Plumbers and Pipefitters Local 501 U.A.

Summary Plan Description

of the

NORTHERN ILLINOIS BENEFIT FUND

Health and Welfare Plan

Effective August 1, 2010

IMPORTANT CONTACT INFORMATION

FUND OFFICE/BOARD OF TRUSTEES

Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879

630-978-4600
Fax: 630-978-4616
Email: benefitfunds@ualocal501.org
website: www.ualocal501.org

PPO NETWORK (BLUE CROSS BLUE SHIELD OF ILLINOIS)

1-800-810-2583

website: www.bcbsil.com

MEDICAL REVIEW PROGRAM (MED-CARE MANAGEMENT)

1-800-367-1934

You or your doctor must call before any non-emergency hospital admission, outpatient surgery, or home health care. Also call when durable medical equipment is prescribed. Call the next business day after an emergency admission.

LIVING WELL HEALTH MANAGEMENT PROGRAMS (MED-CARE MANAGEMENT)

1-866-844-4222

Enroll in these programs to receive help managing diabetes, high blood pressure, cardiovascular disease, and weight problems.

VISION SERVICE PLAN (VSP)

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

1-800-877-7195
1-800-428-4833 (hearing impaired)
website: www.vsp.com

DENTAL PROGRAM (DELTA DENTAL OF ILLINOIS)

Delta Dental of Illinois
P.O. Box 5402
Lisle, IL 60532

1-800-323-1743
1-800-428-4833 (hearing impaired)
website: www.deltadentalil.com

HEARING DISCOUNT PROGRAM (EPIC)

1-866-956-5400

website: www.epichearing.com

DIAGNOSTIC IMAGING PREFERRED PROVIDER (DBM DIATRI)

1-800-331-5720
Show your DBM DiaTri card when you receive the services.

TRANSPLANTS (CASE MANAGEMENT) - Call the Fund Office if you need a transplant.

PRESCRIPTION DRUG PROGRAMS (CVS/CAREMARK)

1-800-421-5501
Fax: 1-888-810-1394

website: www.caremark.com

MEMBER ASSISTANCE PROGRAM (EMPLOYEE RESOURCE SYSTEMS)

1-800-292-2780

website: www.ers-eap.com
Username: local 501 Password: member

LETTER TO NEW PARTICIPANTS

Notice About Your COBRA Rights - The following information is for newly eligible employees and their dependents. (It does not apply to Class B non-bargaining unit participants whose coverage terminates due to lack of contributions.) It is intended to inform you, in a summary fashion, of your rights and obligations under the COBRA coverage provisions of the law. More information about COBRA coverage is on pages 35-39.

Failure to continue your group health coverage by electing COBRA coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and COBRA coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event that is causing your loss of coverage under this Plan. You will also have the same special enrollment right at the end of your COBRA coverage period if you get COBRA coverage for the maximum time available to you.

Qualifying Events and Maximum Coverage Periods - You and your eligible dependents are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"): 1) a reduction in your hours; or 2) termination of your employment.

If you or an eligible dependent are disabled (for the purpose of Social Security disability payments) on the date of one of the qualifying events listed above, or if you or a dependent become so disabled within 60 days after an 18-month COBRA coverage period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the date of that qualifying event.

Your dependents (spouse or children) are entitled to elect COBRA coverage and to make self-payments for the coverage for up to 36 months after coverage would otherwise terminate due to one of the following qualifying events: 1) a divorce or legal separation from your spouse (or if your spouse no longer meet's the Plan's definition of a dependent because you have not been living together in a bona fide marital relationship for 18 months or more); 2) a dependent no longer meets the Plan's definition of a dependent child; or 3) your death.

If your dependents are covered under an 18-month COBRA period and a second qualifying event (one of the events listed in the paragraph above) occurs, their maximum COBRA period may be extended up to a maximum of 36 months minus the number of months of COBRA coverage already received.

COBRA coverage may not be elected by anyone who was not covered under the Plan on the day before the occurrence of a qualifying event except that, if a child is born to you, adopted by you, or placed for adoption with you, after you become covered under an 18-month COBRA period, the child will have the same election rights as your other dependents who were covered the day before the first qualifying event if a second qualifying event occurs.

Notification Responsibilities - You, your spouse, or child, as applicable, must provide written notification to the Fund Office if you get divorced or legally separated, if you and your spouse have not been living together in a bona fide marital relationship for 18 months or more, if a child loses dependent status, or in the event of your death. Notification must be provided within 60 days of the event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. If your dependents are covered under an 18-month maximum COBRA period and then a second qualifying event occurs, it is the affected dependent's responsibility to notify the Fund Office within 60 days after the second qualifying event occurs.

In order to qualify for the 11-month disability extension, the Fund Office must be notified within 60 days of the disability determination by Social Security and before the end of the initial 18-month period. They must also be notified within 30 days of the date Social Security determines that you or the dependent are no longer disabled.

If the Fund Office is not notified within the time limits explained above, the affected person(s) will lose the right to elect or extend COBRA coverage. In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members.

Additional Rules Governing COBRA Coverage - Each member of your family who would lose coverage because of a qualifying event is entitled to make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. A person does not have to show that he is insurable to elect COBRA. If coverage is going to terminate due to termination of your employment or a reduction in your hours and you don't elect COBRA for your dependents when they are entitled to the coverage, your dependent spouse has the right to elect COBRA for up to 18 months for herself and any children within the same election period.

Electing COBRA Coverage - If you don't have sufficient employer contributions to continue coverage, or when the Fund Office is notified of any other qualifying event, you and/or your dependents will be sent an election notice that explains when coverage will terminate, your right to elect COBRA coverage, the due dates, and the amount of the self-payments.

COBRA Coverage Self-Payment Rules - COBRA self-payments must be made monthly. The amount of the monthly COBRA self-payment is determined by the Trustees and is subject to change, but not usually more often than once a year. The amount due will be shown on the election notice. A person has 45 days after the date of the election to make the initial self-payment. Your first COBRA self-payment will be applied to your first month of COBRA coverage—not the month in which you make the payment.

Termination of COBRA Coverage - COBRA coverage for a covered person will end sooner than the end of the applicable maximum coverage period when the first of the following events occurs: 1) a correct and on-time payment is not made to the Fund; 2) the Fund no longer provides group health coverage to any employees; 3) if a person is receiving extended coverage for up to 29 months due to his or another family member's disability, Social Security determines that he or the family member is no longer disabled; 4) after electing COBRA coverage, the person becomes entitled to Medicare benefits; or 5) after electing COBRA coverage, the person becomes covered under another group health plan that does not have a preexisting condition exclusion.

Sincerely,

BOARD OF TRUSTEES

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INTRODUCTION

TO ALL PLAN PARTICIPANTS:

We are pleased to provide you with this updated Summary Plan Description (SPD) benefit book which includes the changes made to your Plan since the last book was printed. This SPD and other important information is also available on the Fund's website at www.ualocal501.org.

This book includes a description of your Benefit Plan. It includes important information about your eligibility, your benefits, and other Plan provisions and rules. It replaces the SPD dated August 1, 2005.

Please read this book carefully (have your spouse read it, too) so that you will know what benefits are available for you and your family. You should become familiar with the items listed in "What the Plan Does Not Cover" starting on page 73 so that you will know before you incur expenses what is not covered by the Plan. After reading this book, keep it with your other important papers for future reference.

Other changes and improvements in your Plan may be made from time to time. An explanation of any such changes in your Plan will be sent to you at your last known address, as well as posted on the Fund's website.

If you have any questions about your eligibility or benefits, please contact the Fund Office. If you call the Fund Office, please have this book available for reference.

Sincerely,
BOARD OF TRUSTEES

The names and addresses of the individual Trustees are shown on page 107.

WHERE TO GET HELP UNDERSTANDING THIS BOOK

This book contains a summary in English of your Plan rights and the benefits available under the Northern Illinois Benefit Fund.

If you have any difficulty understanding any part of this book, contact:

visit us at
www.ualocal501.org

Robert E. Niksa
Administrative Manager
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879
(630) 978-4600
email: benefitfunds@ualocal501.org
website: www.ualocal501.org

Office hours are 8 a.m. to 4:30 p.m., Monday through Friday.

IMPORTANT NOTE

This book is intended to give you an accurate summary of the benefits and provisions of your Benefit Plan. The Plan documents, the Trust Agreement and insurance policies, which you can read at the Fund Office, contain a detailed description of the rules, regulations, benefits, and provisions of your Benefit Plan. If any discrepancy exists between this book and the Plan documents, the provisions of the Plan documents will govern.

Only the full Board of Trustees is authorized to interpret the Plan of Benefits described in this book. The Board's interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious. Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

No agent, representative, officer, or other person from the Union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. Similarly, no individual Trustee has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about eligibility or a claim, only the Administrative Manager is authorized to answer the questions for the Trustees. Matters that are not clear, or which need interpreting, will be referred to the Trustees.

NOTICE REGARDING GRANDFATHERED STATUS

The Trustees of the Northern Illinois Benefit Fund believe this is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits (although that provision was not effective for this Plan at the time this booklet was printed and distributed).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager at 1295 Butterfield Road, Aurora, IL 60502-8879, telephone (630) 978-4600.You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PRONOUNS USED IN THIS BOOKLET

To avoid awkward usage, this booklet uses masculine pronouns when referring to both male and female participants. However, feminine terms are used to refer to spouses, and the feminine terms will apply to male spouses when necessary.

Also, where the term "you" or "your" is used, it means an eligible employee or, where applicable, an eligible retiree.

DOING YOUR PART

The Trustees of the Northern Illinois Benefit Fund constantly work to provide you with the best health care coverage possible within the financial means of the Fund. The Fund Office staff does its best to answer your questions, to see that your claims are paid as promptly as possible, and to notify you of information that is important to you.

You, as a participant in this Plan, must also assume certain responsibilities in order to protect your eligibility and to receive your benefits from the Plan.

1. Be sure you have an up-to-date Participant Data Form (PDF) on file at the Fund Office.
2. Notify the Fund Office or Plumbers and Pipefitters Local 501 immediately of a change of address. It is VERY IMPORTANT that the Fund Office always have your current address so that you can receive information or material as soon as possible. If you change your address, it is your responsibility to send the Fund Office your new address immediately. All you have to do is mail a letter or postcard to the Fund Office. Print or type your old address and your new address on the postcard or on a sheet of paper, making sure you indicate which is the new address. Failure to do so may endanger your eligibility or your benefits because the Fund Office will not be able to send you information about changes in the Plan benefits or rules.
3. Notify the Fund Office if you or a dependent become totally disabled or become eligible for Medicare, or if there is a change in your family status because of marriage, birth of a child, death, divorce or legal separation, or a child losing dependent status. In such cases, you must provide the Fund Office with the appropriate documents, such as a marriage certificate, final divorce decree, death certificate, legal separation papers, etc.
4. If a dependent child age 19 but under 25 is a student, you must furnish the Fund Office with the following documents for each grading period:
   - The child's registration on original school letterhead showing enrollment for at least the minimum credit hours required to meet the school's criteria for full-time status.
   - A copy of the student's grades showing that the student maintained his enrollment of at least the minimum credit hours required for full-time status.
   - If the student has insurance through the school (or an employer), the name of the insurance company and the policy number.

5. You can save yourself and the Plan money if you:
   - Use hospitals and doctors in the Blue Card PPO network; and
   - Call (or have the hospital or doctor call) the medical review organization for precertification prior to incurring a claim for hospitalization, outpatient surgery, home health care or durable medical equipment.
6. Follow the Plan's claim filing directions properly.
7. If you are required to make self-payments, be sure that the Fund Office receives the payments for the correct amount on or before the due date.

SCHEDULE OF BENEFITS

The benefits shown on this Schedule apply only to persons who are eligible for the applicable benefits and are subject to all limitations and exclusions.

BENEFITS FOR EMPLOYEES ONLY

Life Insurance	$20,000
Accidental Death & Dismemberment Insurance (full amount)	$20,000
Loss of Time Benefit:	
Amount of weekly benefit (based on a 7-day week)	$350 per week
Maximum period that benefits are payable per sickness/injury	26 weeks
Benefits start:	
Accident - 1st day of a disability	
Sickness - 8th day of a disability or, if sooner, on the 1st day of hospital confinement.	

