



**HEALTH & WELFARE
FUND BENEFITS
SUMMARY**

**Laborers' District Council
Building & Construction**

2018





SUMMARY OF MATERIAL MODIFICATION FOR 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 Building and Construction Health and Welfare fund Summary Plan Description (hereinafter referred to as the “Plan” except where specified otherwise). Please keep this SMM with your other benefits information.

Please call the Fund office to obtain a complete copy of the Summary Plan Description (SPD). You may also view and/or download the SPD on our website

www.myldcbenefits.com. Go to forms and downloads.

Dear Participant/Member:

The following is an update on your Medical Program, part of the Laborers District Council, Plasterer Tenders and Laborers Health and Welfare Plan.

Your Board of Trustees has taken great effort in maintaining a strong plan design for you and your family. The escalating costs of the current medical plan has now presented a situation where the Board will have to make changes to the plan in order to support the long term continuation of the benefits provided to you and your family. The costs associated with your current medical plan have increased by at least 15% in each year since 2014.

Combating this increase requires changes from the current plan design to an HMO platform including a change in the co-pays the members will experience. The Board of Trustees has voted to merge the Plasterer Tenders and Laborers' Health and Welfare Fund into the Building and Construction Health and Welfare Fund.

Effective, May 1, 2018, benefits will be administered under the Building and Construction Health and Welfare Fund. As it relates to your medical benefits, your coverage will be provided through Independence Blue Cross Keystone Health Plan East, effective May 1, 2018

Enclosed is a Summary of Material Modifications (SMM), which explains the specific changes to the medical plan. There are no changes to your eligibility requirements or your vision, dental, life insurance and prescription benefits. Effective May 1, 2018, we are pleased to announce that a weekly short-term disability benefit has been added to your coverage. Mental Health and Substance Abuse benefits will be administered through the Allied Trades Association Program (ATAP). To facilitate an orderly transition to Independence Blue Cross Keystone Health Plan East (HMO) you will need to select a primary care physician (PCP). We will send you information on selecting a primary care physician shortly.

If we can provide you with any additional information, please feel free to contact Mary Moss at 215-765-2014 ext. 2114.

Sincerely yours

A handwritten signature in black ink, appearing to read "Alan R. Parham". The signature is stylized and cursive.

Alan R. Parham
Administrator

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SUMMARY OF MATERIAL MODIFICATIONS TO THE LABORERS' DISTRICT COUNCIL BUILDING AND CONSTRUCTION HEALTH AND WELFARE FUND

Pursuant to the merger of the Laborers' District Council Plasterer Tenders and Laborers' Health and Welfare Fund (the "Plasterer's Fund") and the Laborers' District Council Building and Construction Health and Welfare Fund (the "Construction Fund"), you will have new medical, short-term disability and mental health/substance abuse benefits, effective May 1, 2018. Those benefits are described below.

Medical Benefits

The schedule of medical benefits, which are offered under the "Steel Tier" of benefits under the Construction Fund, is attached.

The eligibility conditions for Steel Tier benefits will remain the same as your current eligibility conditions under the Plasterer's Fund and, if you are currently working for an employer who contributes to the Plasterer's Fund, your contribution history and eligibility (if any) will transfer to the Construction Fund as of the merger on May 1, 2018.

For work you perform after the merger, you will earn eligibility credit toward Steel Tier medical benefits for employment with a "Merged Employer" and/or a "Steel Employer," as follows:

- Employment with a "Merged Employer" includes hours of work performed under a collective bargaining agreement requiring contributions to the Construction Fund provided that, as of April 30, 2018, the employer was obligated to contribute to the Plasterer's Fund. If your current employer contributes to the Plasterer's Fund on your behalf, then the employer most likely will qualify as a "Merged Employer" as of May 1, 2018.

- Employment with a "Steel Employer" is hours of work performed under a collective bargaining agreement that requires contributions to the Construction Fund and which expressly provides that contributions are being made for Steel Tier benefits. Hours earned or credited toward Steel Tier benefits are not transferable to other Tiers of benefits offered by the Construction Fund.

Short-Term Disability Benefits

Your short-term disability benefits under the Construction Fund are as follows:

- Maximum Weekly Amount: \$200.00
- Waiting Period:
- Due to Injury – None
- Due to Illness - 7 Days
- Maximum Benefit Period (Per Disability) 30 Weeks

Mental Health/Substance Abuse Benefits

The schedule of benefits for mental health/substance abuse benefits under the attached.

