PLUMBERS AND PIPEFITTERS LOCAL 501
NORTHERN ILLINOIS BENEFIT FUNDS

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NOTICE OF BENEFIT FUND CHANGES

To All Northern Illinois Benefit Fund Plan Participants: **November 2002**

The Trustees of the Northern Illinois Benefit Fund are pleased to announce the following improvements and changes in your Plan of Benefits. Please read this notice and keep it with your Summary Plan Description (SPD) binder for future reference.

TRANSPLANT MAXIMUM BENEFIT—Effective July 1, 2002, the transplant maximum benefits will not apply when the covered person contacts and follows the advice of the case management organization. Call the Fund Office at 630-978-4600 if you need a transplant. The Fund Office will put you in touch with the case management organization, who will work with you, your doctor and the hospital to make sure you receive effective, quality care.

If you do not call the Fund Office (and then the case review manager), or if you choose not to have your transplant managed by the case management organization, the maximum benefits shown on page 16 of your SPD will still apply. (Prescription drugs do not apply to the transplant maximums.)

CLAIM PROCESSING AND APPEAL TIME LIMITS—The following claim filing procedures apply to all claims filed on and after July 1, 2002:

When used in the following explanation, the term "Fund Office" means the office or organization designated by the Trustees for handling claims.

When you file a claim, 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).

Claim Processing Time Limits: The amount of time the Fund Office an take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A disability claim is a claim for Loss of Time Benefits.
- A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested.

If all information is provided to the Fund Office, your claim be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- For disability claims (Loss of Time Benefits), within 45 days.
- For all other claims, within 30 days.

You may have an authorized representative (including a health care provider) act on your behalf, although the Trustees will verify that the person has been so authorized.

When Additional Information Is Needed: If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. If the request goes to your medical pro-

vider, you will receive a copy of the request. The request for additional information will be sent within the normal time limits shown above.

It is your responsibility to see that the missing information is provided to the Fund Office. The normal processing period will be extended by the time it takes you to provide the information, and the limit will to run once the Fund Office has received a response to its request. If you do not provide the missing information within 45 days, the Fund Office will make a decision on your claim without it, and your claim could be denied as a result.

If and when all necessary information has been received, approval or denial of a claim will usually be made within the following time periods:

- For disability claims, within 30 days.
- For all other claims, within 15 days.

Plan Extension: The time periods above may be extended if the Fund Office determines that an extension is necessary due to matters beyond the control of the Plan (but not including situations where it needs to request additional information from you or the provider). 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:

- For disability claims, 30 days. A second 30-day extension may be needed in special circumstances beyond the Plan's control.
- For all other claims, 15 days.

Claim Denials: If all or 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 for the claimant 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.
5. If the decision was based on medical necessity or if treatment was deemed experimental, 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.

Claim Appeal Procedure: If you want the Trustees to review your claim after a denial of benefits, write a letter to the Board of Trustees requesting a claim review. Attach any additional information that you think will help a favorable decision to be made on your claim. Submit your request for review within 180 days after the date the denial was mailed to you:

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

You can authorize someone else to file your request for review and otherwise act for you. You and/or your representative can review materials in the Fund's files that are related to your claim. You and/or your representative can submit written issues and comments to support your request for review. You and/or your representative may also make a written request for a personal appearance before the Trustees. If a hearing is granted, your and/or your representative's appearance will be at your own expense.

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, not the subordinate of such party.
2. Not afford deference to the initial adverse benefit determination.
3. Take into account all comments, documents, records and other information submitted by the claimant, 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 judgment, 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 judgment. Such health care provider must be "independent," which means the medical professional consulted must be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.

Notification Following Review: A review and determination of claims 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 meeting of the Trustees. 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 your 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 the claimant's 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 fails to comply with the applicable federal regulations, you may go to court to enforce your rights.

SURVIVING SPOUSE SELF-PAYMENTS—Currently, a surviving spouse's entitlement to make self-payments for coverage terminates if she becomes covered under another group health plan. Effective for surviving spouses of eligible employees and retirees who died on or after January 1, 2001, coverage will no longer terminate when such surviving spouse becomes covered under another group health plan.

DEFINITION OF A SPOUSE—If you and your spouse become separated (i.e., not living together in a bona fide marital relationship) for 18 months or more, your spouse's coverage under the Plan will end on the last day of the calendar month coincident with or next following the end of the 18-month separation period. This rule is effective for separations in existence on and after July 1, 2002, and will apply regardless of the reason for the termination, except for medically necessary events such as long-term confinement in a nursing home. If a spouse's coverage is terminated at the end of an 18-month separation, the spouse will be entitled to COBRA coverage as described on pages 30–33 in your SPD booklet.

CLARIFICATION FOR CLASS B EMPLOYEES—Class B employees are not entitled to make Regular or COBRA Self-Payments for active employee coverage or self-payments for Retiree Benefits.

A retired Class B employee will be eligible for the Plan's retiree benefits if he maintains continuous employer-paid eligibility for a period of 10 years prior to his retirement **and** if he meets the retiree eligibility requirements. (Currently, he must be retired from work for a contributing employer, he must be age 62 if he is receiving a pension from the Northern Illinois Pension Fund, or he must be age 65 and eligible for Social Security Benefits if he is not receiving a pension from the Northern Illinois Pension Fund.)

REMINDER OF COVERAGE FOR BREAST RECONSTRUCTION

The Plan considers charges for the following services and supplies to be covered medical expenses when the charges are incurred by a covered person who is receiving Plan benefits for a mastectomy, and when the person elects (in consultation with their physician) breast reconstruction in connection with the 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 the deductibles, co-payment percentages and maximum benefit limitations applicable to covered services for other covered medical conditions.

Please call the Fund Office with any questions about these changes or your benefits.