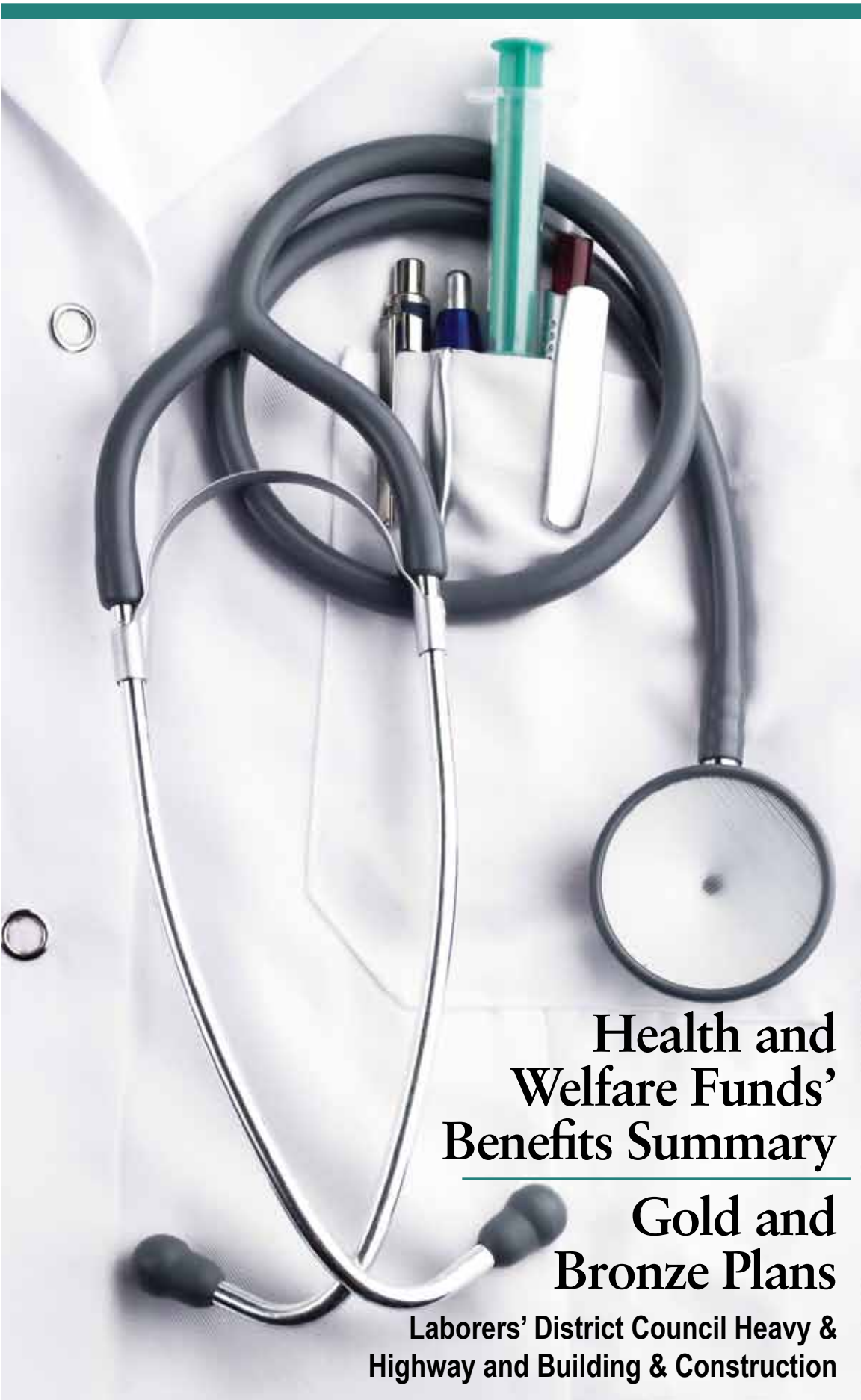

Health and Welfare Funds' Benefits Summary

Gold and Bronze Plans

Laborers' District Council Heavy & Highway and Building & Construction

Summary of Material Modification for Laborers' District Council Heavy & Highway Construction Health and Welfare Fund and Laborers' District Council Building and Construction Health and Welfare Fund

The following information provides a summary of material modifications ("SMM") to the Laborers' District Council Heavy & Highway Construction Health and Welfare Fund Summary Plan Description and Laborers' District Council Building and Construction Health and Welfare Fund Summary Plan Description (hereinafter collectively referred to as the "Plan" except where specified otherwise). Please keep this SMM with your other benefits information.

The changes described in this SMM become effective on the dates noted. For instance, some changes become effective on January 1, 2011 and others become effective on May 1, 2011, and one change becomes effective November 1, 2011.

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Dear Member/Participant:

Since its inception, the Laborers' District Council Health and Welfare Fund has worked to provide members and qualified participants with a selection of broad and generous benefits. With little exception, our benefit packages and plans have been among the best in the region. In the face of one of the most challenging economic periods in recent times, the Board of Trustees worked to thoroughly review, appraise and deliberate the options to reach a decision that would enable the Fund to continue to offer a high quality of service and to sustain the durability of the Fund. We are satisfied that, after more than a year of meetings and evaluations, our actions will enable us to do both.

