October 2019

Cooperation of Benefits Between Medicare and Retiree Health & Welfare Benefits

It is important to understand that Medicare becomes the primary payer of your health claims once you, your spouse or your dependent becomes eligible for Medicare coverage. Let’s say you are first eligible for Medicare the month you turn age 65. Did you know it is recommended that you apply for Medicare benefits four (4) months before your eligibility date?

All health benefit claims under the Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits are processed and paid taking into consideration the date an individual is first eligible for Medicare, whether or not the individual actually elects to enroll in Medicare. The Plan issues benefit payments based on the assumption that you have enrolled in Medicare Part A and Part B. Remember to elect both Medicare Part A and Part B when you enroll.

As soon as you receive your Medicare ID card, please send a copy of it to the Retirement Benefits Department. Please write the retired carpenter’s identification number on the copy of the card. It can be found on your prescription drug ID card or your BCBS card. You can send a copy of your Medicare card one of three different ways:

Scan & E-mail: pension@crccbenefits.org

Fax: Chicago Regional Council of Carpenters Pension Fund
     (312) 951-3986

Mail: Chicago Regional Council of Carpenters Pension Fund
      12 E. Erie Street – 8th Floor
      Chicago, IL 60611

Women’s Health and Cancer Rights Act of 1998

If a participant or dependent had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of 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 treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits are subject to the same eligibility, deductible and coinsurance rules applicable to other medical and surgical benefits provided under the Plan.
Your Right to Receive a Copy of the Fund’s Notice of Privacy Practices

The Chicago Regional Council of Carpenters Welfare Fund (“Fund”) is required by law to maintain the privacy of your health information as described in its Notice of Privacy Practices. You have a right to request and receive a copy of that notice at any time, even if you have received the notice previously. For a copy, visit the Fund’s website at www.crrcbenefits.org. On the left hand side of the screen, under Health Plans, select “Forms.” The forms are in listed in alphabetical order, sectioned by Actives and Retirees.

Or, you may contact the Welfare Fund’s Privacy Official by writing or calling the Fund Office Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m. at:

Chicago Regional Council of Carpenters Welfare Fund
12 East Erie Street
Chicago, IL 60611
Phone: 312-787-9455, option 4

If you have any questions about this notice, please contact the Fund Office Monday through Friday, between the hours of 8:00 a.m. and 4:30 p.m. To speak to a Retirement Benefits Representative, please call (312) 787-9455, Menu Option 4.

Sincerely,

The Board of Trustees

This announcement contains highlights of certain features of the Chicago Regional Council of Carpenters Welfare Fund, Retiree Plan of benefits. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the language contained in this announcement and the documents that establish the Plan, the document language will govern and control. The Trustees reserve the right to amend, modify or terminate the Plan at any time. Receipt of this announcement does not guarantee eligibility.

The Chicago Regional Council of Carpenters Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.
IMPORTANT NOTICE FROM
THE CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you may easily refer back to it. This notice has information about your current prescription drug coverage with the Chicago Regional Council of Carpenters Welfare Fund ("Fund") and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1.) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2.) The Chicago Regional Council of Carpenters Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current prescription drug coverage (and prescription drug coverage for your spouse and dependents) with the Chicago Regional Council of Carpenters Welfare Fund will be CANCELLED.

Information about your current prescription drug coverage is enclosed with this notice.
When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Chicago Regional Council of Carpenters Welfare Fund and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription coverage that’s at least as good as Medicare’s prescription coverage; your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the Retirement Benefits Department at (312)787-9455, telephone menu option 4.

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Chicago Regional Council of Carpenters Welfare Fund changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Chicago Regional Council of Carpenters Welfare Fund
Contact: Retirement Benefits Department
12 E. Erie Street, Chicago, IL 60611
(312)787-9455, telephone menu option 4
**How to Use the Prescription Drug Program**

The Chicago Regional Council of Carpenters Welfare Fund has partnered with Express Scripts (ESI) to provide you with competitive prescription drug pricing. If you use a pharmacist in the ESI network and display your ESI ID card, you will be required to pay a co-payment for each prescription as shown in the chart below.