BENEFITS FOR RETIREES ONLY

Retiree Life Insurance	$5,000

BENEFITS FOR EMPLOYEES, RETIREES AND THEIR DEPENDENTS

● WELLNESS BENEFITS

Adults (employees, retirees and dependent spouses):

Maximum payable per person for covered routine exam expenses	$300 per calendar year
Plan payment percentage (no deductible)	100%

Excess covered expenses carry over to the Comprehensive Benefit.

Children (well-child care):

Maximum benefit payable per person for covered well-child expenses:	
Birth through day before 1st birthday	$1,000
Each year of life from 1st birthday through day before 5th birthday	$300 (per yr. of life)
5th birthday through day before 13th birthday	$600 (for entire period)
13th birthday through day before 19th birthday	$600 (for entire period)
Plan payment percentage (no deductible)	100%

Excess covered expenses carry over to the Comprehensive Benefit.

● SUPPLEMENTAL ACCIDENT BENEFIT

Maximum benefit payable per person per accident	$250
Plan payment percentage (no deductible)	100%

- *This benefit is payable for covered expenses incurred within 90 days of a non-occupational accident.*
- *Excess covered expenses carry over to the Comprehensive Benefit.*

● HEARING BENEFIT

Maximum benefit payable every 5 years per ear	$1,500
Plan payment percentage (no deductible)	80%

Excess expenses do NOT carry over to the Comprehensive Benefit.

● CHIROPRACTIC BENEFIT

Maximum payable per person for diagnostic x-rays per calendar year	$100
Maximum benefit payable per person per calendar year	$750

$750 maximum applies to ALL chiropractic care, including up to $100 for x-rays, plus all other diagnostic services (such as MRIs) ordered by a chiropractor.

Maximum payable per visit	$35 (paid at 100%)

Excess expenses do NOT carry over to the Comprehensive Benefit.

● COMPREHENSIVE MEDICAL BENEFIT (COMPREHENSIVE BENEFIT)

Maximum benefits payable per person:	**PPO**	**Out-of-Network**
Lifetime maximum	$2,000,000	
Calendar year maximum	$500,000	
Deductibles:		
Calendar year deductibles:		
Per person	$200	$300
Per family (can be satisfied by 3 or more family members)	$600	$900

- *PPO deductibles apply to prescription drugs not filled at a participating pharmacy and all ambulance charges. Out-of-network deductibles apply to other non-doctor and non-hospital expenses.*
- *Amounts applied to PPO deductibles also apply to out-of-network deductibles, and vice versa.*

	PPO	Out-of-Network
Plan payment percentages, per person per calendar year:		
Diagnostic procedures performed through Plan's preferred diagnostic imaging provider	100%	
All other covered medical expenses:		
UNTIL applicable out-of-pocket limit has been reached:	80%	60%
AFTER applicable out-of-pocket limit has been reached	100%	100%
Some exceptions are noted in "Special Limitations" section below.		
Out-of-pocket limits, per person per calendar year:		
Per person	$1,500	$3,000
Per family (can be satisfied by two or more family members)	$3,000	$4,000

- *PPO out-of-pocket limits apply to prescription drugs not filled at a participating pharmacy and all ambulance charges. The out-of-network limits apply to other non-doctor and non-hospital expenses.*
- *Amounts applied to PPO out-of-pocket limits also apply to out-of-network limits, and vice versa.*
- *Also see the "Special Limitations" section for some exceptions.*

SPECIAL LIMITATIONS

Unless otherwise stated, the regular Comprehensive Benefit deductibles and payment percentages apply to expenses shown below that are subject to special limitations.

Out-of-network ambulatory surgical centers	not covered	
Mental health and substance abuse disorders	same as medical/ surgical conditions	
* **Infertility** (employees and spouses only):		
Plan payment percentage	80%	60%
Maximum payable per couple	$40,000 lifetime	
Durable Medical Equipment - Plan payment percentage:		
When arranged by the review organization (subject to PPO deductible and PPO out-of-pocket limit)	80%	80%
When NOT arranged by the review organization (subject to non-PPO deductible and non-PPO out-of-pocket limit)	60%	60%

* *Out-of-pocket payments for treatment of these conditions do not apply to out-of-pocket limits and expenses will not be paid at 100% after the person's out-of-pocket limit has been reached.*

		PPO	Out-of-Network
Transplants:			
When transplant is managed by case manager		same as other covered surgical procedures	
When transplant is NOT case-managed, the following maximums apply to each procedure:		Transplant Maximum	Follow-Up Maximum
	Heart	$100,000	$15,000
	Heart/lung	$250,000	$20,000
	Lung	$150,000	$20,000
	Liver	$125,000	$15,000
	Pancreas	$50,000	$10,000
	Kidney	$50,000	$10,000
	Bone marrow	$150,000	$10,000
	Cornea	$10,000	$0
Prescription drugs do NOT apply to transplant maximums.			
Orthotics - Maximum payable per person for covered foot orthotics		$1,000 lifetime	

● PRESCRIPTION DRUG PROGRAM

Retail Card Program (up to a 30-day supply)	
Generic	You pay 10% ($5 minimum)
Brand	You pay 10% ($10 minimum)
Mail Order Program (up to a 90-day supply):	
Generic	You pay $15
Brand	You pay $30
You must use the mail-order pharmacy after 3 fills (original plus 2 refills) of a long-term or maintenance drug at the retail level.	
Maintenance Choice (90-day supplies at CVS pharmacies)	Same as Mail Order
Non-Participating Pharmacy (up to a 30-day supply)	50% initial reduction; remaining balance paid at 80% (subject to $200 deductible)

- *If you use a non-participating pharmacy, you must file a claim for payment under the Comprehensive Benefit.*
- *Neither the 50% reduction nor your 20% co-pay will apply to any Plan deductibles or out-of-pocket limits.*
- *The 50% reduction will not apply if you live more than 15 miles from a participating pharmacy.*

● SCHEDULE OF DENTAL BENEFITS

	Delta Preferred Provider Network	Delta Participating Dentist Network	Out-of-Network
Calendar year deductible	None	None	None
Maximum payable per cal. year*	$1,500	$1,250	$1,000
Delta payment percentages:			
Diagnostic & preventive	100%	100%	100%
Restorative & prosthodontics	80%	80%	80%
Orthodontia (children to age 19):			
Delta payment percentage	50%	50%	50%
Lifetime maximum*	$1,500	$1,250	$1,000
Fee arrangement *(Note: "UCR" means usual, reasonable and customary as determined by Delta.)*	Negotiated fees usually less than UCR—You are not responsible for the difference between the billed charges and negotiated charges.	UCR—You are not responsible for the difference between the billed charges and Delta's UCR fees.	None—The dentist may bill you for charges exceeding Delta's UCR fees.

* *The maximum under the Delta Preferred Provider program also includes payments made under the Delta Participating Dentist Network and Out-of-Network programs. The annual maximum under the Delta Participating Dentist Network program also includes payments made under the Out-of-Network program.*

● SCHEDULE OF VISION BENEFITS

	VSP Network Doctor	Non-VSP Provider Allowance
Vision exam	Covered in full	$30
Frame	$120 allowance + 20% discount on balance	$45
Eyeglass lenses, per pair:		
Single vision	Covered in full	$30
Lined bifocal	Covered in full	$35
Lined trifocal	Covered in full	$45
Lined lenticular	Covered in full	$60
Polycarbonate lenses (dependent children)	Covered in full	N/A
Tints	Covered in full	$5
Contacts (in lieu of frame and eyeglass lenses), per pair:		
Elective	$120	$120
Visually necessary*	Covered in full*	$210

- *Services and allowances are available every 12 months.*
- *When the schedule shows a dollar allowance, VSP will pay the lesser of the reasonable and customary charge, or the allowance for that service or supply.*

* *Contacts are visually necessary when vision cannot be corrected with glasses.*

The benefits currently provided under the Plan are not "vested" benefits. The Trustees have the right and authority, at any time, to change the benefits, eligibility rules or other Plan rules with regard to any class or category of participants as they may determine to be necessary for the administration of the Northern Illinois Benefit Fund.

ELIGIBILITY

BARGAINING UNIT EMPLOYEE ELIGIBILITY

DEFINITIONS APPLICABLE TO ELIGIBILITY

Bargaining Unit Employee - You are a bargaining unit employee if you are a member of a collective bargaining unit represented by the Union and are an employee of one or more contributing employers within the various jurisdictions of the Union. For the purposes of these eligibility rules, the term "employer" means one or more contributing employers.

Credited Hour

- Any hour you work for which an employer contribution is made to the Fund on your behalf under the terms of a Collective Bargaining Agreement;
- An hour credited to you by this Fund because of a reciprocal contribution made on your behalf by another welfare fund (see page 18); and
- Any hour credited to you under the "Eligibility During Disability" rules.

Note: A worked hour will not be considered a credited hour unless an employer contribution has actually been made to the Fund on your behalf for that hour.

Work Quarters and Benefit Quarters

Work quarters are separated from their related benefit quarters by one month. A work quarter is a period of three (3) consecutive calendar months during which you meet the applicable eligibility requirements necessary to provide benefit coverage during the next following benefit quarter (also called the "related benefit quarter"). A benefit quarter is a period of 3 consecutive calendar months during which you and your dependents are covered under the Plan because you have the required number of credited hours during the preceding work quarter.

Work Quarters *Work performed during . . .*	*Related Benefit Quarters* *Determines eligibility for. . .*
March-April-May	July-August-September
June-July-August	October-November-December
September-October-November	January-February-March
December-January-February	April-May-June

Initial Eligibility

You will become initially eligible on the first day of the second calendar month following a period of two or three consecutive months during which you accumulate at least 300 credited hours. Only hours of employment for which an employer has made the required contribution to the Fund will be counted toward the 300 hours needed for initial eligibility.

The date on which you become initially eligible is called your "initial eligibility date." Coverage for you and your family members who already meet the Plan's definition of dependent (starting on page 82) will start on your initial eligibility date. If you later acquire a dependent while you are still eligible, that person's benefits will start on the date he or she meets the Plan's definition of a dependent.

Once you earn initial eligibility, you will remain eligible through the end of the benefit quarter in which your initial eligibility date falls.

Example 1 (Initial Eligibility): You start working for a contributing employer in April and have the following credited hours:

Work Month	*Credited Hours*
April	160
May	160
	320

You accumulated more than 300 credited hours from working during the months of April and May, so your initial eligibility date is July 1 (July is the second calendar month after May). Since July falls in the July-August-September benefit quarter, you will remain eligible through September 30.

Example 2 (Initial Eligibility): You start working for a contributing employer in March and have the following credited hours during your first 3 months of employment:

Work Month	*Credited Hours*
March	80
April	110
May	100
	290

You do not have the required 300 hours during your first 3 months of employment, so your first month's hours are dropped and your credited hours for the fourth month (June) are added. As shown below, this gives you the 300 hours needed, and your initial eligibility date is August 1. You will remain eligible through September 30, the end of that benefit quarter.

Work Month	*Credited Hours*
~~March~~	~~80~~
April	110
May	100
June	100
	310

Continuing Eligibility

After you become initially eligible for benefits for a benefit quarter, you and your dependents will be eligible for Plan benefits during the next benefit quarter if you meet one of the following eligibility requirements:

1. You have at least 250 credited hours during the preceding work quarter; or
2. You have at least 500 credited hours during the two preceding work quarters; or
3. You have at least 750 credited hours during the three preceding work quarters; or

4. You have at least 1,000 credited hours during the four preceding work quarters.

Rules 2-4 above comprise the "lookback rule."

The lookback rule will only be used to continue your eligibility if you are and remain available for work in covered employment, or if you are unable to work due to total disability. This does not apply to retirees who are running out their active eligibility prior to going into the Retiree Benefits program. But it would apply to a Local 501 member who continues to work for a company that terminates its Collective Bargaining Agreement with Local 501—in such case the member will not be eligible for continued health and welfare coverage using the lookback rule. (He would also not be entitled to COBRA coverage since he is still employed.)

Example 3 (Regular Continuing Eligibility): Assume you have already established initial eligibility and your coverage started on July 1. You continue to work and have the following credited hours:

Work Quarter	*Credited Hours*	*Benefit Quarter*
June-July-August	450	October-November-December
September-October-November	450	January-February-March
December-January-February	350	April-May-June
March-April-May	450	July-August-September

You were eligible in each of the benefit quarters because you earned at least 250 credited hours during the work quarter preceding it.