Effective January 1, 2011, the Plan of Benefits offered by the Laborers' Building and Construction Health and Welfare Fund and the Laborers' Heavy and Highway Construction Health and Welfare began to utilize Independence Blue Cross' Keystone Direct Point of Service (POS) and HMO programs to provide medical coverage to our eligible members and their families.

As the passage of Healthcare Reform legislation ushered in a new era of health options for many Americans, we worked with Independence Blue Cross and our providers of dental, vision and other healthcare services to make sure that we complied with the law's guidelines. These providers also helped us to identify ways to contain costs and provide programs that maintain high standards of care.

This booklet provides you with a comprehensive review of the revisions to our Healthcare Plans. Please keep it handy for future reference. While it will answer many of your questions, we recognize that there are questions or circumstances that may not be covered and require direct responses. **As always, service to our members is a priority and a member of the Health and Welfare Fund staff will be available to respond to questions at 215.236.6700. In addition, each of our Healthcare providers is available to respond to specific issues.**

A Keystone Participating Primary Care Physician (PCP) Selection Form must be submitted for all covered members, dependents, and participants. If you have not yet completed and submitted your form, please contact the Health and Welfare Fund office, or Independence Blue Cross at 1.800.275.2583. A medical card will be issued for each enrolled dependent. When you receive your medical card(s), please be sure to check them for accuracy. Confirm that the name of the Primary Care Physician that you indicated on your selection form is the same as that on your card(s). If there is any error, please contact the Health and Welfare Fund office. Please note that the rights of coverage are exclusive to the person named on the card and may not be assigned or transferred, in whole or part, to another person or provider.

New dental or prescription benefit cards will not be issued for current members/ participants. Please continue to use the cards that have been issued to you.

As we all move ahead together, the Board of Trustees will continue to navigate the course and work to make the best decisions possible to ensure a continuum of service to the membership.

Fraternally yours,

Boards of Trustees
Laborers' District Council Building and Construction Health and Welfare Fund
Laborers' District Council Heavy and Highway Health and Welfare Fund

MEDICAL BENEFITS CHANGES

Effective Between January 1, 2011 and April 30, 2011

Medical Benefit Changes Effective January 1, 2011

Effective January 1, 2011, the Plan will provide the medical benefits described in the Keystone Direct Point of Service (POS) in this notice (the "Gold Benefits Plan"). Please note the following regarding this change:

- Effective January 1, 2011, all current enrollees will receive the Gold Benefits (described in this document) until April 30, 2011.
- Anyone who enrolls in the Plan between January 1, 2011 and April 30, 2011 will receive the Gold Benefits until April 30, 2011.
- Current qualified beneficiaries receiving COBRA will receive the Gold Benefits.
- Individuals becoming eligible for COBRA on or after January 1, 2011, but prior to May 1, 2011, will receive the Gold Benefits (if you become COBRA eligible thereafter, your COBRA coverage will be determined by the level of coverage you maintained in the Plan immediately prior to your qualifying event).

Medical Benefit Changes Effective May 1, 2011

Effective May 1, 2011, the following changes to the Plan's medical coverage will apply:

Two Tiered Coverage

Beginning on May 1, 2011, the Plan will provide two separate medical benefit packages.

The type of coverage that applies during an eligibility period depends on the number of hours that the member works in the applicable work period. The following summarizes the work requirements for the respective benefit packages.

ELIGIBILITY

Gold Benefits

- A member must complete at least 450 hours of work during the applicable work period to become eligible for Gold Benefits. If the member completes more than 300 hours but less than 450 hours during the applicable work period, the member will only be eligible for Bronze Benefits subject to the Modified Hours Bank rules discussed below.
- A member remains eligible for Gold Benefits until the member fails to complete at least 450 hours of work during the applicable work period subject to the Modified Hours Bank rules discussed below.

Bronze Benefits

- A member must complete at least 300 hours of work during the applicable work period to be eligible for Bronze Benefits.
- A member is not eligible for Bronze Benefits if the member works less than 300 hours during the applicable work period subject to the Modified Hours Bank rules discussed below.

- A member remains eligible for Bronze Benefits until the member fails to complete at least 300 hours of work during the applicable work period, subject to the Modified Hours Bank rules discussed below.

