

COBRA Continuation Coverage

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

- **COBRA Core Plan**, which includes Medical, Prescription Drug, and Death Benefits as described in this booklet; or
- **COBRA Full Plan**, which includes Medical, Prescription Drug, Dental, Vision, and Death Benefits as described in this booklet.

The COBRA Continuation Coverage will be identical to the coverage you had under the Plan on the day

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 healthcare coverage provided by your employer.

Generally, you are eligible for a leave under the FMLA if you:

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

before your qualifying event. You will not be eligible to continue coverage for Weekly Income or Accidental Dismemberment Benefits.

You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

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

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

Qualifying Events

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

- Termination of your covered employment (for causes other than gross misconduct);
- Reduction in your hours reported for covered employment;
- Your death;
- You become entitled to Medicare Benefits (under Part A, Part B, or both);
- Legal separation or divorce of you or your Spouse; or
- Your child's loss of dependent status under the Plan.

Participant Agreement and Independent Self-Contributors

If you are receiving benefits under a Participation Agreement for Independent Self-Contributors, you are remitting benefits for yourself and possibly other non-bargaining unit employees who are performing collective bargaining work. You are not entitled to COBRA Continuation Coverage if you cease to remit contributions on your behalf. If you do not submit contributions on behalf of your employees covered under a collective bargaining agreement, your benefits will be suspended until such time that all contributions, penalties, interest, and any costs of collection are paid in full. The Trustees reserve the right to terminate a Participation Agreement for Independent Self-Contributors for failure to remit contributions required under that Participation Agreement as well as for failure to remit contributions required under the terms of the related collective bargaining agreement.

Notifying the Fund Office

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

For COBRA Continuation Coverage, you must notify the Fund Office within 60 days of a:

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

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

If your dependent child is age 19 and graduates from high school, he or she is no longer covered under the Plan. Even if your child plans to attend college as a full-time student, you must elect and pay for COBRA Continuation Coverage for the period between high school graduation and the *next* college semester after graduation (usually in the fall). If you provide proof of full-time enrollment at an accredited institution (see page 5), any COBRA premiums you paid will be reimbursed and coverage granted retroactive to the date of graduation.

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

Electing COBRA Continuation Coverage

When the Fund Office is notified that a COBRA-qualifying event has occurred, you and your dependents will be notified of your right to elect COBRA Continuation Coverage. Whether or not you elect coverage for yourself, your dependents have the opportunity to elect coverage independently from you. To elect continuation coverage, you must complete the election form and submit it according to the directions on the form. You then have 60 days from the later of the date the election notice was received or the date coverage ended due to the qualifying event to return the election form to the Fund Office.

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

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

1. They may have pre-existing condition exclusions applied to them by other group health plans if they have more than a 63-day gap in health coverage. Election of COBRA Continuation Coverage may help them avoid such a gap.
2. They will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if they do not elect COBRA Continuation Coverage for the maximum time available to them.
3. They should take into account that they have special enrollment rights under federal law. They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after their group health coverage ends because of the qualifying event. They will also have the same special enrollment rights at the end of continuation coverage if they elect COBRA Continuation Coverage for the maximum time available to them.

The Plan currently offers two levels of COBRA Continuation Coverage, the COBRA Core Plan and the COBRA Full Plan. Once you elect a level of coverage, you may change your election to a different level of coverage only if the 60-day election period has not expired. Once the 60-day election period ends, you are no longer eligible to change coverage level.

Paying For COBRA Continuation Coverage

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

COBRA Payments

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

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

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

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

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

Coverage Period

- ***Coverage Continues for 18 Months.*** You may elect to purchase COBRA Continuation Coverage for yourself and your dependents for up to 18 months if coverage ends due to your termination of covered employment (except for gross misconduct) or your reduction in hours.
- ***Coverage Continues for 29 Months (Extended Disability Coverage).*** Your coverage or your dependent's coverage may continue for a total of 29 months (an additional 11 months) after your covered employment is terminated or you have a reduction in your hours if you or one of your dependents is totally disabled, as determined by the Social Security Administration. The determination must be made either:
 - At the time of your termination from covered employment or reduction in hours; or
 - Within the next 60 days after your termination from covered employment or reduction in hours.

You must notify the Fund Office of your determination of disability by the Social Security Administration before the end of the 18-month period of COBRA Continuation Coverage. *In addition, if, at a later date, you become employed or are no longer considered totally disabled by the Social Security Administration, you must notify the Fund Office.*

- ***Coverage Continues for 36 Months.*** Your dependents may elect to continue coverage for up to 36 months if coverage ends due to your:
 - Death;
 - Attainment of Medicare healthcare coverage entitlement during the first 18 months of COBRA Continuation Coverage;
 - Legal separation or divorce; or
 - Dependent child no longer meeting the definition of child and not qualifying for dependent coverage under the terms of the Plan. See page 5 for the definition of dependent under the Plan.

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

Loss of Continued Coverage

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

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

CHANGES IN FAMILY STATUS

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

Notify the Fund Office

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

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

Adding a Dependent

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

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

Getting Married

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

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

If your dependent reaches age 19 and is a full-time student, he or she may continue coverage under the Plan if you provide the Fund Office with proof of your child's full-time student status. Your child may be covered under the Plan until age 26 if your child maintains full-time student status and you continue to provide the necessary documentation to the Fund Office. Please contact the Fund Office to obtain *Full-Time Student Enrollment Verification Forms*.

Coverage under the Plan will be retroactive to the date of high school graduation after the Fund Office receives proof of college enrollment. Any COBRA premiums paid on behalf of a dependent child for COBRA Continuation Coverage between high school graduation and enrollment in college will be refunded upon receipt of proof of college enrollment.

Your child must receive most of his or her support from you and maintain a permanent residence at your home. See page 5 for the definition of dependent child.

If Your Dependent Loses Eligibility for Coverage

If your dependent child loses eligibility for coverage under the Plan by reaching age 19 (age 26 if a full-time student) or by losing status as a full-time student, your dependent child may continue coverage under COBRA. You or your dependent child must notify the Fund Office of the loss of dependent status within 60 days from the date of loss to be eligible to elect COBRA Continuation Coverage. See page 8 for more information about COBRA Continuation Coverage.

In the Event of Divorce

If you obtain a divorce, you must notify the Fund Office immediately and submit a complete copy of your certified divorce decree. If your ex-Spouse was covered under the Plan on the day before the divorce and wants to continue coverage under COBRA, you or your ex-Spouse has 60 days from the date of the divorce to notify the Fund Office of the divorce and request COBRA information from the Fund Office. See page 8 for more information about COBRA Continuation Coverage.

Qualified Medical Child Support Order (QMCSO)

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

In the Event of Death

If you die, your surviving Spouse or dependents should contact the Fund Office. The Fund Office will assist them in submitting a Claim for a Death Benefit.

If you are eligible for benefits under the Plan at the time of your death, your dependents are eligible for COBRA Continuation Coverage for a period of up to 36 months. The Plan provides the first 18 months of COBRA Continuation Coverage free of charge. After that, if your dependents elect to continue coverage for up to an additional 18 months, they will be required to pay for this coverage at the COBRA rates in effect at that time.

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

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

QMCSO

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

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

MEDICAL BENEFITS

Schedule of Medical Benefits

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

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

Medical Benefits	Benefit Amount/Special Limitations
Annual Deductible	After the Plan pays the first \$10,000 of medical expenses, you must pay: \$200 per person per calendar year \$400 per family per calendar year
Coinsurance	After you pay your annual deductible, the Plan pays the applicable Coinsurance rate of the next \$7,500 per person of eligible expenses each calendar year; the Plan then pays 100% of additional expenses up to the lifetime maximum
Medical Coinsurance Network Provider Non-Network Provider	Plan pays: 90% of covered expenses 80% of covered expenses
Lifetime Maximum	\$1,250,000 per person
Chiropractic and Spinal Manipulation Annual Maximum	\$4,000 per person per calendar year
Home Healthcare Services and Skilled Nursing Facility Services Annual Maximum	180 days up to \$1,000 per day per calendar year
Infertility Treatment Lifetime Maximum	\$12,500 per person (Eligible Members and Spouses only)
Mental or Nervous Disorders Annual Maximum Inpatient Outpatient	Up to 30 days per person per calendar year Up to 50 visits per person per calendar year
Speech Therapy for Dependents ¹ Standard Developmental Therapy Before 5 th Birthday Therapy for Special Diagnoses Before 9 th Birthday	\$10,000 lifetime benefit Additional \$5,000 lifetime benefit (total of \$15,000 combined with standard therapy benefit)
Suicide Attempt Expenses Maximum	\$10,000 (one-time only benefit)
Transplant Benefit	Contact Fund Office to determine coverage

Additional Medical Coverage	The following Additional Medical Coverages are not subject to the Annual Deductible or Coinsurance provisions, except as noted.
Substance Abuse Treatment (Includes Detoxification) Network Provider Non-Network Provider Inpatient Lifetime Maximum Outpatient Lifetime Maximum	Plan pays: 90% of covered expenses 80% of covered expenses Up to \$300 per person per day \$12,000 Up to \$150 per person per visit \$11,000
Diabetes Education	Plan pays 100% of covered expenses up to \$400 per calendar year
Hearing Aids	Plan pays 100% of covered expenses, up to \$1,500, every three calendar years
Infant Wellness Benefits (Up to Age 2)	Plan pays 100% of covered expenses up to \$1,800 per child during the first 24 months of life

Additional Medical Coverage <i>continued</i>	The following Additional Medical Coverages are not subject to the Annual Deductible or Coinsurance provisions, except as noted.
Wellness Benefits for Dependent Children (After Age 2)	Plan pays 100% of covered expenses up to \$600 per child per calendar year
Wellness Benefits for Eligible Members and Spouses	Plan pays 100% of covered expenses up to \$700 per person per calendar year
Colonoscopy or flexible sigmoidoscopy (Eligible Members and Spouses only)	Plan pays 100% of covered expenses up to \$1,065 per person once every five years
Prosthetic Devices ²	
Member	\$150,000 lifetime maximum per limb
Spouses and children age 12 and older	\$50,000 lifetime maximum per limb
Children under the age of 12	\$100,000 lifetime maximum per limb
Initial or replacement device	\$25,000 lifetime maximum
Contraceptives (Eligible Members and Spouses only)	\$500 per calendar year
Smoking Cessation (Eligible Members and Spouses only)	Plan pays 100% of covered expenses up to \$1,000 per person per lifetime
Nebulizers (Eligible Members and Spouses only)	Plan pays 100% of covered expenses, up to \$250, once every three years

¹ See explanation on page 23.

² See explanation on page 22.

Preferred Provider Organization (PPO)

The Plan offers benefits and care from a network of Physicians and Hospitals that participate in the Blue Cross Blue Shield of Illinois (BCBSIL) BlueCard Preferred Provider Organization (PPO). See page 1 for more information about the BCBSIL PPO. When you use a network Provider, you save money for yourself and the Plan because network Physicians and Hospitals have agreed to charge a negotiated price for their services.

PPO

A network of Physicians and Hospitals that have agreed to charge negotiated rates. Since network Providers have agreed to these negotiated rates, you help control healthcare costs for you and the Plan when you use a network Physician or Hospital. It's your decision whether or not to use a network Physician or Hospital. You always have the final say about the Physicians and Hospitals you and your family use.

You do not receive a PPO discount on medical expenses that are not covered by the Plan. Please see pages 25–27 for Plan exclusions.

Example: Using a Network Provider Can Save You Money

Let's compare what Joe pays when using a network Hospital versus a non-network Hospital. Joe is eligible for benefit coverage and has already received benefits of \$10,000 and has satisfied the \$200 annual deductible. When Joe has additional Surgery, his share of the cost is determined as follows:

	Network Hospital	Non-Network Hospital
Expenses Charged for a 2-day Hospital Stay	\$3,200	\$3,200
Network Discount	<u>– \$1,280</u>	<u>– \$0</u>
Adjusted Charges	\$1,920	\$3,200
Plan Pays	\$1,728 (90%)	\$2,560 (80%)
Joe Pays	\$192 (10%)	\$640 (20%)

This example assumes a network savings rate of approximately 40%. The actual savings may vary.

Joe saves \$448 by using a network Hospital.

To select a network Provider in your area you may contact BCBS at 800-810-2583 or visit the BCBS web site at www.bcbsil.com for a free listing of network Providers.

How the Plan Works

Your expenses must be Medically Necessary to be eligible for coverage. *All charges for your care are subject to Usual and Customary Charges.* If you or a dependent use a non-network Provider, you are responsible for any expenses you incur that exceed Usual and Customary Charges. See page 80 for the definition of Usual and Customary Charges.

The Plan provides:

- Medical Benefits that pay 100% of the first \$10,000 in covered expenses, per person each calendar year.
- After you have accumulated \$10,000 in covered medical expenses, you are responsible for payment of your annual \$200 individual or \$400 family deductible.
- After you have met your deductible, the Plan pays 90% of covered expenses if you use a network Provider and 80% if you use a non-network Provider for the next \$7,500 in covered charges.
- After that, the Plan again pays 100% of eligible, covered expenses for the remainder of the calendar year.

Annual Deductible

The annual deductible is the amount of covered medical expenses that you pay after the Plan has paid the first \$10,000 in covered Medical Benefits each calendar year. The amount of your annual deductible is \$200. The annual family deductible will be satisfied when the combined deductibles of all family members reach \$400 in a calendar year. However, no one family member can apply more than his or her individual deductible to the family deductible.

One family member must first meet the \$200 deductible. After that, any combination of other family members' deductible expenses can meet the other \$200 for a maximum of \$400 for the entire family.