Example 4 (Lookback Rule): You want to determine if you are eligible for the January-February-March benefit quarter when you have worked the following hours for a contributing employer:

120 hours in May
175 hours in June
140 hours in July
150 hours in August
100 hours in September
-0- hours in October
-0- hours in November

You do not have at least 300 credited hours in the September-October-November work quarter to continue coverage in the January-February-March benefit quarter. You would then "look back" to the preceding work quarter of June-July-August and add those hours to the September-October-November hours. Since you had 565 hours in those two work quarters (175 + 140 + 150 + 100 = 565), you would be eligible in the January-February-March benefit quarter.

Eligibility During Disability

If you become totally disabled and unable to work, you may be credited with disability hours to help you maintain your eligibility according to the following rules:

1. You must be completely prevented from engaging in any occupation or employment for compensation, wages or profit as a result of accidental bodily injury or sickness.

2. You must:
   - Be entitled to Loss of Time Benefits as a result of your injury or sickness; or
   - Be entitled to benefits under a workers' compensation or occupational diseases law as a result of your injury or sickness.
3. You must provide the Fund Office with all required proofs of total disability and entitlement to Loss of Time Benefits, or workers' compensation or occupational disability benefits.
4. If you meet the requirements of Rules 1, 2 and 3 above, you will be eligible to receive disability hours starting on: a) the first day of a disability due to injury; b) the first day of an inpatient hospital confinement (if before the eighth day of the disability); c) the day outpatient surgery is performed that results in your disability; or d) the eighth day of a disability due to another reason.
5. You will be credited with 21 disability hours for each week that you are receiving or are entitled to receive Loss of Time Benefits or workers' compensation or occupational diseases benefits for up to 26 consecutive weeks during any one period of disability.
6. The disability hours credited to you will be considered regular credited hours and will apply toward maintaining your eligibility for benefits the same as though you had worked the hours.
7. You will no longer be credited with disability hours when the first of the following dates occurs: a) the date you are no longer totally disabled; b) the date your Loss of Time Benefits, workers' compensation or occupational diseases benefits cease; or c) the end of a period of 26 consecutive weeks.
8. If you remain totally disabled for longer than 26 weeks, you can make self-payments to continue your eligibility (see "Regular Self-Payments" starting on page 20 for more information).

Reciprocity

This Fund is signatory to the United Association Reciprocity Agreement. This reciprocity agreement is designed to allow you to retain your eligibility when contributions are made for you to another U.A. welfare fund that is also signatory to the U.A. Reciprocity Agreement.

If you work under the jurisdiction of another welfare fund that is signatory to the United Association Reciprocity Agreement, and if your employer makes contributions for your hours to this Fund, your hours under this Fund will be credited as follows:

- If the other fund's contribution rate is the same or less than this Fund's, you will be granted one credited hour for each reported hour.
- If the other fund's contribution rate is greater than this Fund's, you will receive one credited hour for each reported hour PLUS additional hours equivalent to the excess contribution. To determine your credited hours, the amount contributed will be divided by this Fund's rate and the result will be credited to you as hours.

Example: If this Fund receives a contribution for 150 hours of work at an hourly contribution rate of $8, your credited hours will be determined as follows:

150 hours worked @ $8 rate = $1,200 ÷ $9.90 (this Fund's rate as of June 1, 2010) = 121.21 credited hours.

Military Leave

This Plan allows you to choose between an eligibility freeze and making self-payments if you are called to active military duty in the uniformed services of the United States for 31 days or more.

Under a freeze, any credited hours you have accumulated will be frozen. After your release from active duty under circumstances entitling you to re-employment under federal law, your eligibility and accumulated credited hours will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by federal law.

You and your eligible family members may instead chose to run out your accumulated eligibility immediately and then make self-payments for continued coverage for up to an additional 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are very similar to COBRA coverage. This Plan will pay primary benefits before the military/government pays, except for service-related disabilities.

The eligibility freeze will automatically go into effect unless you tell the Fund Office that you would like to make self-payments instead.

More information about the re-employment rights of persons returning to work from the uniformed services of the United States is available from the Veterans' Employment and Training Administration of the United States Department of Labor. For more information about your self-payment rights during military service, contact the Fund Office.

Two Types of Self-Payments

If you have a work quarter where you do not have sufficient credited hours to continue your benefits during the related benefit quarter, you may be entitled to make self-payments to the Fund to continue your benefit coverage. There are two types of self-payments allowed under the eligibility rules:

1. Regular Self-Payments - You can make Regular self-payments for up to 8 benefit quarters.
2. COBRA Self-Payments - Instead of making Regular self-payments, you can choose to make COBRA self-payments for up to 18 months. You can also elect COBRA after a Regular self-payment period, but you cannot make Regular self-payments after a period of COBRA coverage. Also note that periods of COBRA coverage do NOT count toward the past service requirements when determining your eligibility for Retiree Benefits.

Regular Self-Payments

1. To be eligible to make Regular self-payments, you must be available for covered employment and on Local 501's out-of-work list.

2. Normally, you can make Regular self-payments for up to 8 consecutive benefit quarters of coverage. If, however, at the end of an 8-quarter Regular self-payment period you are totally disabled and have received a Social Security disability award, you can continue making Regular self-payments on a monthly basis until your disability ends and you are once again able to work in covered employment. (If you do not qualify for Social Security disability, you may qualify for the disability extension if an independent medical examiner of the Fund's choosing verifies your total disability.) The 8-quarter limit can also be extended for an employee who is disabled due to an occupational injury or sickness and involved in an active Workers' Compensation case. In that situation, the employee may make Regular self-payments for as long as he remains totally disabled and his workers' compensation case remains unresolved, or for 16 consecutive quarters, whichever is less.

3. If you lack credited hours during a work quarter, the Fund Office will send a self-payment notice to you at your last known address, telling you how much your Regular self-payment will be and when it is due.

4. While the Fund Office will attempt to notify you when a Regular self-payment is due, it is your responsibility to keep track of your credited hours and make any required Regular self-payments on time whether or not you receive a notice from the Fund Office.

5. Currently, the amount of your Regular self-payment is the difference between 250 and the number of credited hours you accumulated during the work quarter multiplied by the hourly rate determined by the Trustees.

6. The properly completed self-payment form along with your Regular self-payment must be received by the Fund Office on or before the first day of the first month of the benefit quarter for which you are paying. You can personally take the form and Regular self-payment to the Fund Office or you can mail them to the Fund Office. However, failure of the U.S. Postal Service to deliver your payment to the Fund Office on time will not extend the due date; so if you mail your payment, be sure to give it more than sufficient time in which to be delivered.

7. A Regular self-payment will provide all of the normal Plan benefits for you and your dependents for one benefit quarter.

8. You must maintain continuous eligibility after making your first Regular self-payment. If you continue to have insufficient credited hours during any following work quarters but fail to make a Regular self-payment on time, you cannot make up the payment. However, you may be entitled to make COBRA self-payments for an additional 18 months.

"Cure" Opportunity for Missed Self-Payment - If an employee fails to make a required Regular self-payment on time, the Fund Office will issue a termination notice to the employee stating that coverage for the employee and his dependents will terminate at the end of the last benefit quarter for which he was last eligible due to cred-

ited hours or a Regular self-payment. The employee will have an opportunity to "cure" this failure by making any required Regular self-payment before the end of the longest of the following periods: 1) the end of the coverage period for which the self-pay is required; 2) the end of the calendar year in which the notice of termination is sent to him; or 3) within 90 days from the date the termination notice is sent. Late self-payments made under this rule will be equivalent for all purposes to self-payments made in a timely manner, including satisfaction of the immediate past coverage requirements under the retiree eligibility rules.

Termination of Eligibility for Bargaining Unit Employees and Their Dependents

Employees - You will cease to be eligible for benefit coverage under the Plan on the first to occur of the following dates unless you are entitled to make a Regular self-payment or a COBRA self-payment and an on-time self-payment is made:

1. The date the Trustees terminate this Plan of Benefits.
2. The end of the last day of the month during which you enter the armed forces of any country on a full-time basis.
3. If you fail to meet the continuing eligibility requirements, at the end of the last day of the benefit quarter related to the last work quarter during which you did meet the continuing eligibility requirements.
4. If your coverage is being continued because you are totally disabled, on the date you fail to meet all the "Eligibility During Disability" requirements.
5. If you are making Regular self-payments, at the end of the last benefit quarter for which you were entitled to make and did make a correct and on-time self-payment.
6. If you are making COBRA self-payments, at the end of the last day of the maximum coverage period to which you are entitled and for which a correct and on-time self-payment has been made or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 38, whichever occurs first.
7. The date of your death.

Dependents - A dependent of yours will cease to be eligible for benefit coverage under the Plan on the first to occur of the following dates unless the dependent is entitled to COBRA coverage and an on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date the Trustees terminate this Plan of Benefits.
2. The date the Trustees terminate dependent benefits under this Plan.
3. The end of the last day of the month during which the dependent enters the armed forces of any country on a full-time basis.
4. The date the dependent becomes covered under the Plan as an employee.
5. The date you cease to be eligible for benefit coverage for reasons other than your death.

6. For your spouse, the date of your divorce or legal separation; or if you and your spouse cease living together in a bona fide marital relationship for 18 months or more, on the last day of the calendar month coincident with or next following the end of the 18-month separation period.
7. For a child, on the date the child loses dependent status by failing to meet this Plan's definition of a dependent child.
8. In the event of your death, on the later to occur of the following dates, unless your surviving dependent elects coverage under the Survivor Program (page 34):
   a. The end of the last day of the last benefit quarter for which you had earned eligibility from employer contributions before your death; or
   b. The beginning of the first day of the calendar month following a period of 90 days after the date of your death.
9. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the maximum coverage period to which the dependent was entitled and for which correct and on-time self-payments have been made or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 38, whichever occurs first.
10. If a child is making self-payments under the Self-Pay Program for Older Students (described below):
    a. At the end of the month during which the child reaches age 25 or otherwise fails to satisfy the requirements for continued eligibility; or
    b. At the end of the month for which the last correct and timely self-payment was made.

Self-Pay Program for Older Students

Normally, coverage for a child who is a full-time student will end on December 31 of the calendar year in which the student's 23rd birthday occurs. However, the Fund allows an unmarried dependent child to continue his coverage after that under the Self-Pay Program for Older Students. In order to qualify for this program, the child must meet these two requirements:

1. He must satisfy all of the requirements for being an eligible dependent other than the maximum age requirement; and
2. At the beginning of any month for which coverage is provided, he must not be older than age 25.

The amount of the monthly self-payment is currently $50. This amount is determined by the Trustees and may be changed at any time. The benefits provided under this program are the same benefits provided to eligible dependents under age 24 at the end of the calendar year.

If the child elects COBRA coverage, he is waiving his right to make student self-pays. Likewise, a child who makes student self-pays is waiving his right to COBRA coverage.

Reinstatement of Eligibility

After Termination of Eligibility - If your eligibility terminates after you have become initially eligible for benefits, and if you remain ineligible for less than twelve (12) months, your eligibility will be reinstated on the first day of the benefit quarter related to the work quarter during which you once again meet the continuing eligibility requirements.

If you remain ineligible for 12 months or more after your eligibility terminates, you must once again meet the initial eligibility requirements before you will again be covered under the Plan.

Reinstatement of Dependent Child Status - If a dependent child loses eligibility for coverage for 18 months or less because he ceases to meet the definition of a dependent, the child may be reinstated as a covered dependent on the first day of the month following the month in which he once again meets all of the applicable requirements for being a dependent child. A child's dependent status may only be reinstated one time under this rule.

If a child remains ineligible for more than 18 months, he cannot be reinstated as a covered dependent, regardless of whether he once again meets the definition of a dependent child. The 18-month time limit will not apply to a dependent child who loses coverage because of service in the U.S. uniformed services, and who returns to full-time student status by the fall (September) term that follows his release from duty.

NON-BARGAINING UNIT EMPLOYEE ELIGIBILITY

There are two classes of non-bargaining unit employees as explained below. Except where specifically stated otherwise, the rules explained in this section apply to both Class A and Class B non-bargaining unit employees.

Class A Non-Bargaining Unit Employee - You are a Class A employee if you are a full-time employee of the Union; the Northern Illinois Benefit Fund; the Northern Illinois Pension Fund, its successor or any pension fund designated by the Trustees; or the Joint Education Fund (JEF), provided that your employer makes contributions to the Fund on your behalf for benefit coverage under the Plan.