Work and Eligibility Periods

The Plan's eligibility periods and work periods remain unchanged except that, effective November 1, 2011, work periods for the Laborers' District Council Building and Construction Health and Welfare Fund will change to March through August and September through February. The following chart summarizes applicable eligibility and work periods:

Eligibility Periods*	Heavy & Highway Work Periods	Building & Construction Work Periods (current)	Building & Construction Work Periods *(effective November 1, 2011)*
May 1 to October 31	March 1 to August 31	May 1 to October 31	March 1 to August 31
November 1 to April 30	September 1 to February 28	November 1 to April 30	September 1 to February 28

**Same for both Building & Construction Plan and Heavy & Highway*

Modified Hour Bank Rules

The Plan's hour bank rules have been modified effective January 1, 2011. Please note, however, that if a member has a balance in the hour bank on December 31, 2010, the hour bank balance will be grandfathered (i.e., it will not be affected by the new rules). The new hour bank rules are summarized as follows:

- A member cannot have an hour bank balance of more than 450 hours. (For example, if a member's grandfathered hour bank has a balance of 425 hours, the member may add no more than 25 additional hours after December 31, 2010. Similarly, if a member's grandfathered hour bank has a balance of 500 hours, the member may not add additional hours until the hour bank falls below 450 hours.)

- A member may not bank any hours unless the member has worked more than 450 hours during the applicable work period. (This means that a member who is eligible for Bronze Benefits – because the member worked more than 300 hours but less than 450 hours – cannot bank any hours, even though the member earned more than the 300 hours necessary to become eligible for Bronze Benefits.)

- Banked hours may be used for eligibility for either Bronze or Gold Benefits.

- Banked hours will be used to attain the highest level of eligibility.

- Effective for eligibility periods beginning on or after May 1, 2011, a member may purchase up to 50 work hours that may be used toward eligibility for either Bronze or Gold Benefits. The cost of each purchased hour will be the then current employer contribution rate as determined by the collective bargaining agreement between the Laborers' District Council and the Contractors Association of Eastern Pennsylvania or the General Building Contractors Association.

OTHER CHANGES

The following changes will also apply, effective as of the dates specified:

Coverage of Dependents to Age 26

Effective January 1, 2011, the Plan will provide coverage for a member's adult children, up to age 26, without regard to the child's marital or student status. *For enrollment guidelines and information, see page 8.*

Preventive Care Coverage

Effective January 1, 2011, the Plan will generally provide first dollar coverage (without any cost sharing) for certain evidence-based preventive care, routine gynecological visits, well child visits, and immunizations. This does not affect preventive services delivered by out-of-network providers.

Access to Certain Care

Effective January 1, 2011, the Plan will:

- Permit each member to designate any participating primary care provider who is available to accept that individual (including a pediatrician for children or an OB/GYN for women.)
- Not require pre-authorization for emergency services and the Plan will provide out-of-network emergency services with the same cost-sharing as in-network.
- Provide direct access to obstetrical and gynecological care without requiring a referral or authorization.

Non-Rescission Policy

Effective January 1, 2011, the Plan may not retroactively terminate coverage except for:

- Fraud or intentional misrepresentation;
- Failure to timely pay required premiums or contributions;
- Untimely notification of a divorce; or,
- Any other administrative reason not based upon your claim history.

The Plan will provide advance notice at least 30 days before a rescission and you will be awarded the opportunity to appeal a rescission.

Annual and Lifetime Limits

Effective January 1, 2011, the Plan will no longer contain any annual or lifetime limits on the dollar amount of benefits.

GETTING STARTED

Choosing a Primary Care Physician

All covered members and their dependents must identify a Primary Care Physician (PCP). In addition to serving as an initial point of contact for your health needs, your PCP will be a resource for regular contact, guidance on healthy lifestyle and preventive care and provide referrals for specialist care when needed. For additional assistance in identifying a PCP, see the next section on "Locating a Provider."

Locating a Provider

There are two key options to aid you in identifying a provider. One is to access the IBX Provider Finder at www.ibx.com. Four quick steps will enable you to search for a participating provider by last name, location, treated body part, or specialty:

1. Go to www.ibx.com
2. Look for the ***Find a Doctor*** heading in the middle of the page.
3. Click on the drop-down menu and select ***Doctor*** or ***Hospital***.
4. Click on Find ***Participating Doctors, Hospitals and Ancillary Providers***.

You may also request a printed copy of the IBX Provider Directory which provides a comprehensive listing of primary care physicians, specialists, hospitals, laboratories and ancillary providers. Simply contact the IBX Customer Service line at 1.800.275.2583. Please note, however, that accessing information on-line will provide you with the most up-to-date information.

Specialized Care

Specialty care is important to you. As a plan member, the IBX Blue Distinction program provides you with access to information needed to make informed decisions about specialty care for such things as weight loss (bariatric surgery), cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, and transplant services.

Facilities that receive the Blue Distinction Center designation have been determined to have extensive experience in these services, have met rigorous quality standards, and have consistently demonstrated positive outcomes. Additional help in finding a doctor or a specialized service is available by calling the IBX Customer Service line at 1.800.275.2583.

Continuity of Care

Occasionally, a provider may not accept Keystone Health Plan East, opt to withdraw as a service provider, or be terminated. Should this happen and a member is in a course of treatment, continuation of an ongoing course of treatment will be provided for the member, for up to 60 days from the date that the member is notified by Independence Blue Cross (IBX) of the provider's termination. A member in her second or third trimester of pregnancy at the time of the provider's termination will be able to continue receiving services through post-partum care related to the delivery.