Any covered expenses that are applied to an individual deductible in the last three months of any calendar year may also be applied to that individual's next calendar year's annual deductible. The family deductible does not carry over to the next calendar year deductible. Remember, this deductible is separate and in addition to the Plan's Prescription Drug Benefits deductible.

Coinsurance

After the Plan pays the first \$10,000 in covered expenses and you or your family have satisfied your annual deductible, the Plan pays a percentage (90% for network Providers; 80% for non-network Providers) of the next \$7,500 in covered expenses. This is called the Coinsurance limit. After that, the Plan pays 100% of covered expenses, subject to Usual and Customary Charges, for the rest of the year.

Certain covered expenses that were incurred during the last three months of the preceding calendar year may be counted toward the Coinsurance limit.

Remember that the Plan pays a greater percentage (90%) of your medical costs if you use a network Provider (rather than 80% if you use a non-network Provider).

If you consistently use network Providers, the amount of covered medical expenses you may be responsible for is \$950 (\$200 annual deductible plus \$750 Coinsurance). If you do not use, or sometimes use network Providers, the amount of your payment responsibility will vary. After your Coinsurance on the next \$7,500 in covered

Annual Deductible

The amount of covered medical expenses that you pay after the Plan has paid your first \$10,000 in covered expenses and before the Plan pays. The amount of your deductible is \$200 each calendar year.

Medically Necessary

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

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

expenses is met, the Plan will pay 100% of any additional covered expenses you incur for the remainder of the calendar year up to your lifetime maximum. **Note: These estimated Coinsurance amounts are applicable to expenses covered by the Plan only. All charges are subject to Usual and Customary Charges and may result in a payment of less than 100% if a non-network Provider is used.**

Example: You and the Plan Cover Your Annual Medical Costs

John and his wife Joan and their daughter Julia are covered by the Plan. They each had medical expenses that exceeded \$10,000 in 2008. John had medical expenses of \$12,000, Joan had medical expenses of \$11,600 and Julia's medical expenses reached \$10,100. The family deductible of \$400 is applied to the family's expenses before the Plan pays a percentage of the family's additional medical expenses. Assuming the family used network Providers, their expenses for the year would be:

Expenses	John's	Joan's	Julia's	Family
Total medical expenses	\$12,000	\$11,600	\$10,100	\$33,700
Less first \$10,000	<u>-\$10,000</u>	<u>-\$10,000</u>	<u>-\$10,000</u>	<u>-\$30,000</u>
Balance	\$2,000	\$1,600	\$100	\$3,700
Less deductible	<u>-\$200</u>	<u>-\$100</u>	<u>-\$100</u>	<u>-\$400</u>
Balance	\$1,800	\$1,500	\$0	\$3,300
Plan pays 90%	<u>-\$1,620</u>	<u>-\$1,350</u>	<u>-\$0</u>	<u>-\$2,970</u>
Member pays 10%	\$180	\$150	\$0	\$330
Total family expenses (deductible and Coinsurance)				\$730

Out of a total of \$33,700 in medical expenses, John and his family pay only \$730.

Lifetime Maximum

The Plan pays up to a lifetime maximum of \$1,250,000 in covered expenses per person covered under the Plan's Medical Benefits.

Medical Covered Expenses

The Plan covers the actual Usual and Customary Charges for the Medically Necessary services and supplies that are listed below. Limitations on the number of treatments and the dollar amount for the treatment are contained in this section and on the *Schedule of Medical Benefits* on page 14.

- *Acupuncture* if treatment is by a licensed acupuncturist for the treatment of pain management only.
- *Alcoholism and/or Substance Abuse treatments* are treated like other medical illnesses, subject to the limitations listed on page 14. The deductible and Coinsurance provisions do not apply to these expenses. An Inpatient treatment center must meet the following criteria:
 - Be a nationally recognized accrediting agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organiza-

Usual and Customary Charge

- The charge that is no higher than the 90th percentile of the Plan's most currently available healthcare charge data, or where there is insufficient data, a value or amount established by the Fund;
- For multiple or bilateral surgeries performed at the same time, 100% for the primary procedure and for the secondary procedures, an amount determined after medical review;
- For surgical assistance by a Physician, 20% of the charge allowed for the Surgery; and
- For PPO Providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.

tion (OAOA), Healthcare Facilities Accreditation Program (HEAP), Rehabilitation Accreditation Commission (CARF));

- Have full-time permanent bed care facilities for five or more resident patients;
 - Have the regular services of a Physician;
 - Provide 24 hour a day services by a licensed medical professional;
 - Perform mainly diagnostic and therapeutic Medical Care of patients, or provide care and treatment for Substance Abuse;
 - Not be a nursing, convalescent, or rest home or residence for the aged; and
 - Be licensed to operate where it is located.
- *Ambulance Service* deemed Medically Necessary and not for patient convenience. The Fund may request additional information on your medical condition to evaluate Medical Necessity for transport via ambulance.
 - *Ambulatory Surgical Centers*, including supplies and facility charges are covered based on Medical Necessity for surgical procedures performed on an Outpatient basis.
 - *Anesthetic and oxygen*, including the purchase of or the rental cost up to the amount of the purchase price.
 - *Anesthesia Services*. However, for charges from both an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA) for services provided on the same day, the Plan will only pay for services performed by one Provider. Payment will be made in the order in which the charges are received.
 - *Assistant Surgeon charges* by Physicians or Certified Surgical Assistants may be covered; however, the Plan may review the Medical Necessity of the assistance during the Surgery performed. The Plan does not cover charges for Physician Assistants and Nurse Practitioner assistance during Surgery. Please contact the Fund Office for more information.
 - *Breast reduction Surgery* that is not cosmetic in nature, but is deemed Medically Necessary by the Fund's Medical Consultant(s). Please contact the Fund Office before Surgery.
 - *Certified Surgical Assistants (CSA)*. The Plan pays the Usual and Customary Charge amount of 85% of the 20% allowed amount of the surgeon's charges for Covered Services provided by Certified Surgical Assistants (CSA).
 - *Chemotherapy* for cancer treatment, including Chemotherapy dispensed as a prescription drug.
 - *Chiropractic and spinal manipulation* if treatment is for back-related care only up to \$4,000 per calendar year. No other payment from any other portion of the Plan will be made.
 - *Cochlear implants* are covered as follows:
 - Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 22);
 - Other expenses (such as Hospital, pathology, radiology, and anesthesia) are covered the same as other Medical Benefits; and

To find a network Provider, contact:

BCBSIL
800-810-2583
www.bcbsil.com

Doctors, Physicians, and other Practitioners

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

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

- Associated Speech Therapy may be covered (see page 23 for more information about Speech Therapy coverage).
- *Colonoscopy or flexible sigmoidoscopy* is covered for routine screening purposes once every five years up to a maximum of \$1,065, which includes all associated charges.
- *Contraception* is covered for prescriptions and devices such as Norplant implants, Intrauterine Devices (IUDs), and diaphragms, including all medical charges associated with the devices, up to \$500 per calendar year for you or your Spouse.
- *Cosmetic Surgery* that is necessary to repair damage caused by an accident if performed within two years of an accident.
- *Diabetes education* up to \$400 per calendar year for participation of you and your family in a diabetes instruction program.
- *Diagnostic Service* as ordered by a Physician to determine treatment of a medical or psychological diagnosis. Procedures may include X-rays, blood tests, MRIs, ultrasound, and other laboratory tests.
- *Dialysis Treatment*, which may include hemodialysis or peritoneal dialysis.
- *Doctors' or Physicians' services* may be provided either in or out of a Hospital and include surgical procedures and other Medical Care and treatment. For benefits to be payable, the individual must be legally qualified and acting within the scope of his or her license when services are performed.
- *Durable medical equipment* is covered under the Plan and includes equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use at home. Rental of durable medical equipment is only covered up to the purchase price of the same equipment.
- *Erectile dysfunction treatment*, provided the dysfunction is physical, not psychological, in nature. Surgeon's fee and device charges are covered the same as other Prosthetic Devices (see page 22).
- *Gardasil injections* for prevention of cervical cancer are covered under the Plan's wellness benefits, see page 24.
- *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 healthcare* following your Hospital stay, up to a maximum of 180 days per calendar year (combined with Skilled Nursing Facility Services) at a rate of \$1,000 per day. Covered expenses include care by a nurse (RN or LPN), evaluation and development of a plan of home care by a Registered Nurse (RN), Licensed Clinical Social Worker, Physical or Occupational Therapist, and medical supplies, drugs, and medications prescribed by your Physician to the extent they would be covered had you been hospitalized. Covered expenses do not include home health aid services. The program of care should be established by a public or private agency that:
 - Is properly licensed in the state in which the patient is receiving care and where it provides services or is certified under Medicare;
 - Provides therapeutic and Skilled Nursing Services;

When you need to see a Physician:

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

A Hospital must:

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

- Has its policies governing services set by a professional group;
- Provides for supervision of its services by a Physician or registered nurse;
- Provides mainly therapeutic and Skilled Nursing Services; and
- Maintains clerical records of all patients.

These expenses are combined with Skilled Nursing Facility expenses for a calendar year total benefit of 180 days at a maximum of \$1,000 per day.

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

Preparing for a Hospice Care period:

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

The following services are covered under the Hospice Care program, limited to \$1,000 per day:

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

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

- Home delivered meals;
- Food in liquid form for the purposes of feeding through a feeding tube to sustain life and prescription drugs, except as covered under the Plan's Prescription Drug Benefits;
- Homemaker or caretaker services and any services or supplies not solely related to the care of the patient, including sitter or companion services for the patient who is ill, house cleaning, and general maintenance of the patient's home;
- Transportation, including, but not limited to, Ambulance Service;
- Traditional medical services provided for the direct care of the terminal illness, disease, or condition;
- Funeral arrangements;

- Pastoral or bereavement counseling;
- Respite Care Services;
- Financial or legal counseling;
- 24-hour Private Duty Nursing Service fees; or
- Hospice Care that extends beyond a one-year period.

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

- *Hospital room and board and charges for services and supplies* include:
 - Charges for a semi-private room with general nursing services;
 - Charges for a private room if Medically Necessary (such as for contagious or communicable diseases);
 - Intensive care units;
 - Nursery charges for newborns;
 - Emergency room treatment; and
 - Charges made by the Hospital for services and supplies for care received while an Inpatient or Outpatient. These services and supplies do not include room and board, Physicians' fees, or specialized or Private Duty Nursing Service fees.
- *Infertility treatment* includes expenses relating to the diagnosis of infertility and attempts to cause pregnancy of you or your eligible Spouse only up to the limit listed on the *Schedule of Medical Benefits*. Treatment may include, but is not limited to, blood tests, medications, lab charges, testing, hormone therapy, artificial insemination, in vitro fertilization, and harvesting of eggs or semen from you or your eligible Spouse. Infertility benefits are not available for dependent children or to individuals who previously had elective sterilization.
- *Mammography*, annually covered by the wellness benefit for Eligible Members and Spouses. See page 24.
- *Mastectomy* related services, see reconstructive breast Surgery on page 22.
- *Mental health treatment (including nervous disorders)*, which is treated like other medical illnesses, is subject to the limitations listed on page 14. 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 a nationally recognized accredited agency;
 - Have full-time permanent bed care facilities for five or more resident patients;
 - Have the regular services of a Physician;
 - Provide 24 hour a day services by a licensed medical professional;
 - Perform mainly diagnostic and therapeutic Medical Care of patients;
 - Not be a nursing, convalescent, or rest home or residence for the aged; and
 - Be licensed to operate where it is located.
- *Midwife services* are covered for the delivery of a newborn child only when provided by a Certified Nurse Midwife (CNM). For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery.

Mental Health Disorders

A Mental Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health disorders include, among other things, autism, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.

- *Naprapath* services are covered only if given by a licensed Naprapath.
- *Nebulizers* for Eligible Members and eligible Spouses, which are paid at 100%, up to \$250, once every three years.
- *Nurse Practitioners (NP)/Physician Assistants (PA)* office services. A NP or PA is a health professional, qualified by academic and clinical training who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a qualified licensed Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plan does not cover NP or PA assistance during Surgery, but will pay for a Physicians services if the surgical procedure warrants assistance.
- *Nursery care for newborn dependents*, including Physician's charges for circumcision or medical treatment, if the newborn dependent is covered under the Plan.
- *Orthotics* are covered up to one pair per calendar year. Orthotics must be custom made or custom fit to qualify for reimbursement.
- *Occupational Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Physical Therapy* as ordered by prescription, by a Physician, to treat a specific covered condition.
- *Pre-admission tests* for Hospital confinement, including X-rays, laboratory examinations, tests, or analyses.
- *Pregnancy expenses* include Physician's fees, Hospital charges, tests, and home birth delivery by an M.D., prenatal office visits, anesthesia, tubal ligations, and other pregnancy-related conditions. For home deliveries, covered charges are limited to the Usual and Customary Charges for a normal delivery. You or your Spouse must be covered under the Plan at the time of delivery or at the time of other services for such services and supplies to be covered. The Plan covers charges for pregnancy in the same way it covers any other medical condition.
- *Prosthetic Devices* are covered only when ordered by a Physician and only for the standard models. Payment will be made up to an overall lifetime maximum benefit, which is \$150,000 per limb for Eligible Members, \$50,000 per limb for Spouses and children age 12 and older, and \$100,000 per limb for children under the age of 12. Payment for an initial or replacement device will be limited to a maximum of \$25,000, subject to the lifetime maximum benefit. Replacement devices are covered once every five years for adults and every two years for a child under the age of 16. Charges for Medically Necessary repairs, adjustments, or servicing of the device, due to changes in the covered person's physical condition, are covered subject to the lifetime maximum benefit. All charges are subject to the Plan's deductible and Coinsurance amounts.
- *Prosthetic bras*, which include the initial cost of up to three prosthetic bras following a mastectomy. Replacement bras 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 Plan in connection with a mastectomy and elect breast reconstruction, federal law requires coverage as determined by you and your Physician for:

Hospital Stays In Connection With Pregnancy

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

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

Prosthetic Device

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

- 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 deductibles and Coinsurance provisions applicable to other physical conditions covered under the Plan.