*If you do not use a network pharmacy or if you do not present your ESI ID card when you purchase a prescription, you must pay the full cost of the prescription and submit a completed claim form to ESI for reimbursement. ESI will reimburse you the amount the Plan would have paid for the prescription had you used an ESI participating pharmacy and presented your ESI ID card, less the applicable co-payment. The co-payment structure is:*

<table>
<thead>
<tr>
<th></th>
<th>ESI Network Retail Pharmacy (Lesser of 100 pills or a 30-day supply)</th>
<th>ESI by Mail (Up to a 90-day supply through mail order)</th>
<th>Accredo (For specialty drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Co-Payment</strong></td>
<td>$5</td>
<td>$12.50</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Single-Source Brand</strong></td>
<td>20% $10 minimum Co-Pay with a $100 maximum</td>
<td>20% $25 minimum Co-Pay with a $250 maximum</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Multi-Source Brand</strong></td>
<td>35% $20 minimum Co-Pay</td>
<td>35% $50 minimum Co-Pay</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Specialty Medications</strong></td>
<td>n/a</td>
<td>n/a</td>
<td>20% $20 minimum Co-Pay with a $100 maximum</td>
</tr>
<tr>
<td><strong>Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>$1,500 per individual / $3,000 per family</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td><strong>Single-Source Brand Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>$1,500 per individual / $3,000 per family</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Medication Out-of-Pocket Maximum per Calendar Year</strong></td>
<td>n/a</td>
<td>$1,500 per individual / $3,000 per family</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** If the cost of the medication is less than the coinsurance, you will only pay the cost of the medication.

If you or your dependent is eligible for prescription drug coverage and your medication is dispensed as a generic drug you will only pay $5 for a 30-day supply. A generic equivalent has the same active ingredient as the brand-name drug, even though it may have a different color and shape. It is very important to realize that you will have a greater out of pocket expense if for any reason you or your doctor refuse a generic equivalent when one is available.
**Prescription Drug Benefits – Specialty Drug Clinical Management Programs**

The Plan participates in Specialty Drug Clinical Management programs. The programs were put in place for new patients with new specialty medication prescriptions. Specialty drugs are medications used to treat complex conditions, such as cancer, hemophilia, immune deficiency, and rheumatoid arthritis, and they require an enhanced level of service.

Accredo has targeted therapy management programs which assist the Plan in reducing the cost of care, while helping participants enjoy an enhanced quality of life. Accredo provides a focused level of care to participants. Specialty-trained pharmacists and registered nurses who are experienced in managing chronic condition therapies work closely with you and your physician to promote positive clinical outcomes. In addition, patient care teams can provide you with drug administration training, patient counseling, side effect mentoring, adherence monitoring, and coordination of delivery with the patient, physician, or infusion center.

**Prescription Drug Benefits – Preferred Drug Programs**

The Plan provides for a Preferred Drug Step Therapy program that identifies generic or brand-name medications in certain drug classes and recommends FDA approved lower cost generic options to the brand-name medication. If your doctor prescribes a non-preferred brand, you will need to switch to a generic or preferred brand-name for the Plan to cover the medication. In certain cases, if your doctor believes you cannot switch medications, he can request a coverage review by ESI.

The Plan also participates in the ESI National Preferred Formulary. The formulary is a broad list of preferred medications used by ESI clients nationwide. The formulary is subject to change from time to time. In the event that your medication is removed from the formulary by ESI, you will be notified well in advance and informed of other drugs available to you in the same therapeutic class. Medications not on the ESI National Preferred formulary are not covered by the Plan.

To find out more about the Preferred Drug Step Therapy program or the National Preferred Formulary contact ESI at 800-939-2089 or visit their website at www.express-scripts.com. Service Representatives are available 24 hours a day, 7 days a week.

**Amount Limitations at a Retail Pharmacy**

The amount of medication usually prescribed for you by your doctor or dentist is covered, but no benefit is payable for more than a 30-day supply or 100-unit doses, whichever is LESS. If your doctor provides a dosage in excess of the maximum dosage recommended by the manufacturer, you may need to obtain a letter of medical necessity before a full supply can be dispensed.