A member will need to complete a Continuity of Care form and submit it to the IBX Keystone Care Management and Coordination department. Contact IBX Customer Service at 1.800.275.2583 for more information.

Important Information About How The Patient Protection and Affordable Care Act Will Affect Benefits For You and Your Adult Children

Q. When will the Fund allow me to cover my adult child(ren) up to age 26?

A. Although under the terms of the Affordable Care Act, the Plan is not required to extend coverage to your adult children until May 1, 2011, the Trustees have elected to extend this coverage effective January 1, 2011.

Q. How soon may I request coverage for my adult child(ren)?

A. You may request coverage within thirty (30) days of the date you receive the notice. However, no coverage will be effective earlier than January 1, 2011.

Q. Which adult child(ren) may I cover?

A. Effective January 1, 2011, you will be able to enroll your adult child(ren) up to age 26. If the adult child(ren) is a child or stepchild within the Plan's rules, you can enroll the adult child(ren) in the Plan, up to age 26, even if the adult child(ren) is not in college or graduate school, is not living with you, is not claimed as a dependent on your taxes and even if he or she is married (although the Plan will not cover the adult child's spouse).

IMPORTANT NOTE: If you would like to enroll and/or keep your adult dependent child(ren) on your coverage, you must complete a LDC Benefit Funds Enrollment Form. If you have recently submitted an Enrollment Form to the Fund Office we will contact you if we require additional information as to your adult dependent child(ren). If you wish to have an Enrollment Form mailed to you please call the Fund office at 215.236.6700.

Q. My 24 year old daughter has a child. May I cover my grandchild also?

A. No. The Plan's rules do not provide for the coverage of grandchildren.

Q. When does coverage for adult children end?

A. Coverage for your adult child will end at the end of the month in which the child attains age 26.

Questions about whether this Plan is "grandfathered" and what it means for you and your family:

Q. Is the Fund a "grandfathered" plan?

A. No, the Trustees believe this plan is no longer a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("the Affordable Care Act").

In order to find out general information about this important Act and how it might apply to you or to the plans of others in your family, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor, 1.866.444.3272 or www.dol.gov/ebsa/healthreform.

MEDICAL PLANS

Eligible participants will receive medical services from one of the two tiers of benefits – the Gold Plan or the Bronze Plan. An outline of each plan's medical coverage follows; however, your Summary Plan Description will provide complete details about your benefits plan. For additional information or clarification on either plan, contact the IBX Customer Service department at 1.800.275.2583. For other questions, contact the Benefit Funds office at 215.236.6700.

GOLD PLAN

A member who completes at least 450 hours of work or more during the applicable work period is eligible for this plan. A member remains eligible for Gold Benefits until the member fails to complete at least 450 hours of work during the applicable work period.

The Keystone Health Plan East Direct Point of Service (POS) Plan provides members with choice in selecting doctors and hospitals from a comprehensive directory of healthcare providers. The plan requires that a member select a Primary Care Physician (PCP). Referrals are required for routine radiology/diagnostic, podiatry, spinal manipulation and physical/occupational therapy.

KEYSTONE DIRECT POINT OF SERVICE PLAN

Benefit	In Network	Out-of-Network*
Deductible		
Individual	$0	$ 500
Family	$0	$ 1,500
Coinsurance Limit		
Individual	None	$ 3,000
Family	None	$ 9,000
Lifetime Maximum	Unlimited	Unlimited
Annual Co-Payment Maximum		
Individual	$2000	Not applicable
Family	$4000	Not applicable
Doctor's Office Visits		
Primary Care Services	$10 Co-Pay [1]	70% after deductible
Specialist Services	$20 Co-Pay	70% after deductible
The following services must be received from your Primary Care Physician's (PCP) designated sites. For a detailed list of PCP designated sites, access www.ibx.com.		
Outpatient X-Ray/Radiology* **		
Routine Radiology/Diagnostic	$20 Co-Pay [2]	70% after deductible
MRI/MRA, CT/CTA Scans/ PET Scans	$40 Co-Pay	70% after deductible
Outpatient Laboratory/Pathology[4]	100%	70% after deductible
Physical and Occupational Therapies *30 visits per calendar year*	$20 Co-Pay [2]	70% after deductible
Podiatry	$20 Co-Pay [2]	70% after deductible