Class B Non-Bargaining Unit Employee - You are a Class B employee if you meet all the following requirements:

1. You are not a member of the bargaining unit.
2. You are employed by a contributing employer as defined in No. 3 under the definition of "Employer; Contributing Employer" on page 86.
3. You are an officer, director or shareholder of the contributing employer, or the spouse or close blood relative of any controlling officer, director or shareholder of the contributing employer.
4. You have performed or do perform bargaining unit work, or supervise, lay out and/or prepare bids or contract documents for such work.

5. You are specifically named as a person who meets the definition of a "Participant" as defined in the Participation Agreement accepted by the Trustees.
6. You agree to make contributions to the Fund for the purpose of obtaining certain benefit coverage under the Plan for yourself and any dependents.

Benefits for Non-Bargaining Unit Employees and Their Dependents

The contributions made on behalf of non-bargaining unit employees will provide covered Class A and Class B employees and their dependents with all of the medical, dental/orthodontia, vision, life insurance and AD&D insurance provided under the Plan to covered bargaining unit employees and dependents.

In addition, Loss of Time Benefits are provided for Class A employees. Class B employees are not eligible for Loss of Time Benefits.

Contributions for Non-Bargaining Unit Employees

Contributions for Class A employees are made to the Fund by the employees' employers. Class B employees make contributions to the Fund on their own behalf.

Subject to the rules explained in this section, if you are either a Class A or Class B non-bargaining unit employee, you and your dependents will be eligible for Plan benefits during each month for which contributions are paid to the Fund on your behalf. All contributions for Class B employees must be paid 15 days before the first day of each month during which you perform any work. Contributions for both Class A and Class B employees must be paid at the rate of 166 hours per month for twelve months per year.

Initial Eligibility for Non-Bargaining Unit Employees

You will become initially eligible on the first day of the first month for which on-time contributions are made to the Fund on your behalf. The date on which you become initially eligible is called your "initial eligibility date," and coverage for you and your family members who already meet the Plan's definition of dependent (see page 82) will start on that date. If you later acquire a dependent while you are still eligible, that person's benefits will start on the date he or she meets the Plan's definition of a dependent.

Continuing Eligibility for Non-Bargaining Unit Employees

Subject to the termination rules, you and any dependents will continue to be eligible for Plan benefits during each month for which an on-time contribution is made to the Fund on your behalf.

Eligibility During Disability for Non-Bargaining Unit Employees (Class A Employees Only)

If you (a Class A employee) become totally disabled while you are covered under the Plan, your coverage may be maintained during your disability in accordance with the "Eligibility During Disability" rules for bargaining unit employees (starting on page 17). The only difference is that you will be credited with 40 disability hours for

every week that you meet the requirements. Disability hours will not be credited to Class B employees.

Returning to the Bargaining Unit

A former bargaining unit participant whose coverage as a Class B non-bargaining unit participant under a Participation Agreement that expires due to the economically necessitated closure of his business may establish initial eligibility by a combination of employer contributions for bargaining unit work and/or self-payments for a total of 300 hours.Thereafter self-payments may be made for the period permitted bargaining unit employees, as long as the participant continues to satisfy all of the following requirements:

1. The participant makes himself available for bargaining unit work in covered employment; AND
2. The participant has had no lapse in eligibility between either: a) his eligibility as a former bargaining unit participant and a Class B participant; and b) his eligibility as a Class B participant and his return to work as a bargaining unit employee; AND
3. The participant does not work in plumbing or pipefitting work or management of plumbing and pipefitting work for an employer who is a non-participating employer in the Fund.

Military Leave

If you are called to active military duty in the uniformed services of the United States for 31 days or more, this Plan allows you to choose between an eligibility freeze and making self-payments. The rules governing these options are the same rules that apply to bargaining unit employees, and are on page 19.

COBRA Coverage for Non-Bargaining Unit Employees and Their Dependents

Class A non-bargaining unit employees may make Regular self-payments and COBRA self-payments according to the same rules that apply to bargaining unit employees.

Class B non-bargaining unit employees may not make Regular self-payments to maintain coverage under any circumstances. If a Class B employee or dependent's eligibility is going to terminate, the only self-payment method available for continuing coverage is to make self-payments for COBRA coverage, provided the person is entitled to make COBRA self-payments. (However, note that ceasing to make contributions to this Fund is NOT a COBRA qualifying event.)

> Class B non-bargaining unit employees cannot make Regular self-payments or COBRA self-payments if coverage is lost because the required contributions are not made to the Fund.

Termination of Eligibility for Non-Bargaining Unit Employees and Their Dependents

Employees - You will cease to be eligible for benefit coverage under the Plan on the first to occur of the following dates:

1. The date the Trustees terminate this Plan of Benefits.
2. The date the Trustees terminate benefit coverage under this Plan for non-bargaining unit employees or for your coverage class.
3. The end of the last day of the month during which you enter the armed forces of any country on a full-time basis.
4. If a correct and on-time contribution fails to be made on your behalf, at the end of the last day of the last month for which a correct and on-time contribution was made.
5. If you are making COBRA self-payments, at the end of the last day of the maximum coverage period to which you are entitled and for which correct and on-time self-payments have been made or on the date of occurrence of any of the applicable events stated in "Termination of COBRA Coverage" on page 38, whichever occurs first.
6. The date of your death.

Dependents - A dependent of yours will cease to be eligible for benefit coverage under the Plan on the first to occur of the following dates unless the dependent is entitled to COBRA coverage and an on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date you cease to be eligible for benefit coverage for reasons other than your death.
2. The date the Trustees terminate benefit coverage under this Plan for dependents of non-bargaining unit employees or for dependents in your coverage class.
3. The end of the last day of the month during which the dependent enters the armed forces of any country on a full-time basis.
4. The date the dependent becomes covered under the Plan as an employee.
5. For your spouse, the date of your divorce or legal separation; or if you and your spouse cease living together in a bona fide marital relationship for 18 months or more, on the last day of the calendar month coincident with or next following the end of the 18-month separation period.
6. For a child, on the date the child loses dependent status by failing to meet this Plan's definition of a dependent child.
7. In the event of your death, at the end of the last day of the month during which your death occurred, provided a correct and on-time contribution was made on your behalf for that month. Your surviving dependent may continue her coverage beyond that date if she elects coverage under the Survivor Program.
8. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the maximum coverage period to which the dependent was entitled and for which correct and on-time self-payments have been made or on the date of occurrence of any of the applicable events stated in "Termination of COBRA Coverage" on page 38, whichever occurs first.

9. If a child is making self-payments under the Self-Pay Program for Older Students (described on page 22):
   a. At the end of the month during which the child reaches age 25 or otherwise fails to satisfy the requirements for continued eligibility; or
   b. At the end of the month for which the last correct and timely self-payment was made.

Self-Pay Program for Older Students

An unmarried child who loses eligible dependent status because of exceeding the age limit may continue his coverage under the Self-Pay Program for Older Students provided he meets the applicable requirements. See page 22 for more information.

Reinstatement of Dependent Child Status

If a dependent child loses eligibility for coverage because he ceases to meet the definition of a dependent, the child may be reinstated as a covered dependent if he once again meets all of the applicable requirements for being a dependent child, subject to the same rules that apply to children of bargaining unit employees (page 23).

RETIREE PROGRAM

Coverage under the Retiree Benefits is not an "accrued" or "vested" benefit. The Trustees specifically reserve the right and have the authority to change the provisions relating to coverage for retirees, at any time and in their sole discretion if they determine that economic conditions warrant such action.

The following rules apply to retired bargaining unit employees and retired non-bargaining unit employees (although there are some special rules for Class B non-bargaining employees.)

You may have a choice of two types of continued coverage under the Plan for yourself and your dependents when you retire:

1. COBRA Coverage - If you do not meet the eligibility rules for the Retiree Benefits, you may be entitled to make COBRA self-payments for up to 18 months after your active employee coverage terminates. The rules governing COBRA coverage explained on pages 35-39 will apply to you and your dependents.
2. Retiree Benefits - You may be entitled to the Retiree Benefits explained below if you meet all of the applicable eligibility requirements and make any required self-payments for the coverage.

ELIGIBILITY REQUIREMENTS FOR RETIREE BENEFITS

Bargaining Unit Employees and Class A Non-Bargaining Unit Employees

If you were covered under the Plan as an active bargaining unit or Class A non-bargaining unit employee, you must meet all of the following eligibility requirements in order to be eligible for Retiree Benefits for yourself and any dependents:

1. You must be retired from work with all contributing employers.
2. You must be receiving early, normal or disability pension benefits from the Pension Fund (the Plumbers & Pipefitters Local 501 Northern Illinois Pension Fund, any successor fund or any pension fund designated by the Trustees).
3. You must be eligible for Plan benefits when you retire (your active and retiree coverage must be continuous with no coverage gap).
4. You must have been covered under the Northern Illinois Benefit Fund as an active eligible employee during any 5 years (60 months) during the 10 years (120 months) immediately prior to retirement.
5. You must have a minimum of 10 years of service in the industry during your lifetime. (The 10 years of industry service can include the 5 years that satisfy Rule No. 4 above.)
6. You must make correct and on-time self-payments to the Fund.

No Self-Payments if You Meet 10-Year Immediate Past Coverage Requirement - You do not have to make self-payments for Retiree Benefits after age 62 if you were con-

tinuously eligible under this Plan as an active employee for the full 10-year period immediately preceding your retirement.

Otherwise, you must continue to make self-payments after you reach age 62.

If you retired under a fund that merged into this Fund before January 1, 1998, then you MUST make self-payments for Retiree Benefits.

The following will be counted toward the 10-year immediate past coverage requirement:

- Quarters during which you were eligible under the Plan's initial or continuing eligibility rules due to your work for a contributing employer.
- Quarters during which you were eligible under the Plan's reciprocity rules.
- Quarters for which you made Regular self-payments (COBRA coverage does NOT count).
- The period of time before you become age 62 during which you are eligible and making self-payments for Retiree Benefits.
- Months of extended eligibility under the Plan's "Eligibility During Disability" rules.

In addition, if you want to cover your dependent children under the Retiree Benefits, you must make correct and on-time self-payments to the Fund for the coverage.

CLASS B Non-Bargaining Unit Employees

The eligibility requirements that apply to bargaining unit retirees also apply to you, except as follows:

1. You will not qualify for Retiree Benefits until you are age 62.
2. You must be entitled to a normal retirement pension from the Pension Fund (at age 62) in order to qualify for Retiree Benefits. However, if you are not eligible for a pension, you can qualify for Retiree Benefits at age 65 (or after) when you start receiving a Social Security retirement benefit.
3. You cannot make self-payments for Retiree Benefits. You will only be eligible for Retiree Benefits if you maintained continuous employer-paid eligibility for a period of 10 years prior to retirement, provided you also meet the other eligibility requirements (eligible at the time of retirement, retire at age 62 with a pension or at age 65 or order with Social Security retirement benefits, etc.).

Note that you cannot receive Retiree Benefits unless you are completely retired from all work in the industry.

BENEFITS PROVIDED FOR RETIREES

The benefits currently provided under the Retiree Benefits are the same medical, dental/orthodontia and vision care benefits provided to active eligible employees and their dependents. In addition, you, the retiree, are eligible for retiree life insurance. Active employee life insurance, AD&D insurance and Loss of Time Benefits are not provided under the Retiree Benefits.

The calendar year and lifetime maximum benefits shown on the Schedule of Benefits do not start over for you when you become covered under the Retiree Benefits. The maximum benefits you and any dependents will be entitled to receive under the Retiree Benefits will be the amounts of any such maximum benefits left unused from coverage under your active employee coverage. For example, if you used $250,000 of your $2,000,000 lifetime maximum benefit under the Comprehensive Benefit as an active covered employee, your remaining Retiree Benefits lifetime maximum benefit under the Comprehensive Benefit is $1,750,000.

Medicare Part D Prescription Drug Plans

Medicare prescription drug coverage is available to everyone with Medicare. This coverage is separate from any coverage provided by the Northern Illinois Benefit Fund. You must pay a monthly premium to a private plan approved by Medicare in order to get Part D coverage.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping their prescription drug coverage under this Plan and switching to a Medicare Part D plan.

Please note that this Plan's prescription drug coverage for retirees is at least as good or better than the coverage provided under a standard Part D plan. Most participants will NOT benefit by switching to a Part D plan, and the Fund is NOT encouraging anyone to switch. You can keep this coverage and not have to pay an extra late enrollment penalty if you later decide to enroll in Medicare Part D coverage. (However, the Medicare Part D late enrollment penalties WILL apply if there is a gap of 63 days or more between your termination date under this plan and the start of your Part D plan.)

