PLUMBERS AND PIPEFITTERS LOCAL 501
NORTHERN ILLINOIS BENEFIT FUNDS

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NOTICE TO ALL PARTICIPANTS

November 2001

To All Plan Participants in the Northern Illinois Benefit Fund:

The Board of Trustees is pleased to announce **several improvements to your Plan of Benefits** which are described in this notice. After you read the notice, please keep it in the pocket of your 3-ring Summary Plan Description (SPD) notebook for future reference.

- **INCREASED HEARING CARE BENEFIT**

  For covered expenses incurred on and after June 1, 2001, the maximum benefit payable per person for hearing care will be $1,500 per ear every 5 calendar years. This replaces the previous $1,000 lifetime maximum for both ears. The Plan co-pay percentage for covered hearing care expenses will remain at 80% with no deductible. A list of covered hearing care expenses is on page 54 of your SPD.

- **INCREASED FRAME ALLOWANCE**

  Your vision benefits are provided and administered by Vision Service Plan (VSP) in accordance with a contract between VSP and the Trustees. Under this program you can choose to receive your vision care from a VSP doctor or from a non-VSP doctor. When you use a VSP doctor, you can get examinations, lenses, and good quality frames at no out-of-pocket expense to you.

  Effective July 1, 2001, the Trustees have arranged with VSP for you to have *an even greater selection of good quality frames when you use a VSP doctor*. The prepaid frames you can choose from have an approximate retail value of $90-$135.

  The $35 allowance for frames obtained from non-VSP doctors will not change.

- **PAYMENT OF BENEFITS FOR AMBULANCE SERVICES**

  Effective June 1, 2001, covered medical expenses for professional ambulance services will be paid the same as covered PPO provider charges. This means that the $100 calendar year deductible will apply (instead of the $200 non-PPO deductible), and your 20% out-of-pocket co-pay share will apply to the $1,000 PPO out-of-pocket limit (instead of the $2,000 non-PPO out-of-pocket limit).

- **SELF-PAYMENT PROGRAM FOR SURVIVORS OF ACTIVE EMPLOYEES**

If an eligible employee dies, his surviving spouse can continue her coverage by making monthly self-payments. The following rules apply:

1. The monthly self-payment amounts are currently $300 for spouses under age 65 and $250 per month for spouses age 65 and over. Payments are due by the first of the month for which coverage is desired. Please note that the amount of the self-payment is determined by the Trustees and can be changed at any time.

2. If a surviving spouse makes the self-payments, she and any covered children will be eligible for the same medical, dental and vision coverage they had before the employee's death. (Covered surviving children include only those who meet the Plan's definition of a dependent child.)

3. There must be no lapse in coverage between the survivor's coverage as a dependent and her coverage as a survivor.

4. When a surviving spouse reaches age 62, she will not have to make self-payments to continue her coverage IF: (1) she had ten years of coverage (including coverage due to survivor self-payments); OR (2) the deceased employee would not have had to make self-payments at age 62 (had he lived). Self-payments will still be required to continue coverage for any covered children.

5. If the employee has no surviving spouse, the self-pay option can be elected by or on behalf of his eligible children.

6. In order to elect the survivor self-pay option, the widow must first reject COBRA Coverage and waive her right to COBRA Coverage in the future (some exceptions are described in No. 7 below).

7. Self-payments will no longer be accepted and the survivor's coverage will terminate if and when any of the following events occur:

    a. The surviving dependent (spouse or child) becomes covered under another group health care plan. This does not apply if the other coverage is Medicare, or to an age 62+ spouse who is not required to make self-payments for her coverage.

    b. If the widow remarries. However, if this occurs before she has had 36 months of survivor coverage, she can make COBRA self-payments for the remainder of the 36-month period. The remarriage of an age 62+ spouse who is not required to make self-payments will not result in termination.

    c. If a surviving child no longer meets the definition of a dependent (for example, when he reaches the age limit). If this happens before the child has had 36 months of survivor coverage, he can make COBRA self-payments for the remainder of the 36-month period.

The same rules apply to surviving dependents of eligible retirees.

The above rules are effective as of January 1, 2001. Survivors of employees who died on or after that date are eligible to participate. Participation is also open to any surviving spouse who, as of January 1, 2001, was making COBRA self-payments due to the employee's death.