Any Keystone Health Plan East participating provider may provide the following services.		
Benefit	**In Network**	**Out-of-Network***
Inpatient Hospital Services Inpatient Stay Hospital Days	 $150 per day; maximum of 5 Co-Pays per admission**** Unlimited	 70% after deductible[3] 70 days per calendar year[3]
Outpatient Surgery	$50 Co-Pay	70% after deductible
Emergency Room	$100 Co-Pay *(not waived if admitted)*	$100 Co-Pay no deductible *(not waived if admitted)*
Ambulance Emergency Non-Emergency	 100% 100%	 100% no deductible 70% after deductible
Spinal Manipulations *20 visits per calendar year*	$20 Co-Pay[2]	70% after deductible
Therapies Cardiac Rehabilitation *36 visits per calendar year* Pulmonary Rehablilitation *36 visits per calendar year* Speech *20 visits per calendar year* Orthoptic/Pleoptic *8 session lifetime maximum*	 $20 Co-Pay $20 Co-Pay $20 Co-Pay $20 Co-Pay	 70% after deductible 70% after deductible 70% after deductible 70% after deductible
Maternity First OB Visit Hospital	 $10 Co-pay $150 per day; maximum of 5 Co-Pays/admission****	 70% after deductible 70% after deductible[3]
Routine Gynecological Exam/PAP *1 visit per calendar year*	100%	70% no deductible
Mammogram	100%	70% no deductible
Nutrition Counseling for Weight Management *6 visits per calendar year*	100%	70% after deductible
Preventive Care for Adults & Children	100%[1]	70% no deductible
Pediatric Immunizations	100%***	70% no deductible
Injectable Medications Standard Injectables Biotech/Specialty Injectables	 100%** $50 Co-Pay	 70% after deductible 70% after deductible
Chemo/Radiation/Dialysis	100%	70% after deductible
Outpatient Private Duty Nursing *360 hours per calendar year*	85%	70% after deductible
Skilled Nursing Facility	$75 per day; maximum of 5 Co-Pays/admission**** *120 days per calendar year*	70% after deductible *60 days per calendar year*
Hospice & Home Health Care	100%	70% after deductible
Durable Medical Equipment	50%	50% after deductible
Prosthetics	50%	50% after deductible

* Out-of-Network providers may bill you the difference between your plan allowance, which is the amount paid by the plan, and the provider's actual charge. Please note that this amount could be significant.

**Office visits subject to co-payment.

***Co-payment not applicable when service is performed in an emergency room or office setting.

****Co-payment waived if readmitted within 10 days of discharge for any condition.

[1] Must select and use Primary Care Physician for primary care services.

[2] Referral is required from Primary Care Physician.

[3] Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.

[4] Lab requisition form required from Primary Care Physician.

GOLD PLAN

Services that are not covered

- Services that are not medically necessary
- Cosmetic services/supplies
- Mental Health & Substance Abuse covered via ATAP
- Self-injectable drugs
- Services or supplies that are experimental or investigative, except routine cost associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids and cochlear electromagnetic hearing devices
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Reversal of voluntary sterilization
- Contraceptives except by additional rider
- Expenses related to organ donation for non-member recipients
- Cranial prostheses including wigs intended to replace hair
- Acupuncture
- Immunizations for travel or employment
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Alternative therapies/complementary medicine
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Routine eye exam except by additional rider
- Music therapy, equestrian therapy, and hippotherapy

BRONZE PLAN

A member who completes at least 300 hours of work, but less than 450 hours during the applicable work period, will be eligible for Bronze Benefits.

The Keystone Health Plan East Health Maintenance Organization (HMO) Plan requires that a member select a Primary Care Physician (PCP), who may also refer the member to other Keystone providers for care, if needed. The Summary Plan Description will provide comprehensive details about this benefit plan including information on exclusions and limitations. For additional information or clarification, contact the IBX Customer Service department at 1.800.275.2583.

KEYSTONE HEALTH PLAN EAST HMO	
Benefit	**Coverage**
Annual Co-Payment Maximum Individual Family	 $2000 $4000
Doctor's Office Visits Primary Care Services Specialist Services*	 $15 Co-Pay $30 Co-Pay
Preventive Care for Adults & Children*	100%
Pediatric Immunizations	100%
The following services must be received from your Primary Care Physician's (PCP) designated sites. For a detailed list of PCP designated sites, access www.ibx.com.	
Outpatient X-Ray/Radiology+ Routine Radiology/Diagnostic MRI/MRA, CT/CTA Scans/ PET Scans	 $50 Co-Pay $100 Co-Pay
Outpatient Laboratory/Pathology	100%
Any Keystone Health Plan East participating provider may provide the following services.	
Inpatient Hospital Services Inpatient Stay *2 admissions per year maximum* Hospital Days	 $150 per day; maximum of 5 Co-Pays/admission** 2 admissions per year maximum
Outpatient Surgery	90%
Emergency Room	$125 Co-Pay *(not waived if admitted)*
Ambulance Emergency Non-Emergency	 100% 100%
Maternity First OB Visit* Hospital *2 admissions per year maximum*	 $15 Co-pay $150 per day; maximum of 5 Co-Pays/admission**
Routine Gynecological Exam/PAP* *1 visit per calendar year, no referral required*	100%
Mammogram *no referral required*	100%
Nutrition Counseling for Weight Management *6 visits per calendar year*	100%

Any Keystone Health Plan East participating provider may provide the following services.	
Benefit	**Coverage**
Chemo/Radiation/Dialysis	90%
Injectable Medications Standard Biotech/Specialty Injectables	 100% $75 Co-pay
Durable Medical Equipment & Prosthetics Coverage for Diabetic Supplies and Insulin only	90%
Hospice and Home Health Care	100%

*Combined in/out-of-network specialist visits limited to four per calendar year.
** Co-payment is waived if readmitted within 10 days of discharge of any condition.
+Co-payment not applicable when service is performed in an emergency room or office setting.