Please take the following information into consideration before you elect a Part D plan:

- You cannot choose dual coverage.
- If you drop this Plan's prescription drug coverage, you can NOT get it back later.
- Your self-payment amount to this Plan (if applicable) will not change if you elect a Part D plan.
- This Plan will not pay your Part D plan premiums.
- If you elect a Part D plan, you can still receive hospital and physician benefits from this Plan—but not prescription drug benefits. The self-payment for this Plan's coverage will NOT be reduced if you drop prescription coverage.

You must inform the Fund Office if you or a Medicare-eligible dependent chooses Part D coverage. If you do not provide timely notification, and if the Plan continues to pay your drug expenses, you will have to repay the Plan for the amount it paid. Your double coverage could also cause problems and overpayment situations with your Part D plan.

You and your spouse can be covered under different drug plans.

MAKING SELF-PAYMENTS FOR RETIREE BENEFITS

The rules governing retiree self-payments are as follows:

1. You must make your first self-payment on or before the date on which a self-payment to maintain continuous coverage is due. There must be no lapse in coverage between active employee coverage and Retiree Benefits coverage.
2. The amount of the monthly self-payment is determined by the Trustees and may be changed at any time.
3. You can make your self-payments in person at the Fund Office or you can mail your self-payments to the Fund Office. Each payment must be personally delivered or postmarked no later than the first day of the month for which you are paying in order to be accepted by the Fund Office. For example, to be covered for benefits during March, your self-payment must be delivered or postmarked no later than March 1.
4. If you fail to make a self-payment on or before the date it is due, your eligibility for Retiree Benefits will terminate at the end of the last month for which you have already paid. You will not be allowed to make any future self-payments.
5. Once a self-payment has been accepted by the Fund Office, it will not be returned.

"Cure" Opportunity for Missed Self-Payment

If a retiree under age 62 fails to make a required self-payment on time, the Fund Office will issue a termination notice to the retiree stating that coverage will terminate at the end of the last month for which a timely and correct self-payment was made. The retiree will have an opportunity to "cure" this failure by making any required self-payment before the end of the longest of the following periods: 1) the end of the calendar year in which the notice of termination is sent to him; or 2) within 90 days from the date the termination notice is sent. Late payments made under this rule will be equivalent for all purposes to retiree self-payments made in a timely manner, including satisfaction of the immediate past coverage requirements for "free" retiree coverage at age 62.

COBRA COVERAGE FOR RETIREES' DEPENDENTS

A dependent who loses Retiree Benefits coverage due to any of the following qualifying events may be entitled to make self-payments for COBRA coverage:

1. Your (retiree's) death (also see "Survivor Program" starting on page 34).
2. Your divorce or legal separation from your spouse, or if you and your spouse cease living together in a bona fide marital relationship for 18 months or more.
3. A dependent child losing dependent status.

The rules governing COBRA coverage explained in "Self-Payments for COBRA Coverage" on pages 35-39 will apply.

TERMINATION OF ELIGIBILITY FOR RETIREES AND THEIR DEPENDENTS

Retirees - You will cease to be eligible for Retiree Benefits on the first to occur of the following dates:

1. The date the Trustees terminate this Plan of Benefits.
2. The date the Trustees terminate Plan benefits for retirees.
3. If you are required to make self-payments for Retiree Benefits, at the end of the last day of the month preceding the month for which you fail to make a correct and on-time self-payment.
4. The date you cease to meet the eligibility requirements for Retiree Benefits.
5. If you return to work for a contributing employer, at the end of the last day of the month preceding the month in which you become eligible under the Plan as an active employee.
6. The date of your death.

Dependents - A covered dependent of yours will cease to be eligible for Retiree Benefits on the first to occur of the following dates unless the dependent is entitled to COBRA coverage and an on-time COBRA election and self-payment is made by or on behalf of the dependent:

1. The date your eligibility for Retiree Benefits terminates for any reason other than your death.
2. The date the Trustees terminate Plan benefits for dependents of retirees.
3. The end of the last day of the month preceding the month for which you fail to make a correct and on-time self-payment for Retiree Benefits coverage for the dependent.
4. The end of the last day of the month during which the dependent enters the armed forces of any country on a full-time basis.
5. With respect to a dependent child, the date on which the child ceases to meet this Plan's definition of a dependent child.
6. For your spouse, the date of your divorce or legal separation; or if you and your spouse cease living together in a bona fide marital relationship for 18 months or more, on the last day of the calendar month coincident with or next following the end of the 18-month separation period.
7. In the event of your death, at the end of the last day of the month during which your death occurs unless your surviving dependent is entitled to make and does make a correct and timely self-payment for continued coverage under the Survivor Program.
8. If COBRA self-payments are being made by or on behalf of the dependent, at the end of the last day of the maximum coverage period to which the dependent is entitled and for which correct and on-time self-payments have been made or on the date of occurrence of any of the events stated in "Termination of COBRA Coverage" on page 38, whichever occurs first.

****Important - Coordination of Benefits With Medicare****

You and any covered dependents who are eligible to participate in Medicare should register in Medicare Part A and enroll in Part B when eligible to do so. This applies whether the person is eligible to participate in Medicare due to reaching age 65 or due to a qualifying disability.

If a retiree or retiree's dependent fails to enroll in Medicare when he or she is first eligible to do so, this Plan's benefits will be calculated as though benefits under both Medicare Part A AND Part B have been paid. This means that the person must pay out of his own pocket any amounts that Medicare would have paid if the person were registered/enrolled in Medicare.

SURVIVOR PROGRAM

DEPENDENTS OF ACTIVE EMPLOYEES

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

1. If a surviving spouse makes the required 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.)
2. There must be no lapse in coverage between the survivor's coverage as a dependent and her coverage as a survivor.
3. The monthly self-payment amounts are determined by the Trustees and may be changed at any time. Payments are due by the first of the month for which coverage is desired.
4. When a surviving spouse reaches age 62 (or if she is 62 or older when the employee dies), she will become covered under the Retiree Benefits program and not have to make self-payments IF she had at least ten years of coverage (including coverage due to survivor self-payments) immediately prior to reaching age 62; OR if the deceased employee would not have had to make self-payments at age 62 had he lived to that age. Self-payments will still be required to continue coverage for any covered children.
5. If there is no surviving spouse, the self-pay option can be elected by or on behalf of the employee's eligible children.
6. In order to elect the survivor self-pay option, each surviving dependent must first reject COBRA coverage and waive their rights 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. If the surviving spouse 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.)
    b. 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.

DEPENDENTS OF RETIREES

The rules stated above for active employees also apply to surviving dependents of eligible retirees. However, the Trustees review this provision each year, and in their sole discretion they will determine whether or not to extend this privilege for another year.

COBRA COVERAGE

Federal law—the Consolidated Omnibus Budget Reconciliation Act (COBRA)—gives you and your dependents the right to be offered an opportunity to make self-payments for continued health care coverage if coverage is lost for certain reasons. This continued coverage is called "Continuation Coverage" or "COBRA coverage."

Failure to continue your group health coverage by electing COBRA coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and COBRA coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event that is causing your loss of coverage under this Plan. You will also have the same special enrollment right at the end of your COBRA coverage period if you get COBRA coverage for the maximum time available to you.

The following is a brief outline of the rules governing COBRA coverage. If you have any questions about COBRA, call the Fund Office.

QUALIFYING EVENTS AND MAXIMUM COVERAGE PERIODS

18-Month Maximum Coverage Period - You and/or your eligible dependents can elect to make self-payments for COBRA coverage for up to 18 months after coverage would otherwise terminate due to one of the following events (called "qualifying events"):

- A reduction in your hours of employment; or
- Termination of your employment (which includes retirement) for any reason other than gross misconduct.

(With respect to Class B participants, ceasing to make contributions to this Fund, even at retirement, is NOT a COBRA qualifying event.)

11-Month Extension Rule - If you or a covered dependent are disabled (as defined by Social Security for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or a covered dependent become so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before that qualifying event. The COBRA self-payment is higher for the extra 11 months of coverage for the family.

This 11-month extension rule does not apply to dependents during a 36-month COBRA maximum coverage period.

36-Month Maximum Coverage Period - Your dependents (spouse or children) can elect to make self-payments for COBRA coverage for up to 36 months after coverage

would otherwise terminate due to one of the following events (called "qualifying events"):

- Your divorce or legal separation from your spouse (or if your spouse's Plan coverage is terminated at the end of an 18-month period during which you and your spouse were not living together in a bona fide marital relationship).
- A child's failure to meet the definition of a dependent.
- Your death.

Multiple Qualifying Events - If your dependents are covered under an 18-month COBRA period, their COBRA coverage may be extended if a second qualifying event occurs, such as your divorce or death, or if a dependent loses dependent status. In that case, your dependent(s) who are affected by the second qualifying event are entitled to COBRA coverage for up to a maximum of 36 months minus the number of months of COBRA coverage already received under the 18-month continuation.

It is the affected dependent's responsibility to notify the Fund Office within 60 days after a second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

Special Medicare Entitlement Rule - A special rule provides that if you (the covered employee) become entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of hours, the period of coverage for your spouse and dependent children will be 36 months measured from the date of your Medicare entitlement, or 18 months from the date you lose coverage because of a reduction in hours or termination of employment, whichever is longer.

During Military Service - Refer to page 19 for information about your self-payment rights when you are called up to active full-time duty.

ADDITIONAL RULES GOVERNING COBRA COVERAGE

1. COBRA coverage may not be elected by anyone who was not covered under the Plan on the day before the occurrence of a qualifying event except that, if a child is born to you (employee), adopted by you or placed with you for adoption after you become covered under an 18-month COBRA period, that child will have the same election rights as any of your other dependents who were covered on the day before the first qualifying event if a second qualifying event occurs.
2. COBRA coverage may be elected for a person who is covered under another group health care plan; however, if the person becomes covered under another group health care plan after he has elected COBRA coverage, the person's COBRA coverage will terminate unless the person has a pre-existing condition that would cause benefits to be excluded or limited under the other plan.
3. COBRA coverage may be elected for a person who is entitled to Medicare on his election date, however, if the person becomes covered under Medicare after he has elected COBRA coverage, the person's COBRA coverage will terminate.

BENEFITS UNDER COBRA COVERAGE

COBRA coverage is the same medical, dental/orthodontia and vision benefits that you and/or your dependents were eligible for on the day before the occurrence of the "qualifying event." Life insurance, AD&D insurance, and Loss of Time Benefits are not provided under COBRA coverage.

NOTIFICATION RESPONSIBILITIES

- You, your spouse, or child, as applicable, must provide written notification to the Fund Office if you get divorced or legally separated (or if your spouse no longer meet's the Plan's definition of a dependent because you and your spouse ceased living together in a bona fide marital relationship for 18 months), or if a child loses dependent status. Notification must be provided within 60 days of the event or within 60 days of the date coverage for the affected person(s) would terminate, whichever date is later. If the Fund Office is not notified within 60 days, the dependent will lose the right to COBRA coverage.
- If your dependents are covered under an 18-month maximum COBRA period and then a second qualifying event occurs, it is the affected dependent's responsibility to notify the Fund Office within 60 days after the second qualifying event occurs. If the Fund Office is not notified within 60 days, the dependent will lose the right to extend COBRA coverage beyond the original 18-month period.

- In order to qualify for the 11-month disability extension, the Fund Office must be notified within 60 days of the disability determination by Social Security and before the end of the initial 18-month period. They must also be notified within 30 days of the date Social Security determines that you or the dependent are no longer disabled.
- It is your employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notification of your election rights as soon as possible, you or a dependent should notify the Fund Office any time any type of qualifying event occurs.
- In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office or that the Fund Office sends to you.

ELECTING COBRA COVERAGE

When the Fund Office is notified of a qualifying event, an Election (self-payment) Notice and an Election Form will be sent to you and/or your dependents who would lose coverage due to the event.

- The Election Notice provides information about COBRA coverage, self-payment amounts, due dates, etc. The Election Form is the form you or a dependent fill in and return to the Fund Office if you want to elect COBRA coverage.
- A person electing COBRA coverage has 60 days after he is provided with the COBRA forms or 60 days after his coverage would terminate, whichever is later, to

return the completed Election Form. An election of COBRA coverage is considered to be made on the date the Election Form is mailed (postmarked) or personally delivered to the Fund Office. If the Election Form is not returned to the Fund Office within the applicable 60-day period, you and/or your dependents will be considered to have waived your right to elect COBRA coverage.