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

- *Second surgical opinion* includes services and supplies necessary to obtain the opinion.
- *Skilled Nursing Facility* services are covered based on Medical Necessity up to a maximum of 180 days per calendar year (combined with Home Healthcare Services) at a rate up to \$1,000 per day. A Skilled Nursing Facility provides Skilled Nursing Services 24 hours a day, 7 days a week, under the supervision of a registered nurse and may provide Outpatient rehabilitative services at least five days per week. The emphasis is on Skilled Nursing Services with restorative, Physical, Occupational, and other Therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an immediate care facility. The services provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge when Inpatient services are provided.
- *Social Worker*. The Plan covers specific services by a Licensed Clinical Social Worker; contact the Fund Office for more information.
- *Speech Therapy* provided by a licensed Speech Therapist under the supervision of a Physician for treatment of your dependent child from birth up to their fifth birthday. This benefit is provided in conjunction with, and as a supplement to, any state or federally mandated Speech Therapy program. When Claiming Speech Therapy benefits, proof of participation in a state or federally mandated Speech Therapy program must be provided. There is a \$10,000 per dependent lifetime limit for treatment of speech conditions resulting from standard developmental or learning disabilities or personality disorders.

An additional \$5,000 lifetime benefit is available for dependents from their fifth birthday up to their ninth birthday for special diagnoses listed below. Special diagnoses are limited to:

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

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

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

- *Sterilization procedures*. The Plan covers standard sterilization procedures, such as tubal ligation, hysterectomy, and vasectomy for the Member and Spouse only. Reversals of such procedures are not covered by the Plan.
- *Substance Abuse treatment*, which is treated like other medical illnesses, is subject to the limitations listed on page 14. The Plan's deductible and Coinsurance provisions do not apply to these expenses. To be covered, an Inpatient treatment center must:
 - Be nationally recognized by an accredited agency (such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Organization (OAOA), Healthcare Facilities Accreditation Program (HEAP), or Rehabilitation Accreditation Commission (CARF));

- Have full-time permanent bed care facilities for five or more resident patients;
 - Have the regular services of a Physician;
 - Provide 24 hour a day services by a licensed medical professional;
 - Perform mainly diagnostic and therapeutic Medical Care of patients or provide care and treatment for Substance Abuse;
 - Not be a nursing, convalescent, or rest home or residence for the aged; and
 - Be licensed to operate where it is located.
- *Suicide attempt.* Medical expenses relating to a suicide attempt are covered once per lifetime, up to \$10,000.
 - *Surgery.* If two or more procedures are performed through the same incision, it will be considered one operation and benefits will be payable for the most expensive procedure.
 - *Temporomandibular Joint (TMJ) Treatment.* The Plan covers injections and Surgery related to TMJ treatment when performed by a licensed Physician, Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD).
 - *Transplants.* The Plan provides organ and tissue transplant benefits. If you need information about organ and tissue transplants, you should contact the Fund Office at 708-562-0200 and ask to speak to the Nurse Consultant.
 - *Vision correction Surgery,* including corrective procedures such as LASIK Surgery, is covered by the Plan for Eligible Members and eligible Spouses up to one procedure per eye per lifetime. The Plan does not cover re-treatment warranties or enhancements. See page 37 for more information.
 - *Well care for dependent child's first two years of life* includes the routine Physician visits, immunizations, and tests up to \$1,800 per child during the first 24 months of life.
 - *Wellness benefits for dependent children over the age of 24 months* include routine child and adolescent immunizations and exams, including well child Physician exams up to \$600 per child per calendar year. The deductible and Coinsurance provisions do not apply to these expenses.
 - *Wellness benefits for Eligible Members and eligible Spouses* include blood chemistry profile, complete blood count, urinalysis, blood pressure analysis, electrocardiogram, colorectal screening, prostate (PSA blood test), pap test, Physician's exam, routine mammography, HIV testing, and other preventative exams as ordered by your Physician up to \$700 per person per calendar year.
 - *Wig,* one after Chemotherapy.

The Plan includes a LASIK network, QualSight. When you use a QualSight facility, the Plan pays 100% of LASIK Surgery costs, including Intralase. If you do not use a QualSight facility, the Plan will reimburse you for the maximum network amount for your particular Surgery. You are responsible for all costs above the maximum PPO allowance.

To find a QualSight facility, call 877-507-4448 or go to www.qualsight.us.

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

Smoking Cessation Benefit

The Plan includes a smoking cessation benefit for all Eligible Members and their Spouses. The Plan reimburses 100% of covered expenses, up to \$1,000 per person per lifetime. You do not need to meet any Plan deductibles before benefits are paid.

Covered medical expenses include:

- Prescription medications;
- Hypnosis; and
- Laser treatments, including Laser Concepts of Chicago.

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

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

Expenses Not Covered Under Medical Benefits

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

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

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

Exclusions

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

14. Infertility expenses beyond the Plan's specific maximum, medical expenses related to the services of a surrogate mother, harvesting of eggs or semen from a donor other than you or your covered Spouse, storage or freezing (Cryotherapy) of eggs or semen for you, your Spouse or a donor and any similar treatments. Infertility benefits are not available for dependent children.
15. Liposuction.
16. All medications, medical supplies, or medical equipment that may be purchased over the counter.
17. Baby formula and breast pumps.
18. Breast reduction surgery that is cosmetic in nature.
19. Expenses of an elective abortion, except when:
 - a. The mother's life is in danger; or
 - b. There are medical complications from an abortion procedure; or
 - c. The abortion is spontaneous.
20. Injuries, illnesses, or diseases you sustained while working and that are covered by any workers' compensation law, employer liability law, occupational disease law, or similar law.
21. Custodial Care, which includes services or supplies, regardless of where or by whom they are provided that:
 - a. A person without medical skills or background could provide or be trained to provide; or
 - b. Are provided mainly to help the patient with daily living activities including walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastrostomy feeding, cleaning, preparation of meal, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care treatment plan not reasonably expected to improve the patient's condition, illness, injury, or functional ability.
22. Maintenance or Developmental Care, which includes services or supplies, regardless of where or by whom they are provided, that are:
 - a. Provided to a patient who has not previously reached the level of development expected for the person's age in the following areas: intellectual, physical, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency;
 - b. Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or
 - c. Educational in nature.
23. Cosmetic surgery, except when it is performed to:
 - a. Correct injuries that occurred as the result of an accident within two years of the accident.
 - b. Repair defects that result from a Surgery for which the covered individual was paid benefits under the Plan within two years from the date of the Surgery that caused the defect.
24. Sex transformation Surgery or treatment.
25. Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures. These include services and treatments that are:
 - a. Not yet officially accepted by the medical community.
 - b. Not recognized as having proven beneficial outcomes to the patient.
 - c. Not yet approved by the Food and Drug Administration.

- d. Still primarily confined to a research setting.
 - e. Are not recommended for an advanced state of an illness or disease.
26. Charges incurred by organ donors that are not related to the original donor transplant procedure or complications that result from such surgeries, procedures, or treatment.
 27. Services provided by a government Hospital where governmental coverage is primary.
 28. Expenses excluded under coordination of benefits clauses.
 29. Expenses that may result from failure to use an HMO, PPO, or EPO Provider when covered under another plan that so requires.
 30. Charges for the reversal of previous elective sterilization, including the use of infertility benefits.
 31. Premarital examinations.
 32. Marriage counseling.
 33. Court mandated counseling or therapy.
 34. Chelation therapy.
 35. Physical Therapy, chiropractic treatment, or Occupational Therapy for developmental delays.
 36. Repairs to or replacement of durable medical equipment.
 37. Maintenance charges or batteries for durable medical equipment.
 38. Expenses for any items that are not corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment. This includes, but is not limited to, air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation including ambulance charges for patient convenience, pillows, mattresses, water beds, and air conditioners.
 39. Expenses for corrective appliances and durable medical equipment to the extent that they exceed the cost of standard models of such appliances or equipment.
 40. Hospital facility and Anesthesia Service charges for dental procedures, except coverage may be provided for dependent children age two and younger when documented evidence of uncooperative behavior and extensive dental work is provided. Hospital confinement for dental work performed on children older than two may be covered under the Plan if in compliance with the Claim Department guidelines (contact the Fund Office for more information).
 41. Massage therapy.
 42. Vision therapy, including orthoptic therapy.
 43. Sterilization procedures that are not standard.
 44. Assistant surgeon charges incurred and billed by Nurse Practitioners or Physician Assistants.
 45. Physical examinations required for employment purposes.
 46. Multiple charges for office visits by the same Physician on the same date. Only one visit per day is covered.
 47. Charges for treatment provided by a patient's family member.
 48. LASIK procedures performed on any child who is covered under the Plan and considered a dependent, as defined by the Plan (see page 5).

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits play an important role in your overall health. The Plan recognizes the importance of this coverage and provides you with prescription coverage through CVS/Caremark Inc., explained on page 1.

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

Schedule of Prescription Drug Benefits Under the Retail Program

The chart below highlights the Plan's Prescription Drug Benefits. Benefits are paid on a calendar year basis. *All covered expenses must be within the guidelines of Usual and Customary Charges.* Additional limitations apply for certain services. These limitations are explained later in this section.

Prescription Drug Benefits (CVS/Caremark Inc.)	Benefit Amount/Special Limits
Basic Prescription Drug Benefit	\$5,000 per person per calendar year (100% covered for eligible expenses)
Annual Deductible ¹	After the Plan pays the first \$5,000 of prescription drug expenses, you must pay: \$200 per person per calendar year \$400 per family per calendar year
Coinsurance ²	After you pay your annual deductible, the Plan pays 80% of eligible expenses for the remainder of the calendar year up to the lifetime maximum

¹ The Prescription Drug Benefit annual deductible is separate from the Medical Benefit annual deductible.

² If you do not go to a participating Pharmacy or you do not show your ID card when you pick up your prescription, you will pay 50% of the cost for your prescription medication. This amount does not count toward your basic Prescription Drug Benefit or your Prescription Drug Benefit annual deductible.

How Prescription Drug Benefits Work Under the Retail Program

- **Prescription drug card.** To receive the negotiated rates with participating CVS/Caremark Pharmacies, you must show your prescription drug ID card at the time you fill your prescription. If you do not use a participating Pharmacy or do not show your ID card, the Plan will only pay 50% of covered prescription drug expenses. In addition, the amount you pay will not count toward your Prescription Drug Benefit annual deductible or toward the basic Prescription Drug Benefit.
- **Basic Prescription Drug Benefits.** The Plan covers your eligible prescription drug expenses at 100% up to \$5,000 for you and each of your dependents each calendar year. The Plan will cover up to \$500 per calendar year of prescription contraceptives for you or your Spouse. You may have your prescriptions filled at any participating retail Pharmacy. To receive the maximum benefits available from the Plan, you must have your prescription filled at a participating Pharmacy and show your ID card.
- **Pay for your prescription when you pick it up and submit a receipt.** When you pick up your prescription, you must pay for your medication in full at the Pharmacy. To receive reimbursement from the Plan, you must submit your Pharmacy receipt to the Fund Office. A cash register receipt is not sufficient. The Fund Office requires a Pharmacy receipt that indicates the Pharmacy, drug name, national drug code, and total charges for your prescription. Your receipt will also indicate if you filled your prescription at a CVS/Caremark network Pharmacy.
- **Contact the Fund Office for early prescription drug refills.** Prescription drug refills are available from your Pharmacy every 30 or 90 days. If you need an early refill of your prescription because you are traveling or are on vacation, you should contact the Fund Office **before** ordering your refill. The Fund Office will contact you once your early refill is approved through CVS/Caremark.

Use Your Prescription Drug ID Card!

If you do not show your ID card when your prescription is filled or you do not use a participating Pharmacy, you are responsible for 50% of the cost of your prescription medication. This amount does not apply to your Prescription Drug Benefit annual deductible or toward your basic Prescription Drug Benefit, so always be sure you use a participating Pharmacy and have your ID card handy to present to your pharmacist when you have your prescription filled.

- **Deductible and Coinsurance.** Once your prescription drug expenses have reached \$5,000, you are responsible for an annual deductible of \$200 per person per calendar year or \$400 per family per calendar year. This deductible is separate and apart from the Medical Benefit annual deductible. After you have satisfied your Prescription Drug Benefit annual deductible, the Plan will cover 80% of any additional prescription drug charges (50% if you do not show your ID card when you have your prescription filled or you do not use a participating Pharmacy) for the remainder of the calendar year.

Using Generics

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

Use of Generics

While the use of generics is not required, you can make your basic \$5,000 Prescription Drug Benefits go a long way and help save the Fund some money by asking your Physician or pharmacist for a generic substitute if there is one available. The Food and Drug Administration tests the most commonly prescribed generic medications to ensure that their quality is high. So, the next time you or your family member needs a prescription, ask your Physician if there is a less expensive generic medication available.

Example: How Generics Can Save Money

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

	Generic	Brand Name
Cost of a one-month supply of medication	\$63	\$131
	<u>× 12</u>	<u>× 12</u>
Total yearly cost of medication	\$756	\$1,572

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

If Luke requests the generic, total yearly prescription costs for just this one medication could be \$816 less. Since the Fund pays the first \$5,000 of covered prescription drug costs, this could be a great source of savings for the Fund. However, if Luke were taking multiple medications, by using brand name medications he would reach the \$5,000 amount a lot quicker than if he chose generic medications.