- **CONTINUED COVERAGE FOR WIDOWS OF RETIREES**

A deceased retiree's surviving spouse may continue to make self-payments through May 31, 2002 to continue her coverage. (This provision is reviewed every year by the Trustees, who decide in their sole discretion whether or not to extend this privilege for another year.)

- **COVERED MENTAL HEALTH THERAPISTS**

LICENSED MARRIAGE AND FAMILY THERAPISTS—Beginning with charges incurred January 1, 2001, services provided by a licensed marriage and family therapist (L.M.F.T.) will be considered covered medical expenses with respect to the treatment of chemical dependency, mental or nervous disorders, and learning or behavior disorders. (The Plan excludes marriage or family counseling that is not medically necessary for the treatment of these conditions.) Any benefits payable for services of an L.M.F.T. are subject to all the same Plan benefit provisions, maximums and other limitations as other treatments for these conditions.

OTHER COVERED THERAPISTS—The Plan covers outpatient treatment of chemical dependency, mental or nervous disorders, and learning or behavior disorders provided by: (1) an M.D.; (2) a licensed psychologist (Ph.D); (3) a licensed clinical social worker (L.C.S.W.); (4) a licensed certified professional counselor (L.C.P.C.), or provider with equivalent training, qualifications and certification; and (5) a licensed marriage and family therapist (L.M.F.T.) (see above). Effective January 1, 2001, the Plan no longer requires that these practitioners be under the supervision of a medical doctor.

- **SUICIDE AND SELF-INFLICTED INJURIES**

As stated in exclusion No. 11 on page 80 of your SPD, the Plan currently excludes all intentionally self-inflicted injuries, suicides, attempted suicides, and intentional drug overdoses, while sane or insane. Effective July 1, 2001, this provision was revised to cover self-inflicted injuries in certain circumstances. The revised exclusion reads:

> [No payment will be made for:] Charges incurred for treatment of injuries caused by suicide, attempted suicide or self-inflicted injury, unless the injuries resulted from a medical condition (including both physical and mental health conditions). However, no benefits will be paid for such charges if the self-inflicted injury, suicide or suicide attempt was the result of the illegal use of drugs, whether or not the person has a medical (physical or mental health) condition. This exclusion does not apply to Life Insurance for Employees or to the Death Benefit for Retirees.

- **CHEMICAL DEPENDENCY WAITING PERIOD REMOVED**

The rule that excluded coverage for chemical dependency treatment during a covered person's first 12 months of coverage under the Plan was removed from the Plan effective July 1, 2001.

- **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROCEDURES**

The Plan is sometimes presented with a court order to provide coverage for a child who would not otherwise be considered a covered dependent. Court orders must meet certain conditions before the Plan may be obligated to provide such coverage. Qualifying orders are called "Qualified Medical Child Support Orders" (QMCSOs).

The Trustees, in consultation with the Fund Attorney, have adopted procedures for determining whether a particular court order qualifies as a QMCSO. If you would like a copy of the Plan's QMCSO procedures, please call or write the Fund Office. If you are a responsible party in a court action involving a child, you should request a copy of the Plan's procedures BEFORE the final order is entered.

- **CLAIMS FOR SUBSEQUENT TREATMENT**

Certain services and supplies are currently covered only if the original injury, surgery or sickness necessitating those services or supplies occurred while the person was covered under the Plan. Effective November 1, 2001, these services and supplies will be covered even if the person was not eligible when the original injury or sickness occurred. Please note that all other applicable provisions, limitations and exclusions will continue to apply.

Below are the Plan provisions affected by this change, the revised rules, and where you can find them in your SPD:

1. Under the **Comprehensive Benefit** (your medical benefits):

   a. Cosmetic or reconstructive surgery will be covered when the surgery is: 1) for repair of injuries sustained in a non-occupational accident; 2) for the repair of congenital defects of newborn children; or 3) for repair of defects which result from surgery for which Plan benefits were paid (or would have been payable if the person had been covered under the Plan). (No. 7 on page 64)

   b. Dental Care Payable as Medical Treatment - The Plan will cover dental services rendered by a doctor, dentist or dental surgeon for the treatment of a fractured jaw or of injury to natural teeth, including replacement of teeth, provided the services are rendered within six months of, and as a result of, a non-occupational accidental injury. (No. 14 on page 65) The Plan will also cover dental prosthetic appliances, including any charges made for the fitting or repair of any of these appliances, if the service or supply was rendered as a result of a non-occupational accidental bodily injury. (No. 27, page 80)