Please retain this summary with your summary plan description for the Construction Fund (which contains other terms and conditions applicable to your participation in the Fund).

WORK AND ELIGIBILITY PERIODS

Eligibility for STEEL

1. You will become initially eligible for Benefits on the first day of the fourth month in which you are employed in covered employment provided you have worked at least 172 hours during the preceding three months for one or more Participating Employers.
2. You will continue to be eligible for each month thereafter following the completion of at least 172 hours, during the preceding three- month period.
3. You must properly complete, sign and return the Census and Enrollment Information to the Health and Welfare Fund Office.

A person who fulfills all of the foregoing requirements is hereinafter referred to as a “Covered Person,” from the beginning of and during the Benefit Period for which he/ she fulfills these requirements.

A person will cease to be eligible to participate and shall not be considered a “Covered Person” as of the end of the month in which such individual has worked less than 172 hours during the previous three-month period. However, eligibility can be re-established as of the first day on the month following the completion of 172 hours in a three-month period.

MONTH ELIGIBLE	WORK PERIOD
JANUARY	SEPTEMBER, OCTOBER, NOVEMBER
FEBRUARY	OCTOBER, NOVEMBER, DECEMBER
MARCH	NOVEMBER, DECEMBER, JANUARY
APRI	DECEMBER, JANUARY, FEBRUARY
MAY	JANUARY, FEBRUARY, MARCH
JUNE	FEBRUARY, MARCH, APRIL
JULY	MARCH, APRIL, MAY
AUGUST	APRIL, MAY, JUNE
SEPTEMBER	MAY, JUNE, JULY
OCTOBER	JUNE, JULY, AUGUST
NOVEMBER	JULY, AUGUST, SEPTEMBER
DECEMBER	AUGUST, SEPTEMBER, OCTOBER

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 postpartum 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.

MEDICAL PLAN

Keystone Health Plan East New C2-F3 Steel

Independence

Laborers District Council

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

To get the most out of your benefits program, below are some key terms that you will need to understand.

1. **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
2. **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact IBC for authorization. For more information on the services requiring precertification, please refer to the back page of this summary.
3. **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefit limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit Period	Calendar year*
Doctor's Office Visits	
Primary Care Services	\$15 Copayment
Specialist Services	\$30 Copayment
Preventive Care for Adults and Children	100%
Pediatric Immunizations	100%
	<i>(office visit copayment does not apply)</i>
Routine Gynecological Exam/PAP	100%
	<i>1 per calendar year for women of any age (No referral required)</i>
Routine Eye Exam	Contact your Benefits Office
Mammogram	100%
	<i>(No referral required)</i>
Nutrition Counseling for Weight Management	100%
	<i>6 visits per calendar year</i>
Outpatient Laboratory/Pathology	100%

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount resets to \$0 at the start of the calendar year on January 1.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefits are administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross- independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

Benefit	Coverage
Doctor's Office Visits	
First OB Visit	\$15 Copayment
Hospital	\$150/day max of 5 Copayments/admission**
Inpatient Hospital Services	
Facility	\$150/day max of 5 Copayments/admission**
Physician/Surgeon	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	
Facility	90%
Physician/Surgeon	100%
Urgent Care Center	\$70 Copayment
Ambulance	
Emergency	100%
Non-Emergency	100%
Outpatient X-Ray/Radiology	
Routine Radiology/Diagnostic	\$50 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	\$100 Copayment
Therapy Services	
Physical and Occupational 30 total visits combined per calendar year	\$40 Copayment
Cardiac Rehabilitation 36 visits per calendar year	\$40 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	\$40 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	\$40 Copayment
Spinal Manipulation <i>20 visits per calendar year</i>	\$40 copayment
Allergy Injections <i>(Copayment waived if no office visit is charged)</i>	100%
Injectable Medications	
Standard Injectables	100%
Biotech/Specialty Injectables	\$100 Copayment

** Copayment waived if readmitted within 10 days of discharge for any condition.

+ Copayment not applicable when service performed in Emergency Room or office setting.

*** Office visits subject to copayment.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	Coverage
Chemo/Radiation/Dialysis	90%
Outpatient Private Duty Nursing <i>360 hours per calendar year</i>	90%
Skilled Nursing Facility <i>360 hours per calendar year</i>	\$75/day maximum of 5 Copayments/admission**
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%
Out-Of-Pocket Maximum <i>(includes copayments and coinsurance)</i>	
Individual	\$3,300
Family	\$6,600

** Copayment waived if readmitted within 10 days of discharge for any condition.
The benefits may be changed by IBC to comply with applicable federal/state laws and regulations

What Is Not Covered?