Prescription Drug Covered Expenses

The Plan covers the following:

- Legend drugs that are not listed as exclusions.
- Insulin.
- Disposable insulin needles/syringes.
- Growth hormones, in specific cases only. Coverage does not include anti-aging treatments; contact the Fund Office for more information.
- Immunization agents, blood, or blood plasma.
- Compound medications in which at least one ingredient is a legend drug.
- Levonorgestrel (Norplant) for Eligible Member and Eligible Spouse only.

- Legend contraceptives for Eligible Member and eligible Spouse.
- Medications obtained in a foreign country. However, under these circumstances the Plan will reimburse only 50% of the cost of legend prescription medications that are prescribed by a Physician.
- Medications, like Viagra and similar oral medications, for a diagnosis of impotence, limited to 10 tablets per month for Eligible Member and eligible Spouse.
- Medications to treat attention deficit disorder and narcolepsy.
- Topical tretinoin, such as Retin-A (restricted to covered individuals age 26 and younger).
- Food in liquid form for purposes of feeding through a gastrointestinal tube to sustain life. This assumes that liquid food is not available as an “over the counter” food supplement in retail Pharmacies. Further, the food will be covered only with a prescription. With the exception of an illness where recovery is not expected, the feeding condition must be expected to improve, otherwise the care will be considered custodial after 12 months. Medical evidence from the patient’s Physician must be provided in writing for review by the Fund’s medical consultant.

Expenses Not Covered Under Prescription Drug Benefits

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

1. Anti-wrinkle agents, such as Renova.
2. Dermatologicals, hair growth stimulants.
3. Drugs that are considered Experimental or are determined by the Food and Drug Administration as lacking substantial evidence of effectiveness.
4. Drugs that require a prescription by state law, but not by federal law.
5. Fluoride supplements.
6. Infertility medications (however, infertility medications are covered under the Plan’s Medical Benefits for infertility, subject to those exclusions and limitations).
7. Non-legend drugs, except those specifically listed as covered.
8. Pigmenting/depigmenting agents.
9. Smoking deterrent or cessation drugs (including patches and Nicorette).
10. Vitamins/mineral supplements, except those prescribed as treatment for a diagnosed medical condition resulting from a covered illness or injury, legend pediatric multi-vitamins with fluoride, and pre-natal vitamins.
11. Drugs labeled “Caution–limited by federal law to investigational use” or Experimental drugs.
12. 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.
13. Medications to promote weight loss or suppress appetite.
14. Medications that can be purchased without a prescription.
15. Medications that are covered under any other portion of the Plan.
16. Expenses that result from not using a PPO or other prescription drug plan when coverage under another plan is primary to this Plan.

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

SPECIALTY DRUG PROGRAM

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

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

How the Specialty Drug Program Can Save You Money

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

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

Example: How the Special Drug Program Can Save You Money

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

	Specialty Drug Program	Retail Program
Annual Cost of Medication	\$18,000	\$18,000
Ken's Coinsurance	<u>\$1,000</u>	<u>\$2,600</u>
Plan Pays	\$17,000	\$15,400

Under the Specialty Drug Program, Ken's Coinsurance is 20% of the cost of the medication, with a maximum out-of-pocket expense of \$1,000 per calendar year. Under the retail program, the Plan pays 100% of the first \$5,000, and then Ken pays 20% of the cost of the medication for the of the calendar year.

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

Specialty Drug Program Advantages

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

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

Please note that infertility medications are not covered under the Specialty Drug Program. Contact the Fund Office for more information on infertility benefits offered to eligible participants in certain Plans.

Participation in the Specialty Drug Program is Mandatory

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

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

How to Enroll in the Specialty Drug Program

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

DENTAL BENEFITS

Schedule of Dental Benefits

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

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

Dental Benefits (Delta Dental)	Delta Dental PPO Preferred Dentist	Delta Dental Premier Dentist and Non-Delta Dental Providers
Non-Orthodontic Benefits Calendar Year Maximum	\$2,000 per person	\$2,000 per person
Basic Care (exams, X-rays, cleaning)	100% Covered	100% Covered ¹
Fillings	100% Covered	70% Covered ¹
Root Canals, Dental Surgery	100% Covered	70% Covered ¹
Dentures ²	You pay:	
Complete Upper	\$88; then the Plan pays 100%	50% Covered ¹
Complete Lower	\$88; then the Plan pays 100%	50% Covered ¹
Dental Implants	50% Covered	50% Covered
Orthodontic Benefits	You pay the first \$242.11; then Plan pays 100%	Plan pays 100%
Lifetime Maximum	\$3,757.89 per person	\$1,000 per person

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

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

Dental Covered Expenses

Dental Benefits help limit the amount you pay for covered dental care services. The Plan covers up to \$2,000 per person each calendar year for your eligible dental expenses. Coverage is provided through Delta Dental of Illinois, a Preferred Provider Organization (PPO).

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

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

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

- In Illinois: 630-964-2400 or 800-323-1743
- Outside Illinois: 800-331-0538

8:30 AM–5:00 PM
Monday–Friday

www.deltadentalil.com

You should always contact Delta Dental before seeking dental care. Delta Dental can help you select a network Dentist. There may be a difference in discounts under the Delta Dental program as Delta Dental has multiple networks, the Delta Dental PPO network and the Delta Dental Premier network. The Plan's benefits are greater if your Dentist is a *Delta Dental PPO* Dentist because these Dentists have agreed to accept the Delta Dental fee schedule as payment in full for certain services. Please note that a Delta Dental Premier Dentist is not a PPO Dentist. So check with your Dentist and with Delta Dental to determine the amount you will be responsible to pay for dental services.

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

- 100% of charges up to approved amounts, which are Usual and Customary Charges for services performed, for your basic care (exams, X-rays, and cleaning) received from a non-network Provider.
- 80% of bite guards for bruxism and TMJ only when obtained through a network Dentist, up to \$500 per appliance (including the cost of any repairs to the appliance). Replacement of a bite guard is limited to once every three years. The lifetime maximum for bite guard appliances is \$1,000.
- 70% of charges up to approved amounts for fillings, root canals, and dental Surgery.
- 50% of charges for dental implants.

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

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

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

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

Orthodontic Care

Orthodontic care is covered by the Plan up to a lifetime maximum. The lifetime maximum is higher when you use network Providers. The *Schedule of Dental Benefits* on page 33 of this section outlines orthodontic benefits and coverage limits.

ROUTINE VISION BENEFITS

To help you manage the cost of routine vision expenses, the Plan provides Vision Benefits for you and your family. Vision Benefits cover expenses such as eye exams, frames, lenses and contacts furnished by a qualified Optometrist or ophthalmologist. The dollar limits for these benefits is listed in the *Schedule of Routine Vision Benefits* below.

You may go to any Optometrist, eye specialty Physician (ophthalmologist), or optician for your examination and covered supplies. You and your vision care Provider must fill out a *Vision Claim Form* for Vision Benefits. If you choose to use a Provider that is not a participating Mid-America Vision facility, you must pay for the services in full and file the Claim with the Fund Office. Covered expenses will be reimbursed directly to you.

Separate Claim Forms

A separate *Vision Claim Form* is required for each family member for each visit. Contact the Fund Office for a form after you have made an appointment with a Mid-America Provider.

You will not receive a *Vision Claim Form* until you have filed your *Annual Claim Form* with the Fund Office. For more information on the Plan's *Annual Claim Form*, see page 50.

Schedule of Vision Benefits

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

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

Routine Vision Benefits (Mid-America Vision)	Benefit Amount/Special Limits
Eye exams (includes refraction, limited to one exam per calendar year)	
Standard Eye Exam	\$30 per person every calendar year; one visit per year
Contact Lens Exam ¹	\$95 per person every calendar year; one visit per year
Lenses ²	One pair per calendar year
Single vision	Up to \$26
Bifocal	Up to \$39
Trifocal	Up to \$55
No line Bifocal	Up to \$89
No line Trifocal	Up to \$105
Contact Lenses (for correction of vision)	Up to \$125
Contact Lenses (after cataract Surgery)	Up to \$175
Disposable Lenses ³	Up to \$250
Frames Maximum	\$75 per calendar year

¹ Contact lens exams are only covered if contact lenses are purchased during the same visit.

² If you go to a Mid-America Provider and select lenses from the network "collection," even if these lenses cost more than the limits specified above, you will not be charged any additional amount. Non-network Provider charges will only be reimbursed up to the limits specified.

³ Disposable lenses are covered up to a maximum amount of \$125 when received from a non-network Provider.

Vision Covered Expenses

As explained on page 2, the Board of Trustees has contracted with Mid-America Vision to provide you with Vision Benefits at discounted rates. When you use a Mid-America Vision facility, the dollar limits generally cover your services in full.

To find a network Provider, contact:

Mid-America Vision
888-760-1010
5:30 AM–3:30 PM

The following services may be covered in full when you use a Mid-America Vision facility:

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

Expenses Not Covered Under Routine Vision Benefits

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

1. More than one exam, one set of frames, or one pair of lenses per person per calendar year (except where Medically Necessary for a child who is younger than age 16).
2. Any charges or portion of charge(s) for services or supplies that are covered in whole or in part under any other portion of the Plan or under any other medical or vision benefits plan provided by an employer.
3. Any charge incurred when you do not use a PPO or other medical or vision plan with vision benefit coverage that is primary to this Plan.
4. Treatment that is solely for cosmetic purposes.
5. Treatment under another benefit provision of the Plan.
6. Treatment covered by workers' compensation benefits.
7. Eye exams required by an employer as a condition of employment.
8. Special procedures or supplies.
9. Visual analysis that does not include refraction.
10. Medical or surgical treatment of the eyes.
11. Non-prescription eyeglasses of any type.
12. Antireflective coating provided by a non-network Optometrist.
13. Claims for expenses that are submitted without a full, itemized receipt.
14. Any vision service not listed on the Schedule of Vision Benefits on page 35, including orthoptic therapy.
15. Scratch coating in conjunction with transition lenses.

VISION CORRECTION SURGERY

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

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

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

Eligible participants should contact QualSight at 877-507-4448. A QualSight Care Manager will register you and conduct a preliminary screening to ensure that you are a potential candidate for Surgery. The Care Manager will explain the Plan and network vision correction Surgery benefits available to eligible participants. The Care Manager will also discuss surgical procedures and answer your questions.

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

Vision Correction Benefits

The Plan pays for one vision correction procedure per eye, per lifetime, for Eligible Members (working laborers) and their eligible Spouses. Vision Correction Benefits are not available for dependent children.

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

Pre-operative exam, Surgery, and post-operative exams are covered at 100% if you are eligible for benefits and choose a preferred Provider in the QualSight network. You do not have to pay any out-of-pocket expenses relating to these specific procedures as QualSight bills the Plan directly for your Surgery.

Non-Network Benefits

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

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

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

	Network Provider	Non-Network Provider
Custom LASIK charges for right eye	\$1,300	\$2,100
Custom LASIK charges for left eye	<u>+ \$1,300</u>	<u>+ \$2,100</u>
Total charges	\$2,600	\$4,200
Plan pays	<u>- \$2,600</u>	<u>- \$2,600</u>
You pay	\$0	\$1,600

This example assumes that you are eligible, use a non-network Provider, and have no deductible or Coinsurance amounts due. Vision correction Surgery pricing varies significantly; your responsibility may be greater.

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

Contact QualSight at 877-507-4448 to find out more about vision correction Surgery and schedule a consultation and exam with a local Provider.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PROGRAM

Highlights

Eligibility

- If you are not self-employed, you will become eligible for the HRA Program on the same day you become eligible for the Plan.
- Your eligibility will continue as long as you remain eligible for the Plan, including periods when your eligibility is maintained through election of the COBRA Full Plan (but not the COBRA Core Plan).
- Your Spouse and dependents are also eligible to participate in the HRA Program as long as they meet the dependent eligibility requirements of the Plan (see page 5 for information on dependent eligibility).

HRA Account Funding

- \$500 will be credited to your HRA Account on the day you become eligible for the HRA Program. On January 1st of each subsequent year, if you are eligible for the HRA Program, an additional \$500 will be credited to your HRA Account.
 - Credits will be applied to the HRA Accounts of all Eligible Members, including Members who are active by virtue of electing the COBRA Full Plan (but not the COBRA Core Plan).
 - All Eligible Members will receive the same credit, regardless of whether they are single or have a family.
- Once the \$500 has been credited to your HRA Account, it is immediately available for use.
- Any unused balance in your HRA Account at the end of each year will roll over into the next year for future use. There is no limit on the amount that can be carried forward from year to year.
- Your HRA Account will not be credited with more than \$500 in a calendar year.

Using Your HRA Account

- **Save your HRA Account for retirement.** Because the balance in your Account rolls over from year to year, you can potentially accumulate a significant balance between now and when you retire. That balance can then be used to cover some of your healthcare expenses in retirement. Refer to the Retiree Medical Plan I Summary Plan Description for more information.
- **Pay for HRA eligible healthcare expenses.** HRA eligible healthcare expenses are reimbursed at 100%, with no deductible required, until you exhaust your HRA Account balance. Examples include:
 - Expenses not covered by the Plan or any other healthcare plan;
 - Premiums for other healthcare coverage or insurance;
 - Medicare premiums; and
 - Long-term care insurance premiums.
- **Make self-payments.** You can use the balance in your HRA Account to make self-payments for COBRA Continuation Coverage.