2. Under the **Dental Benefit**:

   a. Replacement of a prosthetic appliance, crown, inlay, onlay restoration or fixed bridgework (excluding dentures) will be covered under the Dental Benefit if the replacement is required as the result of a non-occupational accidental injury (or if three years have elapsed since the last placement of such an item).

   b. Replacement of an existing partial or full removable denture or the addition of teeth to an existing partial removable denture or to bridgework will be covered if satisfactory evidence is presented that: the replacement is required as the result of a non-occupational accidental injury.

- **LOSS OF TIME (DISABILITY) CLAIMS**

Effective January 1, 2002, the following claim processing and appeal procedures will apply to claims for Loss of Time (disability) benefits:

CLAIM PROCESSING TIME LIMITS—When you file a claim for benefits, be sure to follow the proper claim filing procedures. The Fund Office receives claims during regular business hours 5 days per week (Monday through Friday). If all information is provided to the Fund Office, your claim will usually be processed within 45 days. If you send a claim to the Fund Office and it can't be processed because information is missing, you will receive a notice stating why the claim can't be completed and what additional information is needed.

Notice about incomplete claim information will be sent to you within 45 days. It is your responsibility to send the missing information to the Fund Office. If and when all necessary information has been received, approval or denial of a claim will usually be made within 30 days. An extension may be necessary due to matters beyond the control of the Plan. You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than 30 days. (A second 30-day extension may be needed in special circumstances beyond the Plan's control).

CLAIM DENIALS—If all or a part of your claim is denied after the Fund Office has received a completed claim form and all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of the claim appeal procedure. The notification will state: (1) the specific reason for the determination with reference to the specific Plan provisions on which the determination is based; (2) a description of any additional material or information necessary to perfect the claim, and the reason such information is necessary; (3) a description of the review procedures and the applicable time limits for following the procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA; (4) the specific internal rule, guideline, protocol or similar criterion the administrator relied on to make the decision (if applicable); and (5) if the decision was based on medical necessity, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

HOW TO FILE A CLAIM APPEAL—If you want the Trustees to review your claim after a denial of benefits, request a claim appeal form from the Fund Office. When you receive the form, fill it out completely. Attach any additional information that you think will help a favorable decision to be made on your claim. Return the completed form within 180 days after the date the denial was mailed to you to:

Board of Trustees
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60504-8879

FULL AND FAIR REVIEW—The Trustees will conduct a full and fair review of all the material submitted with your claim, the action taken by the Fund Office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will: (1) be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party; (2) not afford deference to the initial adverse benefit determination; and (3) take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination. You have the right, upon request and free of charge, to have copies of all documents, records and other information relevant to your claim for benefits. With respect to a review of any determination based on a medical judgement, the Board of Trustees must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgement. Such health care provider must be "independent," which means the medical individual consulted must be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision. The Plan will not preclude an authorized representative (including a health care provider) from acting on your behalf, although the Trustees will verify that an individual has been so authorized.

NOTIFICATION FOLLOWING REVIEW—A review and determination of your disability claim will be made no later than the date of the Trustees meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a determination may be made by no later than the date of the second meeting. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a determination will be rendered not later than the third Trustees meeting. Before the start of the extension, you will be notified in writing of the extension, including a description of the special circumstances and the date as of which the determination will be made. After a decision has been made, you will be informed in writing of the Trustees' decision, normally

within 5 calendar days of the review. When you receive the decision on your appeal, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to you claim; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; a statement of your right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed of the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request. If the Plan fails to make timely decisions or otherwise fail to comply with the applicable federal regulations, you may go to court to enforce your rights.

***** REMINDER ABOUT COVERAGE FOR BREAST RECONSTRUCTION *****

This Plan will provide coverage for the following medical and surgical services provided to a covered person in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications relating to all stages of the mastectomy, including lymphedemas.

Plan benefits payable for these services and supplies are subject to all applicable deductibles, co-payment percentages and maximum benefit limitations.

SUMMARY OF MATERIAL MODIFICATIONS
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