BRONZE PLAN

Services that are not covered

- Services that are not medically necessary
- Mental Health & Substance Abuse covered via ATAP
- Routine eye exam except by additional rider
- Services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Skilled nursing facility
- Outpatient services that are not performed by your Primary Care Physician's designated provider
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Therapies: Cardiac Rehab, Pulmonary Rehab, Physical Therapy, Occupational Therapy, Respiratory, Speech, Orthoptic Therapy, Pleoptic Therapy & Spinal Manipulation
- Cosmetic services/supplies
- Self-injectable drugs
- Contraceptives except by additional rider
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Outpatient private duty nursing
- Cranial prostheses including wigs intended to replace hair
- Immunizations for travel or employment
- Alternative therapies/complementary medicines
- Durable medical equipment and prosthetics except diabetic supplies and insulin
- Dental care, including dental implants and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose

SERVICES THAT REQUIRE PRE-APPROVAL

Applies to both the Gold and Bronze Plans

Outpatient Services

Surgical and Nonsurgical Inpatient Admissions
Acute rehabilitation
Skilled nursing facility
Inpatient hospice
Maternity admission *(for notification only)*

Durable Medical Equipment

Purchase items over $500 including repairs and replacements and all rentals except oxygen, diabetic supplies and unit dose medication for nebulizer

Outpatient Facility/Office Services
(other than inpatient)

MRI/MRA
CT/CTA Scan
PET Scan
Nuclear cardiac studies
Hysterectomy
Cataract surgery
Nasal surgery for Submucous Resection and Septoplasty
Transplants *(except cornea)*
Comprehensive outpatient pain management programs *(including epidural injections)*
Obesity surgery
Sleep studies
Day rehabilitation programs
Dental services as a result of accidental injury
Uvulopalatopharyngoplasty *(including laser-assisted)*

Reconstructive Procedures & Potentially Cosmetic Procedures

Abdominoplasty
Augmentation mammoplasty
Blepharoplasty
Chemical peels
Dermabrasion
Excision of redundant skin
Keloid removal
Lipectomy/Liposuction
Orthognathic surgery procedures
Mastopexy
Otoplasty
Panniculectomy
Reduction mammoplasty
Removal or reinsertion of breast implants
Rhinoplasty
Varicose vein procedures
Scar revision
Subcutaneous Mastectomy for gynecomastia

All Home Care Services
(including infusion therapy in the home)

Biotechnology/Specialty Injectable Drugs
(See list included in Open Enrollment packet)

Infusion Therapy Drugs in an Outpatient Facility or in a Professional Provider's Office
(see list included in Open Enrollment packet)

Prosthetics and Orthotics

Purchase items over $500 including repairs and replacements except ostomy supplies

Birthing Center *(for notification only)*

Outpatient Private Duty Nursing

Elective (non-emergency) **Ambulance Transport**

Services by a Non-participating Physician/Provider for Non-Emergency Services

PRESCRIPTION SERVICES

Effective January 1, 2011, prescription drug co-pays will be as indicated below:

	Gold Plan		Bronze Plan	
	Retail	Home Delivery* (3 month supply; 2 month co-pay)	Retail	Home Delivery* (3 month supply; 2 month co-pay)
Generic	$ 5.00	$ 10.00	$ 25.00	$ 50.00
Formulary	$ 15.00	$ 30.00	–	–
Non-formulary	$ 30.00	$ 60.00	–	–
Brand			$ 50.00	$ 100.00
The LDC Benefits Fund will pay $5,000 annually per family, after which a 50% co-pay will apply.				

* Unless otherwise specified, home delivery of maintenance medications through the Express Scripts EHD program will be filled with a three-month supply. Instead of three co-pay amounts, a member will pay two co-pay amounts for a three-month supply.

Effective January 1, 2011, the following benefits have also been added to the prescription drug benefit: (1) Exclusive Home Delivery program for maintenance medications; (2) Generics Preferred; and (3) Step Therapy.

Exclusive Home Delivery and Maintenance Medications

A maintenance medication is a prescribed drug that treats an ongoing condition, such as diabetes or high blood pressure. Under the Home Delivery program, you may receive two refills of up to a 30-day supply of a maintenance medication from a local, participating pharmacy. After that, you will need to order these prescriptions through the Exclusive Home Delivery program from the Express Scripts Pharmacy or pay the FULL cost of the prescription if you choose to have it filled at your local, participating pharmacy.

How This Change Helps You

By using the Express Scripts Pharmacy, you'll save money on your copayments. Plus, you'll receive:

- Free home delivery of your medication.
- Up to a 90-day supply of medication with each order.
- 24-hour access to an Express Scripts pharmacist.

Short-term prescriptions, such as antibiotics, can still be filled at your local, participating pharmacy.