After you/your dependents are no longer eligible to participate in the HRA Program, you can continue to use your HRA Account for up to two years, or until the balance in the Account is zero.

How the Program Works

Health Reimbursement Arrangements (HRAs) are generally designed to enable individuals and their families to receive tax-free reimbursement for certain healthcare expenses that are not covered by their group healthcare plans.

HRAs can also be used like savings accounts, in that the balance can be rolled over from year to year to pay for future healthcare expenses, such as self-payment amounts during retirement.

General Overview

You will have an individual HRA Account that the Fund will set up and maintain on your behalf after you are eligible for coverage under the Plan. Your HRA Account will be credited with \$500 on the date you become eligible for the HRA Program, and on January 1st of each year if you are eligible to participate in the HRA Program on that date (note: your Account will be credited with \$500 only once in a calendar year). If a balance remains in your HRA Account at the end of a year, it rolls over into the next year, allowing you to use it for reimbursement of future expenses. There is no limit to the amount that can be carried forward from year to year.

As long as you are eligible to participate in the HRA Program, the balance in your HRA Account is available for you to use as you see fit. You can:

- Save the balance in the Account for your future healthcare needs;
- File Claims against the balance to pay for current healthcare expenses that the Fund has agreed to cover, including premiums you pay for other healthcare coverage or insurance, Medicare, and long-term care insurance (see page 51 for information on filing a Claim); or
- Make self-payments for COBRA Continuation Coverage, if you are eligible for and elect coverage.

After you are no longer eligible to participate in the HRA Program, your HRA Account will continue to roll forward and may be used for up to two years, or until the balance in the Account is zero.

In addition, your HRA Account balance is available to your surviving Spouse and dependent children in the event of your death, for up to two years, or until the balance in the Account is zero. The Account balance may only be used for the reimbursement of qualifying healthcare expenses and is not available in cash. Please see *In the Event of Your Death* on page 42 for more information.

Eligible Healthcare Expenses

Your HRA Account may only be used to pay for eligible healthcare expenses as defined by Sections 105 and 213(d) of the Internal Revenue Code (IRC) and by HRA rules. However, a range of expenses is eligible (see page 42 for more information).

Not all healthcare expenses can be reimbursed through the HRA Program. For example, reimbursements for expenses related to long-term care services and reimbursements for premiums paid through salary reduction contributions to an IRC Section 125 Plan are not allowed. In addition, reimbursements for deductibles and copayments for services received from non-network providers are limited to the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

HRA Program Administration

The Fund Office will administer the HRA Program. Once you are eligible to participate in the Program and an HRA Account is established in your name, the Fund Office will maintain records of your HRA Account balance by processing the annual credits and requests for reimbursement of eligible healthcare expenses.

If you choose to let your HRA Account balance build to cover your self-payments and/or healthcare expenses in the future, you don't have to do anything until you are ready to draw from the Account. If you choose to use your HRA Account balance to cover current healthcare expenses, including premium self-payments, you will file Claims for reimbursement of eligible expenses throughout the year (see page 51 for information on filing a Claim).

Tax Considerations

Contributions credited to your HRA Account are generally not taxable income when made or when paid out as benefits. However, certain actions may cause your HRA benefits to be taxable, such as if:

- You receive reimbursement from your HRA Account for contributions that are paid through salary reductions under an IRC Section 125 Plan;
- Reimbursements are made for individuals who are not “dependents,” as defined under IRC Section 152; and
- Cash payments are made to an individual for any reason other than as reimbursement of an eligible healthcare expense (for example, the HRA Account cannot be used to pay death benefits).

The HRA Program makes no guarantee that any amounts reimbursed to you, your Spouse, or your dependents under the Program will be excludable from your gross income for federal, state, or local income tax purposes. It is your responsibility to determine whether payments under the HRA Program are excludable, and to notify the Fund Office if you have any reason to believe that any such payment is not excludable.

If you submit an expense for reimbursement under the Plan's HRA Program, you cannot deduct that expense on your tax return.

Eligibility

You become eligible to participate in the HRA Program on the same day you become eligible for coverage under the Plan, unless you are self-employed.

Your eligibility to participate in the HRA Program is based on your continued eligibility for coverage under the Plan. Once you are eligible, your eligibility will continue.

If you do not work enough hours to continue eligibility for coverage under the Plan, and you elect COBRA Continuation Coverage under the COBRA Full Plan, your eligibility to participate in the HRA Program will continue. Your eligibility to continue in the HRA Program will not continue, however, if you elect the COBRA Core Plan.

Generally speaking, as long as you are eligible for coverage under the Plan, you are eligible to participate in the HRA Program.

Dependent Eligibility

As with any Plan coverage, your Spouse and/or your other dependents must meet the Plans' definition of eligible dependent for their healthcare expenses to be eligible for reimbursement. Any reimbursements you submit for your Spouse's and/or your dependents' healthcare expenses will be charged against your HRA Account.

Participation in the HRA Program will likely disqualify you or your Spouse from contributing to a Health Savings Account (HSA) if you or your Spouse participate in another plan that is considered a High Deductible Health Plan (HDHP). You should contact the Fund Office to request exclusion from the HRA Program if you desire to maintain your HSA eligibility.

Your Spouse will be ineligible for a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), due to coverage under your HRA.

When Eligibility Ends

When your eligibility for coverage under the Plan ends, your eligibility to participate in the HRA Program also ends. If you do not work enough hours to continue eligibility for coverage under the Plan, and you elect COBRA Continuation Coverage under the COBRA Core Plan, your eligibility to participate in the HRA Program will end.

If one of your dependents loses eligibility for coverage under the Plan, he/she also loses eligibility to participate in the HRA Program.

In the Event of Your Death

If you die while you are an active participant in the HRA Program and you have eligible dependents, your dependents will lose their eligibility to continue participating in the Program.

Applying for Benefits

You can submit Claims for reimbursement of eligible healthcare expenses at any time; however, Claims must be filed within one year of when the expense is incurred (see page 51 for information on filing a Claim).

Claims for reimbursement from your HRA Account must be filed within one year of when the expense is incurred. Contact the Fund Office and request the required Claims form.

EXAMPLE

Jamal has \$800 in his HRA Account on January 1, 2010. He can use his HRA Account to reimburse up to \$800 in eligible healthcare expenses incurred in 2010, and he has one year from the date of any service he receives to submit his HRA Request for Reimbursement Form. On December 31, 2010, any unused balance in his HRA Account will roll over into the 2011 calendar year.

You will only be reimbursed for eligible healthcare expenses up to the unused amount in your HRA Account during a given calendar year. You cannot apply for reimbursement of expenses in a subsequent year if the balance in your HRA Account was not sufficient to cover the expense in the year in which the expense was incurred.

You will only be reimbursed for eligible expenses up to the unused amount in your HRA Account.

EXAMPLE

Jamal incurs \$1,000 in eligible healthcare expenses in 2010. He can only be reimbursed up to the \$800 he had in his Account on January 1, 2010. He will not be able to submit the unreimbursed \$200 in 2011 after he receives another \$500 credit to his HRA Account on January 1, 2011.

While You Are Eligible to Participate

If you are eligible to participate in the HRA Program as an Eligible Member, you can use your HRA Account balance to pay for eligible healthcare expenses if you choose not to save the balance for your healthcare expenses in retirement.

If you continue your coverage under the Plan by electing the COBRA Full Plan, self-payments are required to maintain coverage. You may use the balance in your HRA Account toward these self-payments. In addition, you may also use your HRA Account balance to pay for eligible healthcare expenses as long as you continue to be eligible for coverage and a balance remains in your Account.

After Eligibility Ends

After your eligibility to participate in the HRA Program ends, the balance in your HRA Account will remain available for up to two years. You may continue to submit eligible healthcare expenses for reimbursement from your HRA Account until the earlier of the date the balance reaches zero or two years from the date eligibility ends.

If you have not been eligible to participate in the HRA Program for two years, any remaining balance in your HRA Account will be forfeited and cannot be reinstated. Any forfeited amounts revert to the Plan's general assets. In no event will forfeited amounts be paid in cash to any person.

In the Event of Your Death

Your HRA Account will continue to be available to provide reimbursement for your surviving dependents' eligible healthcare expenses in the event of your death. Your Spouse and/or dependents may use your HRA Account balance to pay for eligible healthcare expenses (including expenses you incurred before your death) or to make self-payments to continue coverage until the earliest of:

- When your HRA Account balance is zero;
- Two years after the date of your death; or
- When your dependent loses dependent status.

In no event will amounts be paid in cash to any person for other than reimbursement of an eligible healthcare expense. In other words, there are no lump-sum distributions of the HRA Account balance as a death or termination benefit.

While your surviving Spouse and/or dependents may continue to use your HRA Account as long as they are eligible for Plan coverage (including COBRA Continuation Coverage) and the Account balance is greater than zero, no further employer contributions will be made to the HRA Account on their behalf.

If you have no surviving Spouse and/or other eligible dependents at the time of your death, any balance in your HRA Account will be forfeited and become a part of the Plan's general assets.

EXAMPLE

If you died on August 31, 2011, your surviving dependents could use your HRA Account balance (until it is depleted) for the two-year period ending August 31, 2013, as long as they remain eligible for coverage.

Expenses Eligible for Reimbursement

You can use the balance in your HRA Account to pay for eligible healthcare expenses incurred by you, your Spouse, and/or your eligible dependents. Eligible healthcare expenses, as defined by the HRA Program, include (but are not limited to) all of the following:

- Self-payment contributions for COBRA Continuation Coverage, if you are eligible and elect coverage.
- Amounts you and/or your Spouse pay for other coverage (such as employer insurance, individual policy insurance, or Medicare, provided it is not paid with salary reduction contributions to an IRC Section 125 Plan).
- Long-term care insurance premiums.
- Healthcare expenses under the Plan, or any other healthcare plan, including:
 - Out-of-pocket costs, such as deductibles, copayments, and coinsurance; and
 - Expenses not covered, or only partially covered.

Your HRA Account may only be used to pay for eligible healthcare expenses incurred by you and your eligible family members. However, a range of expenses is eligible.

Healthcare expenses may include medical, prescription drug, dental, and vision expenses.

See page 51 for information on filing a Claim.

EXAMPLE

The Chicago Laborers' Dental Plan only covers 50% of the charges for dental implants. Under the HRA Program, you will be able to apply for reimbursement of some or all of the unpaid portion, depending on the balance in your HRA Account.

In general, healthcare expenses eligible for reimbursement only include those that are:

- Incurred for services or supplies provided to you or your eligible dependents under the Plan;
- For services or supplies provided on or after the date your HRA Account became effective;
- Not reimbursed by any other health plan, insurance, or other source or entity;
- Not taken (and will not be taken) as a tax deduction by you, your Spouse, and/or your dependents; and
- Not made through salary reduction contributions under the terms of an IRC Section 125 Plan (if for premium contributions).

Only healthcare expenses that are permitted under the terms of Sections 105 and 213(d) of the Internal Revenue Code (IRC) are eligible for reimbursement from your HRA Account. Please note that federal and state tax regulations are subject to change.

An eligible healthcare expense is defined as an expense incurred by you and/or your dependents for medical care, as defined in IRC Sections 105 and 213(d). For more detailed information on eligible healthcare expenses, please refer to IRS Publication 502 entitled, "Medical and Dental Expenses," Catalog Number 15002Q. It is available on the internet at www.irs.gov/pub/irs-pdf/p502.pdf.

Even if an expense is a medical expense applicable under IRC Sections 105 and 213(d), or listed in IRS Publication 502, it may not necessarily qualify as an eligible healthcare expense under the HRA Program.

For instance, the HRA Program cannot reimburse long-term care expenses or premiums paid through salary reduction contributions to an IRC Section 125 Plan. As another difference, IRS Publication 502 states that nonprescription drugs are ineligible. However, you may be reimbursed for expenses for over-the-counter drugs and medical supplies under the HRA Program so long as they are for the diagnosis or treatment of a medical condition and not only for your general well being. Finally, the HRA Program has the right to limit or deny reimbursements for certain expenses even though they may be allowed under federal law. For example, reimbursements for deductibles and copayments for services received from non-network providers are limited to the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

If you have any questions about whether an expense is eligible for reimbursement, contact the Fund Office.

Healthcare expenses do not include reimbursements for expenses related to long-term care services or for premiums paid through salary reduction contributions to an IRC Section 125 Plan.

Expenses Not Eligible for Reimbursement

Expenses that are not eligible for reimbursement from your HRA Account (as defined by IRC Sections 105 and 213(d)) include, but are not limited to:

- Automobile insurance premiums
- Bottled water
- Cosmetic surgery and procedures
- Cosmetics, toiletries, toothpaste, etc.
- Custodial care

- Diaper service or diapers
- Domestic help
- Funeral, cremation, or burial expenses
- Health programs offered by resort hotels, health clubs, and gyms
- Home or automobile improvements
- Long-term care services
- Marijuana and other controlled substances that are considered illegal
- Massage therapy (unless prescribed)
- Maternity clothes
- Nursing services to care for a healthy newborn at home
- Special schools for children
- Social activities
- Transportation expenses
- Uniforms or special clothing
- Vitamins and food supplements

In addition to the above list of IRS-excluded expenses, deductibles and copayments for services received from non-network providers are not eligible for reimbursement from your HRA Account to the extent they exceed the amounts that would be reimbursable from your HRA Account if you had gone to an in-network provider.

IN THE EVENT OF DISABILITY OR DEATH

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

Schedule of Disability and Death Benefits

The chart below highlights the Plan's disability and death benefits. Additional limitations may apply as explained later in this section.