- Each member of your family who would lose coverage because of a qualifying event can make a separate election of COBRA coverage. If you elect COBRA coverage for yourself and your dependents, your election is binding on your dependents. You do not have to show that you or your dependents are insurable to be entitled to elect COBRA coverage.
- An election on behalf of a minor child may be made by a child's parent or legal guardian.
- If coverage is going to terminate due to your termination of employment or reduction in hours and you don't elect COBRA coverage for your dependents when they are entitled to it, your dependent spouse can elect COBRA coverage for up to 18 months for herself and any children within the time period that you could have elected the coverage.

MAKING COBRA SELF-PAYMENTS

- The amounts of the monthly COBRA self-payments are stated on the Election Form. These amounts are subject to change.
- A person electing COBRA coverage has 45 days after the signed Election Form is returned to the Fund Office to make the initial payment. However, if a person waits 45 days to make the initial payment, one or more monthly payments may also fall due within that period and must also be paid at that time.
- All subsequent monthly COBRA self-payments are due on the first day of the month for which payment is made. A payment will be considered on time if it is received within 30 days of the due date.
- If a COBRA self-payment is not made within the time allowed, COBRA coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

TERMINATION OF COBRA COVERAGE

COBRA coverage for a covered person will end sooner than the end of the applicable maximum coverage period when the first of the following events occurs:

1. A correct and on-time COBRA self-payment is not made to the Fund.
2. The person becomes entitled to Medicare benefits.
3. The Northern Illinois Benefit Fund no longer provides group health coverage to any employees.
4. The person has been receiving extended COBRA coverage for up to an additional 11 months due to his or another family member's disability, and Social Security has determined that he or the other family member is no longer disabled.

5. The person becomes covered under another group health care plan. Exception: This termination rule will not apply if the person has a pre-existing medical condition that would cause benefits to be excluded or limited under the other plan. In such a case, this Plan's COBRA coverage will pay primary benefits for the pre-existing conditions and the other Plan will pay primary benefits for all other causes. When the other Plan's pre-existing condition limitation or exclusion no longer applies to the person, his COBRA coverage under this Plan will terminate.

LIFE INSURANCE

Life insurance benefits are provided through an insurance policy procured by the Trustees from an insurance carrier. If there is any discrepancy between the following explanation and the provisions of the insurance policy, the provisions of the insurance policy will govern.

$20,000 in life insurance is provided for eligible active bargaining unit employees and both Class A and B non-bargaining unit employees. A $5,000 benefit amount is provided for eligible retirees. Life insurance is not provided for any employee whose Plan coverage is being continued under COBRA coverage, nor is it provided for dependents.

If you die while you are eligible for this benefit, your life insurance benefit is payable to your beneficiary regardless of the cause of death. If you wish, you can arrange for your life insurance to be paid to your beneficiary in installment payments instead of in a lump sum. Contact the Fund Office for help in making this arrangement.

YOUR BENEFICIARY

Be sure that the person you want to receive your life insurance has been named as your beneficiary and is on file in the Fund Office on your Participant Data Form. You can change your beneficiary at any time. Just get the proper form from the Fund Office, fill it in and return it to the Fund Office. After the Fund Office receives the change of beneficiary form, the change of beneficiary will be effective retroactive to the date you signed the form.

If you name more than one beneficiary and don't state how much each is to get, the beneficiaries will share equally. If you haven't named a beneficiary, your life insurance will be paid to the first of the following successive classes of survivors: your spouse; your natural and/or adopted children; your parents; your brothers and sisters (in equal shares); or your estate. If there is more than one survivor in the class payment is made to, the survivors in that class will share equally.

WAIVER OF PREMIUM DURING PERMANENT AND TOTAL DISABILITY

If you are an active employee who becomes totally disabled and unable to work, your life insurance may be continued at no cost under the following rules:

1. Your disability must start before your 60th birthday and while you are eligible for life insurance.
2. You must be totally and continuously disabled, and be completely and continuously unable to perform any work or engage in any occupation.
3. You must contact the Fund Office in order to provide the insurance company with notice that the disability has lasted for twelve months. You will be sent an "initial proof" form which should be filled out by you and your doctor, and then returned to the Fund Office who will forward it to the insurance company. If the initial proof is accepted, your life insurance will be continued for one year.

4. Each year afterwards, during the three-month period preceding the anniversary date of receipt of your initial proof, you must provide proof that you remain disabled. If the proof is acceptable, your insurance will be continued for further one-year periods.

When you are no longer totally disabled, or if you fail to comply with the proof requirements, your life insurance will no longer be continued.

CONVERSION PRIVILEGE WHEN YOUR LIFE INSURANCE TERMINATES (Active Employees Only)

If you are an active employee and your life insurance is going to terminate because your eligibility for life insurance terminates, or because the group insurance policy terminates, you can convert your life insurance to an individual policy for which you pay the premiums as follows:

- You can convert to any type of individual life insurance policy customarily issued by the insurance company except term insurance, and no medical examination or proof of good health is required.
- Your written application and first premium payment must be made within 31 days after termination of eligibility for life insurance or termination of the group insurance policy.
- If you die within the 31-day period allowed for conversions, your life insurance will be paid even if you haven't applied for conversion.
- If your eligibility for life insurance terminates, you can convert up to but not more than the amount you had under the Plan. If the group insurance policy terminates, you can convert up to $10,000 if you have been continuously eligible under the Plan for five or more years. However, the $10,000 will be reduced by any amount of group life insurance that you become eligible for under any other group plan within 31 days of the policy termination.

LIFE INSURANCE CLAIMS

A life insurance claim must be submitted as soon as possible, and no later than one year, after your death. The Fund Office should be contacted for help in submitting the claim.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

AD&D insurance benefits are provided through an insurance policy procured by the Trustees from an insurance carrier. If there is any discrepancy between the provisions of the insurance policy and the following explanation, the provisions of the insurance policy will govern.

AD&D insurance is provided for eligible active bargaining unit employees and both Class A and B non-bargaining unit employees. AD&D insurance is not provided for any employee whose Plan coverage is being continued under COBRA coverage, nor is it provided for dependents or retirees.

AD&D insurance benefits are payable if you suffer any of the losses shown on the Table of Losses below. The loss must result from an accident that occurs to you while you are eligible for AD&D insurance and must occur within 90 days of the date of the accident.

AMOUNT OF BENEFIT

The full amount of your AD&D insurance is $20,000. The amount payable for all losses resulting from any one accident cannot exceed this full amount. If you suffer any combination of the losses on the Table of Losses as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for accidental death (loss of life) is in addition to your life insurance benefit, and will be paid to your life insurance beneficiary.

For each of the following losses, the Plan will pay as follows:

Table of Losses

Loss of	Benefit Amount
Life	Full amount paid to your beneficiary
Two hands or two feet or sight of two eyes	Full amount paid to you
One foot and sight of one eye, one hand and sight of one eye, or one hand and one foot	Full amount paid to you
One hand, one foot or sight of one eye	One-half of full amount paid to you
Thumb and index finger of same hand	One-fourth of full amount paid to you

Loss of a hand or foot means severance at or above the wrist or ankle joint. Loss of sight in an eye means total loss of sight in that eye. Loss of thumb and index finger means the severance of two or more phalanges of both the thumb and the index finger.

LOSSES NOT COVERED

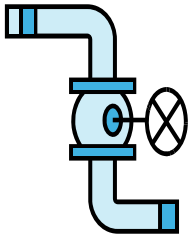
No AD&D insurance benefits will be paid for any of the following:

1. Any loss which occurs more than 90 days after the date of the accident.

2. Any loss which is not permanent.
3. Any loss caused directly by bodily or mental illness or disease of any kind; intentional self-inflicted injury; suicide or attempted suicide while sane or insane; or participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion.
4. War or act of war, declared or undeclared; or any act related to war, or insurrection; service in the armed forces of any country while such country is engaged in war; or police duty as a member of any military, naval or air organization.

AD&D CLAIMS

An AD&D claim must be submitted as soon as possible, and no later than one year, after the loss. The Fund Office should be contacted for help in submitting the claim.



LOSS OF TIME BENEFIT

Loss of Time Benefits are provided for active eligible bargaining unit employees and active eligible Class A non-bargaining unit employees. Loss of Time Benefits are not provided for Class B non-bargaining unit employees or for employees whose Plan coverage is being continued under COBRA coverage. It is also not provided for dependents or retirees.

ELIGIBILITY FOR LOSS OF TIME BENEFITS

To be eligible to receive Loss of Time Benefits, you must be eligible for Plan benefits on the date your disability begins, and you must be totally disabled and be completely prevented from engaging in any occupation or employment for compensation, wages or profit as a result of a non-occupational accidental bodily injury or sickness.

PAYMENT OF BENEFITS

The amount of your weekly benefit is currently $350. Benefits will be paid on the basis of a 7-day week. If benefits are due you for a partial week, you will receive one-seventh of the weekly benefit for each day of the partial week, payable at the end of the period of disability.

In accordance with Federal law, the Plan will withhold your share of the FICA (Social Security) tax from each weekly payment. Also, keep in mind that you must include the weekly benefits you receive in your gross income and pay Federal Income Tax on them. If you have any questions about this, check with a tax advisor.

PERIOD OF PAYMENT/WHEN BENEFITS START

Weekly benefits are payable for up to 26 weeks while you are totally disabled, but not for more than 26 weeks for any one continuous period of disability (see "Successive Periods of Disability" below).

Weekly benefits will begin:

1. On the first day of disability due to an accidental injury.
2. For disabilities due to sickness:
   - On the first day of disability due to outpatient surgery, or
   - On the first day of a hospital stay if hospitalized before the eighth day of sickness; or
   - On the eighth day of disability if not hospitalized.

If a female employee is disabled due to maternity or a pregnancy-related condition, the disability will be treated as a disability due to sickness.

A disability will not be considered to have started until the first day that you are actually examined or treated by a doctor.

SUCCESSIVE PERIODS OF DISABILITY

Two or more periods of disability due to the same or related causes will be considered one period of disability unless you return to full-time work and have contributions made on your behalf for at least 80 hours between the periods of disability.

Successive periods of disability separated by less than 80 hours of contributions will be considered one period of disability unless the second disability is entirely unrelated to the causes of the first disability and begins after you return to full-time work for at least one full day.

EXCLUSIONS AND LIMITATIONS

No Loss of Time Benefits will be paid for any period or day of disability for which you are not under the direct care of a doctor; or any disability which results from any injury or sickness for which you are or may be entitled to receive benefits in whole or in part under any workers' compensation law, occupational diseases law, employer's liability law or similar law.

SPECIAL PROGRAMS

MEMBER ASSISTANCE PROGRAM

The Northern Illinois Benefit Fund offers a Member Assistance Program (MAP) through Employee Resource Systems (ERS). The MAP provides access to free counseling services designed to help you and your family members deal with a variety of situations such as:

- Alcohol and drug abuse
- Marital and family problems
- Divorce adjustment
- Emotional problems
- Job-related stress
- Legal and financial difficulties
- Bereavement

Through this program, you and your family members can receive up to six (6) free counseling sessions per incident with an ERS counselor. If the ERS counselor believes an issue cannot be addressed in the sessions provided or that another kind of resource would be more appropriate, they will consult with you about the resources available in the community or through the regular Plan.

ERS counselors are available 24/7 by calling 1-800-292-2780. Local ERS representatives are available from 8:30 a.m. until 5:30 p.m., Monday through Friday. After business hours, the ERS phones are answered by clinical professionals who can provide immediate assistance. All services provided by the MAP are completely confidential and your records will not be released without your written permission.

All Plan participants also have access to the Union Select Enhanced Work-Life Services program. This program offers a comprehensive collection of web-based informational tools and resources, including access to on-line consultations, assisted searches, child and elder care databases. There is also an online Wellness Center to help you set and meet your fitness, nutrition, and weight goals, and a Savings Center that provides discounts from brand name retailers and thousands of discount tickets. Refer to your MAP brochure for more information.