**Maintenance Medications - Mail Order Prescription Drug Service**

The mail-order prescription drug service allows you to receive a 90 day supply of prescription medication delivered directly to your home for one co-payment. All maintenance medications MUST be filled by ESI’s mail-order prescription drug service. Maintenance medications are medications that are continually taken on a regular basis (e.g. high blood pressure, cholesterol lowering, allergy, etc.). If you take a maintenance medication prescription drug, you will be allowed a maximum of three (3) times to have the prescription for that medication filled at a retail pharmacy (drug store). After that, the maintenance medication prescription will still be covered by the Plan, provided that you use the mail-order service. Note that the mail-order prescription drug service is only mandatory for maintenance medication. You will still be able to have prescriptions for illnesses that are temporary in nature, such as antibiotics for respiratory infection, filled at a retail pharmacy (drug store).

**How the Mail Order Program Works**

If you are currently taking a maintenance-type medication or your doctor prescribes one, ask the doctor to prescribe a 90-day supply with refills. If a generic drug can be effectively substituted for a brand name drug, have your doctor indicate that as well. Check your prescription before leaving your doctor’s office to make sure that: the doctor’s name is legible; the doctor’s phone number and address are on the prescription; the exact daily dosage is indicated; the exact strength is indicated; the exact quantity with number of refills is indicated; and the full first name and last name of the patient are legible. You can obtain a Mail Order Form by calling ESI at 1-800-939-2089. Mail the original prescription along with the appropriate co-payment and completed order form in the envelope that will be provided. Your prescription will be filled within two weeks after ESI receives your order.
Lower Costs
You save money when you order a prescription using ESI’s Mail Order Program because you receive greater quantities of medication at one time—up to a 90-day supply.

Convenience
You save the time and trouble of going to the pharmacy. All you have to do is mail your prescription to ESI. You’ll receive your prescription at home by First Class Mail or UPS, postage paid.

Customer service
For questions that you or your doctor may have about your prescriptions, Express Scripts can be reached toll free at 1-800-393-2089. Express scripts representatives are available 24 hours a day, 7 days per week.

For questions pertaining to Specialty Medications, Accredo Representatives can be reached toll free at 1-800-803-2523 Monday thru Friday 7a-10p (CST) and Saturday 8a-4p (CST).

Drugs Covered
Drugs covered include any “legend” drug that is lawfully obtainable only from a person licensed to dispense drugs upon the written order (prescription) of a physician or dentist. A “legend” drug is any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled “Caution – Federal Law prohibits dispensing without prescription.” Prescribed syringes and hypodermic needles are also covered. Injectable insulin, although not a “legend” drug, is also covered.

Drugs/Items NOT Covered
The exclusions listed below are not all-inclusive, and are only representative of the type of charges for which benefits are limited or not payable under the Plan.

The Plan does not cover:

1. Prescription drugs, indications and/or dosage regimens determined to be not medically necessary or experimental, investigational or unproven medication or therapies, or drugs not approved by the United States Food and Drug Administration (FDA) for the intended use (off label).
2. Prescription drugs requiring prior authorization that are dispensed without prior authorization from the contracted provider.
3. Any medication prescribed in a manner other than in accordance with criteria developed by the contracted provider.
4. Erectile dysfunction drugs, except as prescribed as a medically necessary treatment plan for an illness, other than erectile dysfunction.
5. Drugs or medicines lawfully obtainable without a prescription from a physician or dentist, except to the extent required under the Affordable Care Act.
6. Therapeutic devices, support garments or other appliances regardless of their intended use.
7. Any charges for the administration of a prescription drug.
8. Medication that is to be taken by or administered to the covered individual, in whole or in part, while he or she is a patient in a licensed hospital, extended care/skilled nursing facility or similar institution that operates a facility for dispensing pharmaceuticals on its premises or allows to be operated on its premises, except as provided in for extended care/skilled nursing facility exceptions.
9. A prescription in excess of the quantity specified by the physician or dentist, or any refill dispensed after one year from the order of a physician or dentist.
10. Prescription drugs that may be properly received without charge under local, state or federal programs, including workers compensation.
11. Weight loss drugs.
12. Smoking cessation products, except as required for preventive care under the Affordable Care Act guidelines and interpretive guidance.

13. Drugs to stimulate hair growth.


15. Acne drugs for cosmetic reasons.

16. Vitamins, food supplements, infant formulas or homeopathic drugs.

17. Growth hormones unless medically necessary, as determined by the contracted provider and obtained through the Specialty Care Pharmacy Program.

18. Certain drugs deemed by the UBC Clinical Advisory Committee (and adopted by the Plan) to be excluded from coverage, generally because other alternative medications are available.

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