Weekly Income Benefit	Eligible Member Only
Weekly Income Benefit Maximum Non-Occupational Injury or Illness Occupational Injury or Illness	\$450 per week \$25 per week
Benefits Begin	On the first day you are unable to work due to an injury; On the eighth day after you are unable to work due to an illness; or On the eighth day after your Physician's first treatment for an illness
Weekly Income Benefit Maximum Period	26 weeks
Extended Weekly Income Benefit (Non-Occupational Only)	Up to 26 additional weeks per person per lifetime (certain restrictions apply)

Death Benefits	Benefit Amount
Your Death	\$50,000 (payable to your beneficiary)
Death of Your Spouse or Child (6 months old or older)	\$10,000 (payable to you)
Death of Your Child (less than 6 months old)	\$200 (payable to you)

Accidental Dismemberment Benefits	Eligible Member	Dependent
For one hand, one foot, or sight of one eye	\$11,000	\$3,750
For one hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	\$22,000	\$7,500
For both hands, both feet, or sight in both eyes	\$22,000	\$7,500

Weekly Income Benefits (Eligible Members Only)

The Plan provides a Weekly Income Benefit, also called loss of time benefits, if you cannot work in your own occupation due to an injury or illness, whether it is work-related or not. Your period of disability must be certified by your Physician. Your Physician must specify the weight restrictions when completing the form.

You are eligible for Weekly Income Benefits if:

- You are covered by the Plan at the time the injury or illness occurs and on the day your period of disability begins;
- You are under the care of a Physician;

If your disability is a result of an accident, you are required to complete a *Participant Loss of Time Accident Claim Form*. You, your Employer, and your Physician must complete the form in full. In addition, you may be required to complete *Subrogation Forms*. The Weekly Income Benefit will not be paid until the *Participant Loss of Time Accident Claim Form* and *Subrogation Forms* are returned to the Fund Office (see page 60 for more information on subrogation).

- The injury or illness is not self-inflicted; and
- You do not receive benefits from the Laborers' Pension Fund or the Laborers' International Union of North America (LIUNA) Pension Fund.

Weekly Income Benefits begin when the Fund Office receives proof of your disability. Partial weeks of disability will be paid at a daily rate of one-seventh of the weekly amount (listed below) provided you are receiving workers' compensation disability benefits. Benefits, which are payable for a maximum of 26 weeks, are:

If You Are Unable to Work Due to:	Weekly Benefit Amount
Non-occupational accident or illness	\$450
Occupational accident	\$25

You must apply for the Extended Weekly Income Benefit before your Weekly Income Benefits would otherwise end.

You are encouraged to begin the application process for the Extended Weekly Income Benefit a minimum of two months before your initial Weekly Income Benefits end. If you are eligible for an extension of benefits beyond 26 weeks, starting the application process early may mean that you will not experience a delay in weekly benefit payments.

Weekly Income Benefits generally begin on the first day of your disability that is due to an accident. If your disability is due to illness, benefits begin on the eighth day after the first day you are unable to work or the eighth day after your Physician first treats you for the illness. Occupational and non-occupational (explained below) Weekly Income Benefits may also be paid if you are released for light duty with weight restrictions up to 50 pounds.

Extended Weekly Income Benefit

Under certain circumstances, the Plan allows you to extend your Weekly Income Benefits for up to an additional 26 weeks. You are eligible for this extension if you meet all of the following:

- Your disability is due to a non-occupational accident or illness; **and**
- You were an active Eligible Member when the disability began and for at least five years before the disability began, including the six consecutive month period immediately before your disability began; **and**
- After 26 weeks of Total Disability and coverage under the Weekly Income Benefit, you continue to be Totally Disabled and unable to perform your normal work as a laborer (or if you are employed in a position other than a laborer, the type of work you normally perform).

You must apply for the Extended Weekly Income Benefit before your Weekly Income Benefits would otherwise end.

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

Example: How the Extended Weekly Income Benefit Works

After 10 consecutive years of employment covered under the Plan, John becomes disabled due to a non-occupational accident. John is eligible for up to 26 weeks of Weekly Income Benefits. After 26 continuous weeks of disability, John is not able to return to work and is eligible for the Extended Weekly Income Benefit for up to 26 additional weeks. After 52 weeks of continuous disability, John is able to return to work.

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

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

If your Total Disability prevents you from returning to gainful employment, you may be eligible for disability pension benefits from the Laborers' Pension Fund. Once benefits begin under the Pension Fund, the Extended Weekly Income Benefit will end as of the first day of the month in which the disability pension benefits begin. However, since disability benefits under the Pension Fund may not begin right away, you must sign an agreement to reimburse the Plan in the event benefits are later paid retroactively by the Laborers' Pension Fund. The amount of the reimbursement is based on the amount of benefits paid by the Pension Fund. If the Pension Fund disability benefits are less than the Weekly Income Benefit amount, you will only need to reimburse the amount you are paid by the Pension Fund.

Totally Disabled

Due to a disabling condition that is non-occupational, you are (and continue to be) totally disabled from performing the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement. If you are employed in a position that does not require work as a laborer, you must be disabled from performing the work that you are normally assigned.

Extension of Benefits in Event of Total Disability

If you become Totally Disabled and you remain disabled until you receive these Plan benefits, your benefits may be extended after your coverage would otherwise end. Once your coverage under the Plan ends due to a reduction of hours or termination of covered employment, you will be offered COBRA Continuation Coverage (see page 8). If you elect COBRA Continuation Coverage, you *and* your dependents may receive coverage under the Plan. If you do not elect COBRA Continuation Coverage, you will receive these extended benefits that relate to medical expenses for your disability only. Your dependents will not be covered. If you elect COBRA Continuation Coverage, you are not entitled to any extension of Medical Benefits under this Plan provision.

Eligible Medical Benefits include:

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

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

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

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

Death Benefits

In the event of:

- Your death, your beneficiary will receive a Death Benefit of \$50,000.
- Your Spouse or dependent child's (age six months or older) death, you will receive a Death Benefit of \$10,000.
- Your dependent child's (less than age six months) death, you will receive a Death Benefit of \$200.

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

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

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

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

Your beneficiary may direct the Welfare Fund to assign benefits, up to \$10,000 of the Death Benefit, to be paid to the person who assumes responsibility for funeral expenses or to the funeral home directly.

Death Benefits Exclusions and Limitations

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

Extension of Death Benefits in Event of Total Disability

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

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

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

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

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

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

- You were eligible for benefits under the Plan through hours worked in covered employment at the time of your disability;
- Your death was within 12 months from the day your coverage under the Plan ended; and
- The Fund Office receives proof that your Total Disability was uninterrupted from the date your coverage under the Plan ended until the date of your death.

You must notify the Fund Office of your Total Disability no later than 12 months from the initial date of your Total Disability. The Fund Office will provide you with an *Application for Total Disability 3-Year Extension of Death Benefit Form* and an *Estimated Functional Capacities Form* to be completed by you and your Physician. If you are collecting Weekly Income Benefits as a result of this disability, the Fund Office will send you the forms following 26 weeks of Weekly Income Benefit payments. In addition to the completed forms, you must supply pertinent medical records supporting your Total Disability.

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

If the Fund Office determines that you are Totally Disabled in accordance with the Plan's definition of Totally Disabled, your Death Benefit will be extended for three years, beginning on the date you lose coverage under the Plan due to a reduction in hours required to maintain coverage, see page 3. (Election of COBRA Continuation Coverage will not delay the three-year extension of Death Benefits). To continue the extension of coverage, you must provide the Fund Office with proof of your continued Total Disability once a year. The Fund Office will notify you when the information is due. This coverage will end on the earlier of:

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

Accidental Dismemberment Benefits

Accidental Dismemberment Benefits are available if you or any of your eligible dependents suffers the loss of limbs or eyesight due to an accident. For the Accidental Dismemberment Benefit, your eligible dependents are your Spouse and any children age six months or older. Your dependents must meet the Plan's definition of dependent, as outlined on page 5.

Type of Loss	Your Benefit	Your Dependent's Benefit
Loss of both hands, both feet, or sight in both eyes	\$22,000	\$7,500
Loss of one hand and one foot, one hand and sight in one eye, or one foot and sight in one eye	\$22,000	\$7,500
Loss of one hand, one foot, or sight in one eye	\$11,000	\$3,750

Accidental Dismemberment Benefits Exclusions and Limitations

The Plan does not cover losses that:

1. Are not permanent.
2. Occur before coverage under any Chicago Laborers' Welfare Fund Plan.
3. Result from self-inflicted injury, illness, suicide, or suicide attempt.
4. Occur while committing a felony.

CLAIM AND APPEAL INFORMATION

Annual Claim Form

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

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

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

Filing Claims

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

Be sure that each bill indicates the name of the patient, name of the participant, and participant's Social Security Number or 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 appropriate ICD-9 code (diagnosis) and specific services provided, as defined by the appropriate CPT, HCPC, NDC, or other nationally recognized codes, including the expense charged for each service.

The Fund Office does not accept handwritten bills.

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

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

The Fund will pay Claims only when covered under the terms of the Plan provisions under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from

An *Annual Claim Form* is required by the Fund Office each year before benefits are payable to update general information on you, your dependents, and other medical insurance coverage you may have.

In addition, you may be asked to complete a separate *Accident Claim Form* if your medical Claims provide a diagnosis that the Fund Office suspects may be an injury due to an accident (e.g., automobile accident).

Submit:

- **Medical and professional Claims.** Your Provider must file Claims directly with their local BCBS plan.
- **Dental Claims to:**
Delta Dental of Illinois
P.O. Box 5402
801 Ogden Avenue
Lisle, IL 60532
- **All other Claims to:**
Laborers' Welfare Fund
Claim Department
11465 W. Cermak Road
Westchester, IL 60154

you, your eligible dependents, or any other entity or organization that was required to make the payment or that received an erroneous payment. Recovery of such erroneous payments may be made through, but is not limited to, an offset or reduction of any future benefits you or your eligible dependents may be entitled to receive from the Fund (see page 60 for more information).

Claim Types

There are three basic types of Claims under the Plan:

- **Healthcare Claims**, which include medical, prescription drug, dental, and vision Claims;
- **Disability Claims**, which include Weekly Income and Extended Weekly Income Benefits; and
- **Other benefit Claims**, which include Death Benefits and Accidental Dismemberment Benefits.

HRA Procedures

You may submit eligible healthcare expenses for reimbursement at any time. The amount reimbursed for any eligible healthcare expense will not exceed your HRA balance at the time reimbursement is requested. Reimbursement is paid directly to you; you are responsible for paying any providers.

To receive reimbursement for Plan deductibles and coinsurance amounts, you must file a Claim. The Fund Office will not automatically apply the balance in your HRA Account to those expenses.

To receive reimbursement for eligible healthcare expenses, you must submit a properly completed HRA Request for Reimbursement Form, with the required supporting documentation, in accordance with the Plan's Claim procedures. The HRA Request for Reimbursement Form can be obtained from the Fund Office. The form will include a statement that you must sign verifying that:

- The eligible expenses were incurred for services or supplies provided to you or your eligible dependents under the Plan;
- The eligible expenses were for services or supplies provided on or after the date your HRA Account became effective;
- You have not been, and will not be, reimbursed for these expenses by any other health plan, insurance, or other source or entity;
- You have not deducted, and will not deduct, any of the expenses reimbursed through the HRA Program on your individual income tax return; and
- Premiums submitted for reimbursement were not made through salary reduction contributions under the terms of an IRC Section 125 Plan.

Along with the form, you must provide any of the following, as applicable:

- An itemized bill from the service provider that includes the name of the person incurring the charges, date of service, description of services, name of provider, and amount of charge.
- An Explanation of Benefits (EOB) when requesting reimbursement of the balance of charges for which coverage is available from either this Plan or another plan, plus original receipts verifying payment. Only eligible expenses that have not been reimbursed, as shown on the EOB, will be eligible for reimbursement.
- Proof of the amount, the name of the covered person, date paid, and coverage period when requesting reimbursement for other insurance premiums, such as a Spouse's group health coverage premiums, and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.

You must file a written Claim for reimbursement with the Fund Office as soon as possible. If your Claim is not filed within 12 months of the date the expense is incurred, your Claim will be denied.

- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- A receipt on which the name of the product has been imprinted by a cash register for over-the-counter medicines and medical supplies. Unreasonable quantities of such items cannot be reimbursed under IRS rules.
- Any additional documentation requested by the Plan.

HRA Claims will be handled in the same manner as all other healthcare Claims.

Benefit Pre-Certification

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

Benefit Claims

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

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

What is NOT a Claim

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

- A cash register receipt;
- An Explanation of Benefits (EOB) form from another plan;
- Handwritten bills (invoices) or handwritten statements of services;
- A balance due statement;

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

What is a Claim?

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

- An inquiry from a participant, Physician, care Provider, other insurance carrier, participant's authorized representative, Hospital, or facility regarding:
 - Plan coverage (e.g., a question about whether the Plan covers Diagnostic Service);
 - Plan benefit amounts (e.g., a question as to whether the Plan would pay 100% of Surgery costs if the Surgery was tomorrow);
 - Plan eligibility (e.g., if you are scheduled for Physical Therapy at a facility twice a week and your Physician calls to ask if you are eligible for benefits); or
 - Consideration of additional payment on a Claim.

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

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

- Calling 708-562-0200;
- Writing to Chicago Laborers' Welfare Fund, 11465 W. Cermak Road, Westchester, IL 60154; or
- E-mail at Claims@chilpwf.com.