1. Services not medically necessary
2. Routine Eye Exams
3. Spinal Manipulations
4. Mental Health and Substance Abuse : Covered via ATAP 1-800-258-6376
5. Services or supplies that are experimental or investigative except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
6. Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
7. Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
8. Reversal of voluntary sterilization
9. Expenses related to organ donation for non-member recipients
10. Acupuncture
11. Dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
12. Music therapy, equestrian therapy, and hippotherapy
13. Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (TTY: 711).

PRESCRIPTIONS

Express Scripts will continue to serve as our provider of prescription benefits.

	Retail	Home Delivery
Generic	\$5.00	\$10.00
Formulary	\$15.00	\$30.00
Non-Formulary	\$30.00	\$60.00

After the fund pays \$2,000 per family a 50% co-pay applies

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 copay amounts, a member will pay two copay 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 will save money on your copayments. In addition, you will 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 Horne 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 Horne 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. The U.S. Food and Drug Administration (FDA) has approved any prescribed generic drug 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

Fidelio Dental Insurance Company will continue to serve as our provider of dental care.

<u>COVERAGES</u>	<u>IN-NETWORK</u> Participating Dentist	<u>OUT-OF-NETWORK</u> Non-Participating Dentist				
Annual Maximum - \$2000 per family per Calendar Year Pre-determination of treatment plans over \$300 No Deductible	PATIENT HAS NO BALANCE BILLING! Dentist Accepts Fidelio UCR Fee Schedule	PATIENT IS SUBJECT TO BALANCE BILLING! Dentist <u>DOES NOT</u> accept Fidelio's UCR Fee Schedule The difference between dentist's charge and Fidelio's UCR Fee Schedule is the <u>responsibility</u> of the patient (balance billing)				
Preventive / Diagnostic (cleaning, fluoride treatments, exam, x-rays, etc.)	<table border="1"> <thead> <tr> <th><u>Fidelio</u></th> <th><u>Patient</u></th> </tr> </thead> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>		<u>Fidelio</u>	<u>Patient</u>	100%	0%
<u>Fidelio</u>	<u>Patient</u>					
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Basic Services (fillings, etc.) Amalgams (silver fillings) and composites (white fillings) are a benefit for both front and back teeth.	<table border="1"> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>		100%	0%		
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Major Restorations (dentures, crowns, etc.)	<table border="1"> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>		100%	0%		
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Endodontics (root canal therapy, etc.)	<table border="1"> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>	100%	0%			
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Oral Surgery (extractions, etc.)	<table border="1"> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>	100%	0%			
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Periodontics (treatment of gum disorders, etc.)	<table border="1"> <tbody> <tr> <td>100%</td> <td>0%</td> </tr> </tbody> </table>	100%	0%			
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Orthodontics * (straightening of teeth, etc.)	<table border="1"> <tbody> <tr> <td>\$1,750</td> <td>\$750</td> </tr> </tbody> </table>	\$1,750	\$750			
\$1,750	\$750					

*Orthodontic benefits per eligible dependent up to age 19 with a separate lifetime maximum of \$1750 per patient. (Invisalign is not a covered benefit.)

For information on eligibility or to locate an in-network dentist, a 24 hour hot-line is available seven days a week at 215.885.2453 or 1.800.929.0340 (outside 215 and 610 area codes). Information is also accessible via the company's website at www.fideliodental.com.

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. For 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.