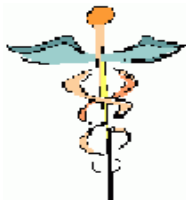
LIVING WELL HEALTH MANAGEMENT PROGRAMS

The Living Well Health Management Programs are designed to provide education and information to the Fund's participants who have or have a family member with diabetes, hypertension, heart disease, or a weight problem. By participating in one of the programs, members and their families learn self-management tools that may prevent acute flare-ups or the long-term complications associated with these conditions. Having one or more of these problems is not easy, but when managed properly you can enjoy a healthier life. Participation is voluntary and all information is confidential. There is no cost to you. You will, however, still have your normal plan deductibles and coinsurance for doctor's visits etc. Call 1-866-844-4222 to enroll.

These programs are administered by Med-Care Management, Inc. Refer to the separate brochure for additional information.

MEDICAL BENEFITS

Medical benefits are provided for active eligible bargaining unit employees, active eligible Class A and Class B non-bargaining unit employees, and eligible retirees. Medical benefits are also provided for eligible dependents of participants in all these classes, and for persons whose Plan coverage is being continued under COBRA coverage.



BLUE CROSS BLUE SHIELD (BCBS) PPO

You and your family are encouraged to use providers (hospitals and doctors) that participate in the national Blue Card network through Blue Cross Blue Shield of Illinois (BCBS-IL).

PPO providers will provide medical services at reduced charges to you and the Fund. Your out-of-pocket costs will be further reduced because higher Plan benefits are payable when you use PPO providers. See the Schedule of Benefits for details. Also see "PPO Benefits and Out-of-Network Benefits" on page 51.

How to Find PPO Providers - For a current list of PPO providers, you may visit the BCBS-IL website (www.bcbsil.com) or call BCBS-IL at 1-800-810-2583. The providers in the PPO network sometimes change—you should verify that the provider still participates whenever you schedule medical services.

I.D. Cards - You should already have received two medical care I.D. cards. Present your I.D. card whenever you or a family member receive medical care (inpatient, outpatient or office). The I.D. card identifies you as a Blue Card PPO participant so that the proper discounts can be applied to the bill. It also tells the providers how to submit their bills.

MEDICAL REVIEW PROGRAM

Protecting your medical benefits is an extremely important issue for the Board of Trustees, especially during this time of steeply rising costs. To assist in managing claim costs, the Trustees have retained Med-Care Management, Inc. to review the use of expensive medical services such as inpatient hospitalizations. This is to your benefit, since Med-Care will let you know and plan for how many days you can expect to be confined in the hospital. It will assure that you or your dependents will not be confined any longer than necessary and that you will not have to undergo any unnecessary treatment or surgery. You will also be assured that you receive the maximum benefit payment possible under our health care benefit plan.

How to Use the Review Program - Participation is easy. You simply call or have your physician call Med-Care Management whenever hospitalization, outpatient surgery, home health care or durable medical equipment is recommended for you or one of your covered family members. Med-Care's toll-free number is on your I.D. card and on the inside front cover of this booklet.

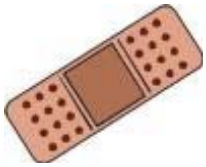
Be sure to show your I.D. card to your medical providers so that they will know to call Med-Care on your behalf.

Medicare Patients - If Medicare is your primary healthcare plan (for example, because you a retiree or the spouse of a retiree), you do not have to contact Med-Care prior to obtaining medical services. Medicare patients should follow Medicare's rules and use Medicare-approved providers.

SUPPLEMENTAL ACCIDENT BENEFIT

The Plan pays 100% (no deductible) up to $250 per person per accident for covered expenses incurred within 90 days of an accident.

Covered expenses under the Supplemental Accident Benefit are charges incurred for: hospital treatment, doctors' care, x-ray and lab examinations, and local ambulance service.



No benefits will be paid for:

1. Charges incurred more than 90 days after the accident.
2. Treatment of sickness or intentionally self-inflicted injury.
3. Treatment of intentional drug abuse or overdose, including acute alcoholism.
4. Expenses in excess of the $250 maximum benefit for that accident. (However, covered accident expenses that are in excess of $250, or that are incurred more than 90 days after the accident, will be considered for payment under the Comprehensive Benefit.)
5. Charges for which benefits are excluded in the section titled "What the Plan Does Not Cover" starting on page 73.

WELLNESS BENEFITS

Employees, Retirees and Spouses

The Plan pays 100% (no deductible) up to $300 per person per calendar year for covered expenses incurred for the covered wellness services listed below. This benefit is only for eligible employees, retirees, and dependent spouses of employees and retirees.

Any covered adult wellness expenses in excess of $300 during a year will carry over for consideration under the Comprehensive Benefit.

Benefits paid for these expenses will be applied to the person's Comprehensive Benefit lifetime and calendar year maximum benefits.

Well-Child Care

The Plan pays 100% (no deductible) up to the following maximum benefits for well-child care for a covered dependent child under age 19:

Birth through day before 1st birthday	$1,000
1st birthday through day before 2nd birthday	$300

2nd birthday through day before 3rd birthday	$300
3rd birthday through day before 4th birthday	$300
4th birthday through day before 5th birthday	$300
5th birthday through day before 13th birthday	$600 for entire period
13th birthday through day before 19th birthday	$600 for entire period

Covered expenses in excess of the maximum benefit for a specified time period WILL carry over for consideration under the Comprehensive Benefit (subject to deductible and coinsurance).

Covered Wellness Expenses

The following are covered for eligible adults and children, subject to the maximum benefit limitations:

1. Doctors' services and supplies for routine physical examinations.
2. Lab and x-ray tests, including Pap smears and mammograms for female employees, retirees and dependent spouses only.
3. Immunizations, inoculations, flu shots, etc.
4. Any other routine diagnostic tests or procedures ordered by the examining doctor.

Wellness Benefit Exclusions

Wellness Benefits are not payable for:

1. Charges that exceed the maximum benefit specified for that time period.
2. Any examination or service provided for non-routine purposes.

   Wellness Benefits are for routine physical examinations to determine if the person has any health problems when there are no symptoms of any problems. If you go to a doctor for an exam when you have symptoms of a health problem, that exam is not considered "routine" and the exam expenses are considered for payment under the Comprehensive Benefit. The same applies to any treatment for a condition that is diagnosed during an otherwise routine exam.
3. Routine check-ups or preventive services for a dependent child over age 18.
4. Any treatment of a condition diagnosed as a result of a routine examination.
5. Charges for which benefits are excluded in the section titled "What the Plan Does Not Cover" starting on page 73.

HEARING BENEFIT

The Hearing Benefit covers the diagnosis or treatment of hearing disorders and impairments, and appliances to correct the disorder or impairment.

The Plan pays 80% (no deductible) of the covered expenses you or a dependent incur for hearing care up to $1,500 per ear every five calendar years.

This is the only benefit that covers hearing care. Excess expenses do NOT carry over for payment under the Comprehensive Benefit. Any such excess amounts are your responsibility.

Benefits paid for hearing care do NOT apply to a person's Comprehensive Benefit lifetime maximum benefit.

Covered Hearing Expenses

The Hearing Benefit covers charges incurred for:

1. A physical examination by a specialist doctor (otologist or otolaryngologist).
2. A test of hearing ability and condition by a specialist doctor or a licensed audiologist.
3. A hearing aid, if required, including services and supplies provided for manufacture of ear molds by a specialist doctor or licensed audiologist, and a hearing aid, including hearing aid rental and audiologist consultation fees during an evaluation period, whether or not a hearing aid is found to be satisfactory and is purchased.

You will save money on your hearing care if you use the Fund's preferred hearing provider. For more information see the brochure provided to all participants, or call Epic at 1-866-956-5400.

Hearing Benefit Exclusions

Hearing Benefits are not payable for:

1. Charges incurred for hearing care after a person has received benefits totaling the $1,500 maximum benefit during that 5-year period.
2. Replacement of a hearing aid more often than once every 60 months.
3. Examination or testing by other than an otologist, otolaryngologist or licensed audiologist.
4. Services or supplies provided by an audiologist when not prescribed by a specialist doctor.
5. Diagnostic x-ray and laboratory tests.
6. Repair or replacement of a damaged or lost hearing aid; hygienic cleaning of a hearing aid; or batteries or their installation.
7. Charges for which benefits are excluded in the section titled "What the Plan Does Not Cover" starting on page 73.

CHIROPRACTIC BENEFIT

Payments are made under this benefit for chiropractic care. For the purpose of this Plan, "chiropractic care" means services and supplies provided in connection with the detection and correction by manual or mechanical means of structure imbalance distortion or subluxation in the human body for the purposes of removing nerve inter-

ference and its effects when such interference is the result of, or related to, a distortion, misalignment or subluxation of or in the vertebral column. This includes MRIs and physical therapy performed in connection with such treatment. Chiropractic care can be provided by a doctor, a surgeon, or a chiropractor providing services within the scope of his license.

The Plan pays 100% (no deductible) of the expenses you or a dependent incur for chiropractic care up to a maximum benefit of $35 per visit, with a calendar year maximum benefit of $750. All expenses for chiropractic care are subject to the $750 annual maximum, including amounts paid under the $100 chiropractic x-ray allowance. Chiropractic Benefits DO apply to a person's Comprehensive Benefit lifetime maximum benefit.

This is the only benefit that covers chiropractic care. Expenses incurred by a person for chiropractic care during a year after he has received $750 in chiropractic benefits do not carry over for payment under the Comprehensive Benefit. Such excess amounts are your responsibility.

Chiropractic Benefit Exclusions

Payments will not be made under the Chiropractic Benefit for:

1. Charges incurred during a calendar year for chiropractic care or x-rays after a person has received the calendar year maximum benefit for such treatment or x-rays.
2. More than one visit per day.
3. Preventive or maintenance care or treatment.
4. Chiropractic treatment, services or supplies which are not provided within the limits set forth by the practitioner's state license.
5. Charges for which benefits are excluded in the section titled "What the Plan Does Not Cover" starting on page 73.

COMPREHENSIVE MEDICAL BENEFIT (COMPREHENSIVE BENEFIT)

The Comprehensive Medical Benefit is the major medical portion of your medical plan. Under the Comprehensive Benefit each person pays a certain amount (a deductible) of the first covered medical expenses he incurs during a year. Then the Plan pays a percentage (co-payment) of the remaining covered medical expenses he incurs during the rest of the year until his out-of-pocket payments for his co-pay shares of his covered medical expenses (also called "coinsurance") reach a certain limit.

PPO Benefits and Out-of-Network Benefits

The Plan's benefits are generally lower if you use out-of-network providers. However, the PPO deductible, PPO payment percentage and PPO out-of-pocket limit will apply to out-of-network expenses in the following situations.

1. If a covered person receives treatment for a life-threatening emergency at a hospital or covered medical facility.
2. If a covered person receives non-emergency care from an out-of-network provider (hospital or doctor) and there is no equivalent (same medical specialty) PPO provider within ten miles of the out-of-network provider location.
3. Local professional ambulance services.

Deductibles

A deductible is the amount that is deducted from a person's covered medical expenses each year before the Plan will begin to pay its payment percentage of any additional covered medical expenses incurred during that year. Once that amount has been deducted, the deductible is considered "satisfied."

Calendar Year Deductibles

Calendar year deductibles apply to all medical expenses, unless a specific exception is noted on the Schedule of Benefits. There are two sets of calendar year deductibles.

1. $200 PPO Deductible - Each calendar year you pay the first $200 of your covered PPO medical expenses. These are the charges made by PPO doctors and hospitals for covered services and supplies, and for prescription drugs (whether or not a PPO doctor prescribes the drug). A family maximum of $600 applies to all PPO calendar year deductibles that must be met by your covered family members during any one calendar year.
2. $300 Out-of-Network Deductible - Each calendar year a $300 deductible applies to your covered out-of-network expenses. These are the expenses you incur for services and supplies provided by out-of-network doctors and hospitals (non-PPO providers) as well as by other non-doctor and non-hospital service providers. A family maximum of $900 applies to all out-of-network calendar year deductibles that must be met by your covered family members during any one calendar year.

Amounts applied to PPO deductibles also apply toward out-of-network deductibles, and vice versa. If you incur both PPO and out-of-network covered medical expenses during a calendar year, the most you will have to pay in individual deductibles is $300.

Additional Rules Governing Calendar Year Deductibles

1. Only covered medical expenses can be used to satisfy deductibles.
2. If a person incurs covered medical expenses for the same condition in two or more years, the applicable deductible must be satisfied each year.
3. Family deductibles are aggregate limits, and can be satisfied by three or more family members who may or may not have satisfied their individual deductibles.
4. If two or more members of your family are injured in the same accident, only one applicable individual deductible will be applied to all covered medical expenses incurred by all members of your family as a result of that accident.