Claim Filing Procedures

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

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

Claim Processing Deadlines

The deadlines for processing Claims vary, as follows:

- **Initial Determination.** An initial determination regarding payment or denial of a Claim will be made for:
 - *Healthcare Claims*, within 30 days of receipt of the Claim.
 - *Disability Claims*, within 45 days of receipt of the Claim.
 - *Other benefit Claims*, within 90 days of receipt of the Claim.
- **Extension of Initial Determination Period.** In some instances, an extension of the initial determination period may be requested due to matters beyond the Plan's control. If an extension is necessary, you will be notified. The notice will include the special circumstances requiring the extension and the date the Plan expects to render a decision. You (or the Claimant) will be notified, for:
 - *Healthcare Claims*, within the 30-day initial determination period that one 15-day extension is necessary.
 - *Disability Claims*, within the 45-day initial determination period that up to an additional 60 days maximum is necessary. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.
 - *Other benefit Claims*, within the 90-day initial determination period that up to an additional 90 days may be necessary. The extension cannot be more than 90 days from the end of the initial 90-day period, or 180 days total.

Who Is a Claimant?

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

- **Additional Information Needed to Process a Claim.** In some instances the Plan may need additional information or required information that was not originally provided to process a Claim. If such information is needed, you (or the Claimant) will be notified, for:
 - *Healthcare Claims*, within the 30-day initial determination period of the information needed. You (or your Provider if your Provider is notified) have up to 45 days to provide the requested information. If the Fund Office receives the requested information in the 45-day period, the Claim will be processed within 15 days following the receipt of the additional information.
 - *Disability Claims*, within the 45-day initial determination period of the information needed. You have up to 45 days to provide the requested information.
 - *Other benefit Claims*, within the 90-day initial determination period of the information needed. The 90-day extension of initial determination period listed above includes any time needed by the Plan to obtain this information.

Claim Denial

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

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

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.

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

Claim Appeal

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

Send your written Appeal to:

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

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

- Your Appeal must be submitted in writing within the applicable timeframe.
- Your Appeal must state the reasons you disagree with the Claim determination.

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

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

Appeal Review

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

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

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

- *Healthcare Claims*, will generally be made within 30 days of receipt of the Appeal and the written decision will be mailed to your last known address no later than 60 days after your Appeal is received.
- *Disability Claims*, will generally be made within 45 days of receipt of the Appeal. If special circumstances require an extension of time, you will be notified within the 45-day Appeal determination period that up to an additional 45 days (no more than 90 days total from receipt of the Appeal) may be necessary. The written decision will be mailed to your last known address within five days after the decision is made.
- *Other benefit Claims*, will generally be made within 60 days of receipt of the Appeal. If an extension is necessary, the Claimant will be notified within the 60-day Appeal determination period that up to an additional 60 days (no more than 120 days total from receipt of the Appeal) may be necessary. The written decision will be mailed to the Claimant's last known address no later than 60 days (or 120 days if an extension is necessary) after receipt of the Appeal.

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

If an extension is needed, you will be notified, in writing. The written notice will include the reason why an extension is needed as well as the date by when a decision will be made.

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

Payment in Event of Incompetency

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

Rights to Information

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

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

Discretionary Authority

The Trustees have full discretionary authority to:

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

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

Coordination of Benefits

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

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

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

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

“Another plan” means any:

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

“Another plan” does not mean any:

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

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

Order of Payment

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

The following rules determine the order of payment:

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

A plan that covers you or your dependents as active employees pays benefits before a plan covering you or your dependents as retired or laid off employees.

If a dependent child is covered under more than one plan, the following rules determine the order of payment:

- If the parents are *not divorced or separated*:
 - The plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule);
 - If the parents have the same birthday, then the plan covering the parent for the longest time is primary;
 - 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;

Medicaid

The Plan honors any Medicaid assignment of rights made on your behalf.

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

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

- Where there is no court decree, or the decree does not establish who has responsibility for medical expenses or such responsibility is shared equally between the parents, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year is primary (the birthday rule);
- Where there is no court decree and the parents have the same birthday, then benefits are coordinated in the following order:
 - » The plan of the parent with custody; then
 - » The plan of the custodial stepparent, if remarried; then
 - » The plan of the non-custodial parent.

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

Exclusions from Coverage and Coordination of Benefits with Other Healthcare Plans

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

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

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

Benefits will be coordinated as follows:

- If a plan's fee-for-service option is primary (pays first), it will pay its regular benefits.
- If it is secondary (pays after another plan covering the person), it will pay a reduced benefit that, when added to the benefit paid by the other plan, will not exceed the highest amount allowed among two plans for services rendered.
- If an employer of a participant's dependent has one or more other plans that would be primary under this Plan's rules or the model COB regulations of the Association of Insurance Commissioners, and any such other plan contains a provision denying or capping benefits for the participant's dependents (having the effect of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of coordination of benefit rules), the Plan will not be liable to provide benefits until and unless the other plan(s) provides the customary benefits of a primary plan as determined without regard to such exclusion or cap.

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

If Your Dependent Has Employer-Sponsored Coverage

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

Medicare

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

Coordination of Benefits with Medicare

If you or your eligible dependents are eligible for Medicare, the Active Plan 1 coordinates benefits with your Medicare benefits. Covered Services include your Medicare Part A and B deductibles and copayments. The Plan pays for Covered Services after Medicare pays benefits.

Medicare is a multi-part program:

- **Medicare Part A.** Officially called “Hospital Insurance Benefits for the Aged and Disabled,” Medicare Part A primarily covers Hospital benefits, although it also provides other benefits.
- **Medicare Part B.** Officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled,” Medicare Part B primarily covers Physician’s services, although it also covers a number of other items and services.
- **Medicare Part C.** Called Medicare Advantage, Medicare Part C is the managed care portion of Medicare; specific choices depend on where you live. If you are covered by an HMO, the Plan will presume that you have complied with the HMO rules necessary for your expenses to be covered by the HMO.
- **Medicare Part D.** Called “Medicare Prescription Drug Coverage,” Medicare Part D is Medicare’s prescription drug coverage that is offered through private companies to all Medicare-eligible individuals.

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

The Plan is primary while you are actively working, even if you are over age 65. The Plan is secondary when you are not actively working. Since the Fund treats you as having enrolled in both Medicare Part A and B when you are first eligible for this coverage, if you do not obtain Medicare Part B coverage for the month you are first eligible and Medicare is primary, you will not receive benefits from the Fund that would have been paid by Medicare.

While, in general, you are not required to file an application for enrollment in Medicare Part A, you are required to file an application for enrollment in Medicare Part B. To be entitled to receive Medicare Part B benefits in the month in which you first become eligible, you must file an application for Part B in the three-month period before the month in which you first become eligible. For example, if you turn age 65 on April 15, you must file your Part B application during the preceding January, February, or March to become entitled to receive Part B benefits on April 1. If you file your application in April, you would not be entitled to receive Part B benefits until May 1 and you will be responsible for the payment of medical expenses incurred during April that Medicare Part B would have paid had you enrolled. After you have enrolled in Medicare Part B, you must provide the Fund Office with proof of your eligibility.

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

As an active Eligible Member or the dependent of an active Eligible Member, as long as the Plan provides creditable prescription drug coverage, which means it is expected to pay out as much as standard Medicare Prescription Drug Coverage, you do not need to enroll for Medicare Prescription Drug Coverage. However, if you are eligible and choose to enroll, your prescription drug coverage will be coordinated with Medicare.

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

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

Subrogation and Reimbursement

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

Subrogation

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

Definitions

Throughout this section, these words have the following meaning:

- **You.** All Plan participants, including eligible dependents.
- **Third Party.** Any person, corporation, government, or insurance coverage, including underinsured, uninsured, and medpay provisions, and workers' compensation coverage.
- **Benefits.** All payments related to the injury or illness, including, but not limited to, medical expenses and income replacement or lost time benefits.
- **Recovery.** Any and all payments from another source as a result of an injury or illness, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless of whether any amount is specifically included or excluded as medical expenses.

Fund's Rights

The Fund has the following rights:

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

Your Responsibilities

You have certain responsibilities, as follows:

- You must comply with all Claim and records procedures and cooperate fully with the Fund in the recovery of the benefits paid by the Fund and the Fund's exercise of its reimbursement and subrogation rights.
- You will be required to complete and submit an *Accident Claim Form, Statement of Injured Party Form,*

Subrogation and Reimbursement Agreement, and perhaps other documents. The Agreement must also be reviewed and signed by your attorney, confirming your and your attorney's understanding that the Fund is entitled to reimbursement.

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

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

Procedures

You must immediately notify the Fund Office whenever you make a Claim against a third party. If you do not meet this responsibility, the Fund may withhold payment of benefits. You are also responsible for compliance by your agents and attorneys with these procedures. If you receive payment from a third party, you or your attorney must hold that money separately from other assets until the Fund's rights have been satisfied. The Fund has a Claim, lien, or constructive trust on that money and it must remain segregated and under your control. Once the Fund's reimbursement rights have been determined, you must make immediate payment to the Fund out of the recovery proceeds. If you do not pursue a Claim against the third party, and the Fund, at its discretion, elects to do so, you must allow the Fund to assert the Claim in your name or on your behalf in the Fund's name and cooperate with the Fund's prosecution of the Claim.

Noncompliance

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

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

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

Conclusion of Claim

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

PRIVACY POLICY

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

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

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your rights to privacy with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and with the Secretary of the Department of Health and Human Services (HHS); and
- The person or office you should contact for further information about the Fund's privacy practices.

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act (HIPAA). You may find these rules at *45 Code of Federal Regulations* Parts 160 and 164. This Privacy Policy attempts to summarize these regulations. The regulations will supersede any conflicting provisions contained here if there is any discrepancy between the information here and the regulations.

Your Protected Health Information

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

When the Fund May Disclose PHI

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

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

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

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

PHI refers to your health information maintained by the Fund.

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

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

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

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

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

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

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

When Disclosure of PHI Requires Written Authorization

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

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

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

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

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

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

When Use or Disclosure of PHI Does Not Require Authorization

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

Psychotherapy Notes

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

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

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

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

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

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

Other Uses or Disclosures

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

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

Individual Privacy Rights

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

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

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

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

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

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

Right to Inspect and Copy PHI

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

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

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

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

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

Right to Amend PHI

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

The Fund has 60 days after receiving your written request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your written request

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

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

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

in whole or part, the Fund will provide you with a written denial that explains the basis for the decision. You or your Personal Representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

Your written request to amend PHI should be sent to:

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

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

Right to Receive an Accounting of Funds PHI Disclosures

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

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

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

Right to Receive a Paper Copy of Funds Privacy Notice

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

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

Personal Representative

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

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

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

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

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

Fund's Duties

Maintaining Your Privacy

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

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

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

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

Disclosing Only the Minimum Necessary PHI

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

However, the minimum necessary standard will not apply to:

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

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

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

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

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

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

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

Right to File a Complaint with the Fund or HHS Secretary

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

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

You may also file a complaint with:

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

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

If You Need More Information

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

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

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

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

PLAN ADMINISTRATIVE INFORMATION

Fund Name

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

Summary Plan Description

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

Plan Sponsor and Plan Administrator

A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for Employer contributions, answer participant inquiries, process Claims and benefit payments, and handle other routine administrative functions. The Administrator contracts with various providers for services, as indicated on page 1. The Fund's Certified Public Accountant prepares required government reports.

Trustee

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

Board of Trustees

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

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

The Trustees of the Plan are:

Union Trustees	Employer Trustees
James P. Connolly Chicago District Council of Laborers 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527	Alan Esche Esche & Lee 306 W. Campus Drive Arlington Heights, IL 60004
Martin T. Flanagan Laborers' Local Union No. 118 2430 E. Rand Road Arlington Heights, IL 60004	Charles J. Gallagher Gallagher Asphalt Paving Co. 18100 S. Indiana Avenue Thornton, IL 60476
Richard Kuczowski Laborers' Local Union No. 2 8842 W. Ogden Avenue Brookfield, IL 60513	Richard E. Grabowski The Pickus Companies 3330 Skokie Valley Road Highland Park, IL 60035

Plan or Benefit Plan

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

Fund, Trust Fund, or Welfare Fund

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

Union Trustees	Employer Trustees
Scott Pavlis Laborers' Local Union No. 75 1923 Donmaur Drive Joliet, IL 60431	David H. Lorig Lorig Construction Co. 250 E. Touhy Avenue Des Plaines, IL 6001
Tim Riley Laborers' Local Union No. 96 800 Roosevelt Road Glen Ellyn, IL 60137	Dennis P. Martin Martin Cement Company 25 Forestwood Drive Romeoville, IL 60446
Richard Sherman Chicago District Council of Laborers 999 McClintock Drive, Suite 300 Burr Ridge, IL 60527	Tim J. Scully Scully, Inc. 7 N. 130 Medinah Road Medinah, IL 60157

Plan Interpretation and Continuation

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

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

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

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

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

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

Collective Bargaining Agreements

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

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

Identification Numbers

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

Contributions

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

The collective bargaining agreements specify the amount of contributions, due date of Employer contributions, type of work for which contributions are payable, and the geographic area covered by these agreements.

Trust Fund

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

Plan Year

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

Plan Year

June 1 through the following May 31.