Three Easy Ways to Get Started

By Mail – Complete a Home Delivery order form and select your payment option. Mail the form, along with your prescription, to Express Scripts.

By Internet – Access **www.express-scripts.com/mail/startmail**. Complete the requested information and Express Scripts will contact your doctor for a new prescription for Home Delivery.

By Phone – Call 1.800.467.2006 and speak with an Express Scripts patient care advocate who will help you get started with Home Delivery.

The first time you fill a prescription through the Express Scripts pharmacy, you should expect delivery of your order within two weeks from the time Express Scripts receives the prescription from your doctor. **It is recommended that you have a 30-day supply of your medication on hand at the time of your order. Refills typically take three to five days to process and ship.**

Generics Preferred

Generic drugs are copies of brand-name drugs whose patents have expired. A generic drug contains the same active ingredients and is available in the same strengths as the original brand-name drug. They are chemically equivalent to their non-generic drug counterpart. Any prescribed generic drug has been approved by the U.S. Food and Drug Administration (FDA) and meets strict requirements for quality and purity.

How This Change Helps You

Generic drugs cost about half the cost of brand-name drugs to produce. The savings are passed on to you, in the form of a lower co-payment.

How Does the Generics Preferred Program Work?

When you have a prescription filled, the pharmacy will check to see if a generic is available.

- If a generic is available, you will pay the standard co-payment for a generic drug. This cost will be less than for a brand-name drug.
- If, instead, you choose the brand-name medication, you will pay your co-payment plus the difference in cost between the generic and the brand-name drug.

When a generic drug is available, the pharmacy will be required to fill a prescription with the generic drug, unless otherwise determined by the member's doctor.

Step Therapy

Step Therapy only applies to new prescriptions filled on or after January 1, 2011. If you are currently taking a medication that would be eligible for Step Therapy, you will be "grandfathered in," meaning you will not have to change your current medication.

How This Change Helps You

The Step Therapy program is about value. For people who have certain medication needs - arthritis, high blood pressure, and high cholesterol, for example - Step Therapy means receiving a medication that is proven safe and effective, at the lowest possible cost.

The Step Therapy Process

Step 1 medications are the first recommended to you. They are usually generics and you will pay the lowest co-payment for these drugs.

Step 2 medications are brand-name and are recommended if a Step 1 medication does not work for you. Step 2 drugs will almost always be more expensive.

Step 3 medications are the most expensive brand-name drugs. If the Step 1 or Step 2 medications do not work for you, you may then be prescribed the higher cost Step 3 drug.

When your doctor prescribes a new medication, always ask if you can first try a Step 1 medication. If the Step 1 drug does not work for you, or if your doctor decides a Step 2 or Step 3 medication would be better, the member should contact Express Scripts to inquire about prior authorization.

DENTAL SERVICES

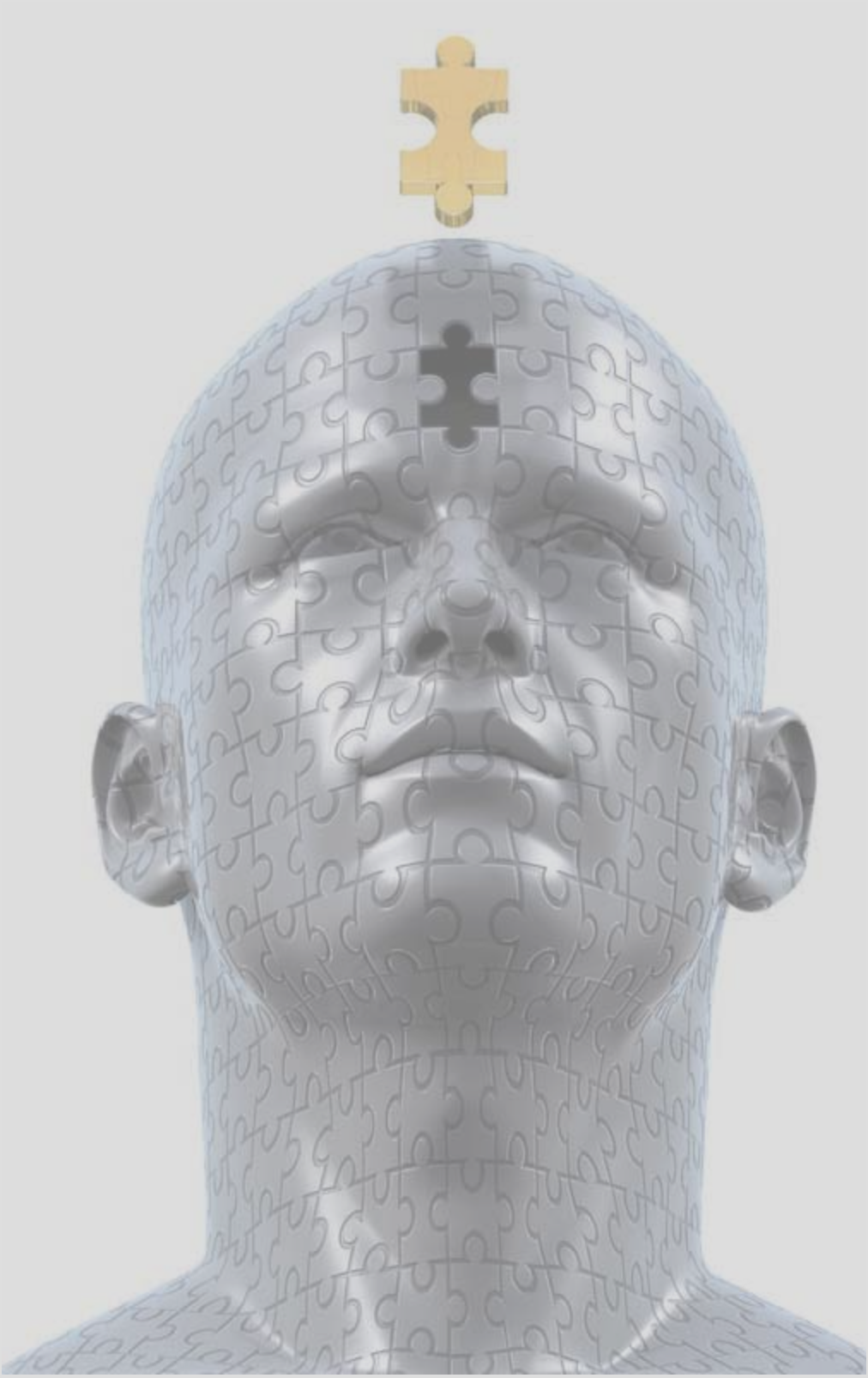
Fidelio Dental Insurance Company will continue to serve as our provider of dental care. Effective January 1, 2011, coverage limits are as indicated below:

Gold Plan	Bronze Plan
$3,000 annual family maximum $1,000 annual maximum per covered person	One exam per covered person, per benefit period One cleaning per covered person, per benefit period
The Gold Plan has a lifetime orthodontic maximum of $2500. This orthodontic maximum is not included in your yearly family maximum. Orthodontic benefits are for dependents up to the age of 19 years.	*Must use network provider.*

For information on eligibility or to locate an in-network dentist, a 24 hour hotline is available seven days a week at 215.885.2443 or 1.800.929.0340 (outside 215 and 610 area codes). Information is also accessible via the company's website at **www.fideliodental.com.**

IMPORTANT

Current members/participants will not receive new identification cards for dental or prescription benefits. Please continue to use the cards that have been issued to you.



MENTAL HEALTH AND SUBSTANCE ABUSE

The Allied Trades Assistance Program (ATAP) is an Employee Assistance Program (EAP) created by Philadelphia Trade Unions to address the needs of union members arising out of substance abuse and mental health issues as well as related problems. Service delivery is provided for drug and alcohol abuse, mental health concerns and related issues to union members, retirees and dependents. Member services include:

- **24-Hour Staffed Helpline** provided and staffed by professionally trained counselors and available 24 hours a day, 365 days a year
- **Telephone Screening** for initial assessment and to determine whether there is a need for emergency services. Based upon this initial assessment, either an immediate referral is made or an appointment is scheduled for a formal evaluation.
- **Referral Services** based upon the initial telephone screen and/or the formal evaluation. Individuals may then be referred to treatment.
- **Follow-up Contacts**, to support the participant, are made both during and after an individual has entered a treatment program in order to supplement and monitor the care received. These contacts are conducted according to an individually established schedule depending upon the needs of the individual and continue for not less than six months after completion of treatment.
- **Stress, Family and Other Problem Services** are offered.
- **A 12-week Aftercare Program** designed to provide support and direction in the early phases of recovery.

Additional service needs may be discussed with ATAP directly. Any participant currently receiving Mental Health and Substance Abuse support services should contact ATAP at 215.677.8820 or 1.800.258.6376 to discuss his/her current treatment plan and a possible transition process.

OTHER BENEFITS

There are no changes to the following benefits regardless of whether a member qualifies for the Gold Plan or the Bronze Plan:

- Vision
- Member Life Insurance
- Dependent Life Insurance
- Weekly Short-Term Disability.

CONTACTS

Laborers' District Council Benefits Fund
www.ldc-phila-vic.org
215.236.6700 or 215.765.4633
1.877.LABOR.77 or 1.877.522.6777 (outside the Philadelphia area)
Fax: 215.763.4380

Independence Blue Cross Customer Service
www.ibx.com
215.241.2273
1.800.275.2583 (outside the Philadelphia area)

Allied Trade Assistance Programs
www.alliedtrades-online.com
215.677.8820; 1.800.258.6376

Express Scripts
www.express-scripts.com
1.800.467.2006

Fidelio Dental Insurance Company
www.fideliodental.com
215.885.2443; 1.800.262.4949
(24 hour hotline) 215.885.2453; 1.800.929.0340

LDC Benefit Funds
P.O. Box 37003 • Philadelphia, PA 19122-0703
215.236.6700 215.765.4633

GCC/IBT 525-M

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