General Comments:		
To ensure full payment of benefit, each covered person and his/her dependents must contact ATAP before receiving treatment for mental illness or drug/alcohol addiction.		
The number for ATAP is 800-258-6376 or 215-677-8820.		
Claims received without an ATAP authorization should be reviewed with ATAP prior to denial. If they confirm that the service was not authorized, no payment will be issued.		
	In Network Benefits	Out of Network Benefits
General Benefits	With ATAP Approval	Benefits
Deductible	\$0	Not Applicable
Lifetime Maximum	Unlimited to plan allowance	Not Applicable
Annual Copayment Maximum	\$3,300 Individual/\$6,600 Family	Not Applicable
Copays-Office Visits- 4 visits total per plan year for all outpatient services	\$30 Specialist	Not Applicable
Annual Coinsurance Limit	Not Applicable	Not Applicable
Coinsurance	Not Applicable	Not Applicable
Benefit's tracked by Plan Year or Calendar Year?	May-April - Plan Year	Not Applicable
Dependents Covered Through	End of month in which they turn 26	Not Applicable
Additional medical benefits payable by Aicare?	Not applicable	Not Applicable
Inpatient Hospital Copays/Coinsurance - (Waived for the first admission but applied to subsequent admission within 12-month period)	\$150 copay per day up to 5 copays.	Not Applicable
Inpatient Hospital Days	10 days per plan year	Not Applicable
	In Network Benefits	Out of Network Benefits
General Benefits	With ATAP Approval	Benefits
Psychiatric - Partial Day Facility Charges- If a member is stepped down from an inpatient unit as a part of a continuum of care plan into a partial hospitalization program, then the copay will be waived. If the member goes into a partial program without the initial hospitalization admission, then the copay will be applied.	\$30 copay	Not Applicable
Psychiatric Room & Board Facility Charges - (Waived for the first admission but applied to subsequent admission within 12-month period)	\$150 copay per day up to 5 copays.	Not Applicable
Psychiatric Facility- Miscellaneous Facility Charges	Included in Room & Board Facility Charges	Not Applicable
Psychiatric Facility- Outpatient	\$30 copay	Not Applicable
Psychiatric Testing - Inpatient Professional Charges	Inpatient included in Room & Board Facility Charges.	Not Applicable
Psychiatric Testing- Outpatient Professional Charges	\$30 copay	Not Applicable
Psychotherapy - Inpatient Professional Charges	Included in Room & Board Facility Charges	Not Applicable
Psychotherapy - Outpatient Professional Charges	\$30 copay	Not Applicable
Substance Room & Board Facility Charges - (Waived for the first admission but applied to subsequent admission within 12-month period)	\$150 copay per day up to 5 copays.	Not Applicable

Substance Abuse- Inpatient Physician Visit	Included in Room & Board Facility Charges	Not Applicable
Substance Abuse- Outpatient Physician Visit - Therapist or Certified Addiction Counselor Visits Only.	\$30 copay	Not Applicable
Substance Abuse- Partial Day Facility Charges - <i>If a member is stepped down from an inpatient unit as a part of a continuum of care plan into a partial hospitalization program, then the copay will be waived. If the member goes into a partial program without the initial hospitalization admission, then the copay will be applied.</i>	\$30 copay	Not Applicable
Substance Detox- Inpatient Facility Charges - <i>(Waived for the first admission but applied to subsequent admission within 12-month period)</i>	\$150 copay per day up to 5 copays.	Not Applicable
Substance Abuse Hospital Misc. Facility Charges	Included in Room & Board Facility Charges	Not Applicable
Substance Abuse- Outpatient Facility Charges	\$30 copay	Not Applicable
Pharmacological Management Inpatient Physician Charges	Included in Room & Board Facility Charges	Not Applicable
Effective 5/1/2018		

OTHER BENEFITS:

Vision

National Vision Administrators will continue to serve as our provider of Vision care.

NATIONAL VISION ADMINISTRATORS (NVA) Customer Service Number 1-800-672-7723		
	In-Network	Out-of-Network
Vision (Routine Eye Exam only) Exam, once every 24-month period. (Children under 19 may receive exam & lenses yearly if required due to change in vision.)	100% List of participating providers and claim forms available, call NVA 1-800-672-7723. In-network provider will accept allowance paid by Fund.	\$20 Bill should be sent to NVA.
Lenses (per pair) (In-network providers will accept the allowance as payment in full)	100% basic clear lenses. Extras at wholesale cost plus 25%.	\$12 Single vision \$15 Bifocal lenses \$18 Trifocal lenses
Frames	Wholesale cost less \$25; member pays balance plus 20%.	\$60 includes exam.
Contact Lenses (Elective Cosmetic) (Benefit limited to contacts <u>or</u> frames and lenses once in a 24-month period.)	\$60 allowance toward retail minus 25%; includes exam.	\$150 maximum includes exam.
Contact Lenses (Medically Necessary)	\$150 (provider must obtain pre-authorization)	
Use your Medical Insurance (Personal Choice) for medical conditions of the eye.		

Member Life Insurance

Coverage	Benefit
Life insurance Covered Person	5,000.00
Accidental Death and Dismemberment Covered Person	5,000.00

Weekly Short-Term Disability

Your short-term disability benefits under the Construction Fund are as follows:

- Maximum Weekly Amount: \$200.00
- Waiting Period:
- Due to Injury- None
- Due to Illness - 7 Days
- Maximum Benefit Period (Per Disability) 30 Weeks

CONTACT

Laborers' District Council Benefits Fund

www.ldc-phil-a-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