Purpose

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

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

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

Plan Inspection

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

Legal Process

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

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

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

YOUR ERISA RIGHTS

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

Receive Information about Plan and Benefits

You have the right to:

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

Continue Group Health Plan Coverage

You also have the right to:

- Continue healthcare coverage for yourself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. The Fund Office will provide you with the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the Plan when:
 - You lose coverage under the Plan;
 - You become entitled to elect COBRA Continuation Coverage; or
 - Your COBRA Continuation Coverage ceases.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Questions

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

National Office

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

Nearest Regional Office

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

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

DEFINITIONS

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

Ambulance Service	Local transportation in a specially equipped certified vehicle from your home, scene of the accident, or medical emergency to a Hospital, between Hospitals, between Hospital and Skilled Nursing Facility, or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Service then means the transportation to the closest facility that can provide the necessary service. Ambulance Service does not include transportation to a medical facility for patient convenience (i.e., transportation from your home to a Physician's appointment or therapy session).
Ambulatory Surgical Center	A facility (other than a Hospital): <ul style="list-style-type: none"> • Whose primary function is the provision of surgical procedures on an ambulatory basis; and • That is duly licensed by the appropriate state and local authority to provide such services.
Anesthesia Services	The administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist that may be legally rendered by them respectively.
Appeal	A Claimant has filed a written request within the specified timeline to have an initial Claim benefit determination reviewed by the Trustees of the Claim Committee of the Chicago Laborers' Welfare Fund.
Certificate of Creditable Coverage	A certificate disclosing information relating to your Creditable Coverage under a healthcare benefit program for purposes of reducing any preexisting condition exclusion imposed by any group health plan coverage.
Certified Nurse Midwife (CNM)	An individual who: <ul style="list-style-type: none"> • Practices according to the standards of the American College of Nurse-Midwives; • Has an arrangement (or agreement with a Physician) for obtaining medical consultation, collaboration, and Hospital referral; • Is a graduate of an approved school of nursing and holds a current license as a registered nurse; and • Is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.
Certified Registered Nurse Anesthetist (CRNA)	An individual who is: <ul style="list-style-type: none"> • A graduate of an approved school of nursing; • Duly licensed as a registered nurse; • A graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; • Certified by the Council of Certification of Nurse Anesthetists or its predecessors; and • Recertified every two years by the Council on Recertification of Nurse Anesthetists.

Certified Surgical Assistant (CSA)	<p>An individual specializing in surgical assistance who performs functions such as scrubbing for an operative session, assisting in the positioning of a patient, draping the operative site, retracting and exposing the operative site during a surgical procedure, and, providing homeostasis (clamping or tying off bleeders) and suture. A CSA must:</p> <ul style="list-style-type: none"> • Have completed a specialized course of training, including classroom instruction and clinical application regarding the skills and requirements of a surgical assistant; • Bill for services as a CSA; • Be licensed if such licensure is required by the state in which he or she practices; • Practice under the direct supervision of a Physician or surgeon who is working within the scope of his or her own license; and • Have a Physician or surgeon physically present while the CSA is providing billed services. <p>A bachelor's degree from an accredited college or university is not required to be a CSA.</p>	<p>A CSA does not include an individual who is a Surgical Technician (ST), Certified Surgical Technician (CST), Physician Assistant (PA), or Nurse Practitioner (NP).</p>
Chemotherapy	<p>The treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.</p>	
Chiropractor	<p>An individual who is licensed to practice as a chiropractor in the state in which services are being provided.</p>	
Claim	<p>A request for Plan benefits made by a Claimant according to the Plan's Claim filing procedures. Claims may be submitted in paper form or through Electronic Data Interchange (EDI). A Provider may submit a Claim on behalf of a Claimant to receive direct payment, but in no case will the Fund treat the Provider as the assignee of such Claim (assignment of Claims is prohibited).</p>	
Claimant	<p>A patient, who can be the Member, Spouse, or natural parent of an underage child who files a Claim for benefits.</p>	
Clinical Psychologist	<p>A Psychologist who:</p> <ul style="list-style-type: none"> • Specializes in the evaluation and treatment of mental health; • Has a doctoral degree from a regionally accredited university, college, or professional school; • Has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program or is a registered Clinical Psychologist with a graduate degree from a regionally accredited university or college; and • Has not less than six years as a Psychologist, with at least two years of supervised experience in health services. 	
COBRA	<p>Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, that regulate the conditions and manner under which an employer can offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate.</p>	
Coinsurance	<p>A percentage of an eligible expense that an eligible individual is required to pay toward a Covered Service.</p>	

Creditable Coverage	<p>Coverage under any of the following:</p> <ul style="list-style-type: none"> • A group health plan; • Health insurance coverage for Medical Care under any Hospital or medical service policy plan, Hospital or medical service plan contract, or HMO contract offered by a health insurance issuer; • Medicare (Parts A or B of Title XVIII of the Social Security Act); • Medicaid (Title XIX of the Social Security Act); • Medical Care for Members and certain former Members of the uniformed services and their dependents; • Medical Care program of the Indian Health Service or of a tribal organization; • State health benefits risk pool; • Health plan offered under the Federal Employees Health Benefits Program; • Public health plan established or maintained by a state or any political subdivision of a state, the U.S. government, or a foreign country; • Health plan under Section 5(e) of the Peace Corps Act; or • State Children’s Health Insurance Program (Title XXI of the Social Security Act).
Custodial Care	<p>Any services or supplies provided primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed. Custodial Care services:</p> <ul style="list-style-type: none"> • Can be safely provided by trained or capable non-professional personnel; • Are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.); and • Are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). <p>Custodial Care also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement.</p>
Dentist (DDS OR DMD)	<p>A duly licensed dentist.</p>
Diagnostic Service	<p>Tests rendered for the diagnosis of symptoms and are directed toward evaluation or progress of a condition, disease, or injury. Tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.</p>
Dialysis Facility	<p>A facility (other than a Hospital):</p> <ul style="list-style-type: none"> • Whose primary function is the treatment and/or provision of maintenance dialysis on an ambulatory basis for hemodialysis or peritoneal dialysis patients; and • Is duly licensed by the appropriate governmental authority to provide such services.

Dialysis Treatment	One unit of service, including the equipment, supplies, and administrative service that are customarily considered as necessary to perform the dialysis process.
Eligible Charge	<ul style="list-style-type: none"> • In the case of a Provider that has a written agreement with the Fund to provide care at the time Covered Services are rendered, the Provider's Claim charge for Covered Services; • In the case of a Provider that does not have a written agreement with the Fund to provide care at the time Covered Services are rendered, the amount for Covered Services as determined by the Fund Office based on the following order: <ul style="list-style-type: none"> – The charge that is within the range of charges other similar Hospitals or facilities in similar geographic areas charge patients for the same or similar services, as reasonably determined by the Fund Office, if available; – The amount that the Centers for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to those in the Medicare program; or – The charge that the particular Hospital or facility usually charges its patients for Covered Services.
Eligible Member or Member	An employee of an Employer who meets the eligibility requirements for this Plan's coverage, as described in the eligibility section of this booklet.
Employer	The company with which you are employed.
Hospice Care	Palliative and supportive care designed to provide for the physical and psychological well being of dying persons and their families. The goal of Hospice Care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and quality of life. Hospice Care is available in the home, Skilled Nursing Facility, or special Hospice Care unit.
Hospital	<p>An institution that:</p> <ul style="list-style-type: none"> • Is duly licensed for the care of the sick or injured to provide service under the care of a Physician, including the regular provision of bedside nursing by registered nurses; • Is accredited by a nationally recognized accrediting agency; • Has full-time permanent bed care facilities for five or more patients; • Has the regular services of a Physician; • Provides 24 hour a day nursing services by registered nurses; • Perform mainly diagnostic and therapeutic medical and surgical care of patients or provides care and treatment for Substance Abuse; and • Is licensed to operate in the state where it is located. <p>A Hospital does not include health resorts, rest homes, nursing homes, Skilled Nursing Facilities, convalescent homes, custodial homes of the aged, or similar institutions.</p>
Inpatient	A registered bed patient being treated in a Hospital or other healthcare facility.

Investigational, Experimental, or Inappropriate Drugs, Devices, Treatment, or Procedures	<p>Procedures, drugs, devices, services, and/or supplies that:</p> <ul style="list-style-type: none"> • Are provided or performed in special settings for research purposes or under a controlled environment that are being studied for safety, efficiency, and effectiveness; • Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the patient; • Specifically with regard to drugs, combination of drugs, and/or devices are not finally approved by the Food and Drug Administration at the time used or administered to the patient; • Are not officially accepted by the medical community; • Are not recognized as having proven beneficial outcomes to the patient; and/or • Are not recommended for an advanced state of an illness or disease.
Licensed Clinical Professional Counselor (LCPC)	A duly licensed clinical professional counselor.
Licensed Clinical Social Worker (LCSW)	A duly licensed clinical social worker.
Maintenance or Developmental Care	<p>Those services that are:</p> <ul style="list-style-type: none"> • Administered to a patient to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.
Maintenance Occupational Therapy or Maintenance Physical Therapy	<p>Therapy that is:</p> <ul style="list-style-type: none"> • Administered to maintain a level of function at which no demonstrable and/or measurable improvement of a condition will occur; • Not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or • Educational in nature.
Marriage and Family Therapist (LMFT)	A duly licensed marriage and family therapist. Marriage counseling is not covered under the Plan.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.
Medically Necessary or Medical Necessity	<p>Services, treatments, or supplies ordered by your Physician that are:</p> <ul style="list-style-type: none"> • Required to identify or treat an injury or illness; • Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, illness, or injury; • In keeping with acceptable National Standards of Good Medical Practice; and • The most appropriate that can be safely provided under the circumstances on a cost-effective basis.
Medicare	The program established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).
Mental Health Disorder	Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) Manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Mental health disorders include, among other things, depression, schizophrenia, and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by certified mental health practitioners.
Naprapath	A duly licensed naprapath.

Naprapath Services	The performance of naprapathic practice by a Naprapath that may legally render such services.
Occupational Therapist	A duly licensed occupational therapist.
Occupational Therapy	Constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.
Optometrist	A duly licensed optometrist.
Outpatient	Treatment received while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room, diagnostic laboratory tests and X-rays, medications, and supplies.
Participating Provider Option	A program of healthcare benefits designed to provide economic incentives for using designated Providers of healthcare services.
Pharmacy	Any licensed establishment in which the profession of pharmacy is practiced.
Physical Therapist	A duly licensed physical therapist.
Physical Therapy	The treatment of a disease, injury, or condition by physical means by a Physician or registered professional Physical Therapist under the supervision of a Physician that is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.
Physician	A legally qualified physician duly licensed to practice medicine in all of its branches.
Physician Assistant (PA) or Nurse Practitioner (NP)	A duly licensed physician assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider. An NP or PA is a health professional, qualified by academic and clinical training, who performs tasks often reserved for a Physician and who works under the direction, supervision, and responsibility of a qualified licensed Physician. These professionals may take medical histories, examine patients, order and interpret laboratory tests and X-rays, and make diagnoses. They may also treat minor injuries by suturing, splinting, and casting. However, the Plan does not cover NP or PA assistance during Surgery, but will pay for a Physician's services if the surgical procedure warrants assistance.
Podiatrist (DPM)	A duly licensed podiatrist.
Private Duty Nursing Service	Skilled Nursing Service provided on a one-to-one basis by an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN). Private Duty Nursing Service is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private Duty Nursing Service is not covered under the Plan except to the extent that it can be covered under the Plan's home healthcare benefits when provided by a home health agency.
Prosthetic Device	A prosthetic appliance or device that is a type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and artificial eyes.
Provider	Any healthcare facility (for example, a Hospital or Skilled Nursing Facility), person (for example, a Physician or Chiropractor), or entity duly licensed to render Covered Services.
Psychologist	A Clinical Psychologist registered in a state where statutory licensure exists. The Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, must meet the qualifications specified in the definition of a Clinical Psychologist.
Reconstructive Surgery	A surgical procedure that is intended to improve bodily function and/or correct deformity resulting from congenital anomaly that causes a functional effect or results from a prior covered therapeutic procedure. Call the Fund Office for further information.

Respite Care Service	Those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services. Respite Care Service is not covered under the Plan.
Skilled Nursing Facility	An institution or a distinct part of an institution that is: <ul style="list-style-type: none"> • Primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care; and • Duly licensed by the appropriate governmental authority to provide such services.
Skilled Nursing Service	Those services provided by a registered nurse (RN) or Licensed Practical Nurse (LPN) that require the clinical skill and professional training of an RN or LPN and that cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care service.
Speech Therapist	A duly licensed speech therapist.
Speech Therapy	The treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes that is designed and adapted to promote the restoration of a useful physical function. Speech Therapy for developmental delay is limited to children under the age of five or children under the age of nine for specific diagnosis. Speech Therapy for older children and adults does not include therapy for developmental delay, educational training, or services designed and adapted to develop a physical function.
Substance Abuse	The uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, including the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.
Substance Abuse Treatment Facility	A facility (other than a Hospital) whose primary function is the treatment of Substance Abuse that is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.
Surgery	The performance of any medically recognized, non-Investigational surgical procedure, including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures.
Temporomandibular Joint Dysfunction (TMJ) and Related Disorders	Jaw joint conditions, including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves, and other tissues relating to that joint.
Totally Disabled or Total Disability	With respect to an Eligible Member, you are (and continue to be) unable to perform the type of work that you are normally assigned as a laborer in accordance with the collective bargaining agreement due to a disabling condition that is non-occupational. If you are employed in a position that does not require work as a laborer, you must be disabled from performing the work that you are normally assigned.
Usual and Customary (U&C) Charge	<ul style="list-style-type: none"> • The charge that is no higher than the 90th percentile of the Plan's most currently available healthcare charge data; • Where there is insufficient data, a value or amount established by the Fund; • For multiple or bilateral surgeries performed at the same time, 100% for the primary procedures and an amount determined after medical review for the secondary procedures; and • For surgical assistance by a Physician, up to a maximum of 20% of the charge allowed for the Surgery. • For PPO Providers, Usual and Customary Charges are amounts that do not exceed the negotiated rate.





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