5. Any amount of covered medical expenses incurred by a person and applied to the applicable individual deductible during the last three months of a year will also be applied toward satisfaction of the applicable deductible for the next year.

Plan Payment Percentages

A "Plan payment percentage" is the percentage the Plan pays for a person's covered medical expenses after any applicable deductible has been satisfied—and before any out-of-pocket limits have been reached. (Keep in mind that benefits are payable only for charges that are considered covered medical expenses and only up to, but not to exceed, any maximum benefit limitations that apply.)

You are responsible for paying the remaining percentage of the covered expenses on behalf of yourself and your dependents.

The Plan pays 80% for most types of treatment rendered by PPO providers, and 60% for out-of-network expenses (before the applicable out-of-pocket limit is met). However, there are some exceptions—see the Schedule of Benefits (starting on page 9) for a complete list of the Plan's payment percentages.

Calendar Year Out-of-Pocket Limits

The Plan limits the amount you must pay in coinsurance each year.

$1,500 PPO Out-of-Pocket Limit - When your 20% coinsurance amounts for PPO covered medical expenses reach $1,500 for a calendar year, you will have met your PPO out-of-pocket limit. The Plan will then pay 100% (subject to all maximum benefits) of the PPO covered medical expenses you incur during the rest of that year.

The Plan also has a family PPO limit of $3,000 that can be met by two or more family members. After the PPO coinsurance amounts during a calendar year for all your eligible members aggregate $3,000, the Plan will then pay 100% (subject to all maximum benefits) of the covered PPO expenses incurred by your covered family members during the rest of that year.

$3,000 Out-of-Network Out-of-Pocket Limit - When your 40% coinsurance amounts for out-of-network covered medical expenses reach $3,000 for a calendar year, your non-PPO out-of-pocket limit will have been met. The Plan will then pay 100% (subject to all maximum benefits) of the out-of-network covered medical expenses you incur during the rest of that year.

After the out-of-network coinsurance amounts during a calendar year for your eligible family members aggregate $4,000, the Plan will then pay 100% (subject to all maximum benefits) of the covered out-of-network expenses incurred by your covered family members during the rest of that year.

Additional Rules Governing Out-of-Pocket Limits - Amounts applied to PPO out-of-pocket limits also apply toward out-of-network out-of-pocket limits, and vice versa. If you incur both PPO and out-of-network covered medical expenses during a calendar year, the most you will have to pay in coinsurance for your own individual covered expenses is $3,000.

Amounts accumulated toward an out-of-pocket limit do not carry over to the next year.

Out-of-Pocket Payments Not Applied to Out-of-Pocket Limits - Amounts paid out-of-pocket for the following do not apply to any out-of-pocket limits:

1. Deductibles.
2. Prescription drug co-pays, or benefit reductions for non-participating pharmacy purchases.
3. Infertility expenses.
4. Charges not considered covered medical expenses, including any portion of a charge which is more than the reasonable and customary charge for that service or supply.

In addition, the Plan will not at any time pay 100% for these expenses even if the person's out-of-pocket limit was previously met.

Maximum Benefits

Each person who is covered under this Plan may be entitled to several different types of maximum benefit amounts which are shown on the Schedule of Benefits.

$2,000,000 Lifetime Maximum Benefit - A $2,000,000 lifetime maximum benefit applies to all Comprehensive Medical Benefits paid by the Plan on a person's behalf during his lifetime.

$500,000 Calendar Year Maximum Benefit - Once all Comprehensive Benefit payments on behalf of a covered person for all causes for charges incurred during a calendar year total $500,000, that person will not be entitled to any further Comprehensive Benefits for any cause for charges incurred during that calendar year. Amounts applied to a person's calendar year maximum benefit also apply to the person's $2,000,000 lifetime maximum benefit.

Other Maximums - There are separate maximum benefits for particular types of care or treatment. These are listed in the "Special Limitations" section on your Schedule of Benefits. Amounts applied to these maximums also apply to your Comprehensive Medical Benefit lifetime maximum. Once a person has received benefits totaling any maximum benefit, no further benefits will be payable for that person for that type of treatment during that year or during his lifetime, as applicable.

Application of Paid Benefits to Maximum Benefit Amounts - The accumulation of paid benefits to maximum benefits includes all benefits paid for a person under any previous major medical plans of the Fund plus all Comprehensive Benefits paid for the person currently and in the future, whether the benefits are paid for PPO or out-of-network covered medical expenses. The accumulation of paid benefits to maximum benefit amounts will apply even if the person's coverage is or has been interrupted or if his status changes—for example, from dependent to employee status or vice versa, or from employee to retiree status.

Covered Medical Expenses

Covered medical expenses are the actual reasonable and customary charges incurred for the services, supplies and types of treatment listed below which are medically necessary and required in connection with the treatment of a person's injury or sickness and which are acceptable to be considered for payment under the Comprehensive Benefit. The amount payable by the Plan for covered medical expenses is subject to the Comprehensive Benefit rules governing deductibles, payment percentages, out-of-pocket limits and maximum benefits.

1. Hospital room and board, including general nursing services and nursery care of newborn infants during the period the child and mother are both hospital-confined after the child's birth, excluding professional services of doctors, private duty nurses or any individual nursing care whatever it is called.

2. Other medically necessary hospital services and supplies, professional services of doctors and private duty nursing, including but not limited to: a) operating room services and supplies; b) outpatient services and supplies; c) emergency room services and supplies; and d) prescription drugs/medications prescribed or ordered by a doctor while a person is hospital-confined.

   A licensed immediate care, emergency care, or other specialized care facility that provides diagnostic and therapeutic services will also be considered a hospital for the purposes of benefit payments.

3. Ambulatory surgical center services and supplies when the facility is in the Blue Card PPO network. (The Plan does not cover out-of-network facilities except when Medicare is primary and covers that facility.)

4. Doctors' services and supplies, provided in or out of a hospital.

5. Surgical services and supplies provided by a doctor, including necessary post-operative care, provided in a doctor's office, clinic, hospital outpatient department or ambulatory surgical center.

6. Surgical assistants' services if the surgery would normally require the assistance of another physician. The maximum allowable charge for the services of a surgical assistant will be 10% of the primary surgeon's fee. "Surgical assistant" means a medical practitioner who is not a physician but who is licensed to serve as an assistant surgeon in the state where the services are rendered. These services will be covered only if the surgical procedure is covered under the Plan, and only if surgical assistance is medically necessary.

7. Anesthesia and its administration, including administration by a Certified Registered Nurse Anesthetist.

8. Circumcisions for newborn infants during the period the mother and child are both hospital-confined following the child's birth.

9. Cosmetic or reconstructive surgery, but ONLY for repair of: accidental injuries, congenital defects of newborn children, and 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). The Plan also covers reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance.

10. For female employees and spouses of male employees only, services and supplies provided for and in connection with maternity, childbirth, miscarriage, pregnancy and pregnancy-related conditions, including therapeutic abortions (abortions performed because the female's life would be endangered if the fetus were carried to full term).

    Note about length of maternity hospitalizations: A federal law requires that a covered person and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. Further, a Plan cannot require the provider (hospital or doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) The Plan will provide benefits for the covered medical expenses incurred by an eligible female employee or dependent spouse during the prescribed time periods, subject to all applicable Plan benefit provisions, maximums and limitations.

11. For employees, retirees and their spouses only, elective sterilization procedures, including but not limited to vasectomies, tubal ligations, vasligations and salpingectomies, limited to one sterilization procedure during a person's lifetime. (Reversal or attempted reversal of any such procedure is not covered.)

12. Treatment of mental health disorders.

13. Treatment of substance abuse disorders. (Note: the Plan excludes charges related to abuse or dependence on tobacco, and no benefits are provided for smoking cessation.)

14. Services and supplies provided to a transplant organ recipient (and donor) for and in connection with a covered transplant procedure, up to the maximums shown on the Schedule of Benefits for that procedure.

    Call the Fund Office if you need a transplant. They 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. The transplant maximum benefits on the Schedule of Benefits will not apply when the covered person contacts and follows the advice of the case management organization.

15. Surgical removal of impacted teeth.

16. Dental services rendered by a doctor, dentist (D.D.S.) 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 an accident.

17. Physical therapy provided by a licensed physiotherapist when ordered by a doctor.

18. Occupational therapy provided by a licensed occupational therapist when ordered by a doctor to restore functional loss due to injury or sickness.

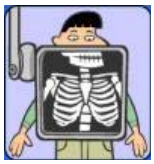
19. Speech therapy provided by a licensed speech therapist when ordered by a doctor for you and your spouse, and for dependent children only when necessary after correction of a congenital anomaly or to restore functional loss due to injury or sickness.

20. Nursing services provided by an R.N. when ordered by a doctor.

21. Radiological services and supplies for treatment by x-ray, radium and radioactive isotopes.

22. Chemotherapy.

23. X-rays, laboratory tests and diagnostic images and scans.



You will save money on x-rays, mammograms, MRIs and CT scans if you use the Fund's preferred provider for outpatient radiology services (MRIs, CT scans and standard x-rays). Not only are the services discounted, but the Plan will pay 100% of your covered charges (no deductible). For more information check the brochure provided to all participants, or call the Fund Office.

24. Transportation as follows:

    a. Local professional ambulance service to and from a hospital.

    b. If a doctor certifies that a person's disability requires specialized treatment which is not available in a local hospital, transportation to obtain such treatment is covered. Covered transportation is only from a hospital in the city where the disability occurred to the nearest hospital qualified to render the special treatment, and may only be within the continental limits of the U.S.A. or Canada or within the geographical boundaries of Hawaii or Alaska.

25. For you (employee) only, one routine lead test in any period of twelve consecutive months.

26. For you (employee) only, services and supplies provided for administration of a routine hepatitis B vaccination (HBV) series once per lifetime. If a covered person other than an employee is exposed to hepatitis B, services and supplies provided for administration of one hepatitis B vaccination series for the exposed person will be covered.

27. Surgical treatment of temporomandibular (TMJ) syndrome, including pre- and post-operative care.

28. Infertility treatment as follows for employees and spouses only:

    a. Office visits, consultations and diagnostic tests performed to diagnose the cause of the infertility.

    b. Hormone treatments, such as Clomid, Metrodin or Pergonal.

    c. Intrauterine insemination (IUI) surgery (such as to open blocked fallopian tubes or repair varicose scrotal veins).

    d. In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote Intrafallopian transfer (ZIFT), and intracytoplasmic sperm injection (ICSI).

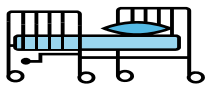
    After satisfaction of the calendar year deductible, the Plan will pay covered infertility expenses at 80% (60% out-of-network) up to a lifetime maximum of

$40,000 per couple, including prescription drugs. The maximum will not be reinstated if the couple divorces and the covered employee remarries.

The Plan covers only involuntary infertility. It does not cover reversal or other treatment following a prior sterilization procedure.

29. Drugs and medicines which may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription.

30. Rental (up to the purchase price) of durable medical equipment, such as wheelchairs, oxygen and respiratory equipment, hospital beds, infusion pumps, pneumatic compressors and TENS units. Purchase of the equipment will be covered if the projected rental fee would exceed the purchase price and purchase is approved by Med-Care Management (the review organization).



Call for pre-certification before obtaining durable medical equipment. In addition to certifying that the equipment is medically necessary, Med-Care Management is often able to negotiate prices that are advantageous to you and the Fund. The Plan's benefits for durable medical equipment are higher when the rental or purchase is arranged by Med-Care Management.

If Medicare is your primary healthcare plan, you do not have to contact Med-Care prior to obtaining durable medical equipment. Medicare patients should follow Medicare's rules and use Medicare-approved medical equipment providers.

31. Other medical supplies, including but not limited to:

    a. Blood or blood plasma.

    b. Oxygen and its administration.

    c. Surgical dressings, casts, splints, trusses, braces and crutches.

    d. Artificial limbs and eyes.

32. Second surgical opinions.

33. Services and supplies provided outside of the U.S.A. to a covered person for treatment of an injury or sickness, provided the services, supplies and type of treatment are medically necessary and are covered under the Plan. In addition, any such service, supply or treatment must be considered to fall within generally accepted standards of good medical practice in the U.S.A. for the condition involved.

34. Services and supplies provided by a doctor for casting, fabrication, dispensing or adjustment of foot orthotics that require a doctor's prescription. The maximum benefit payable for covered foot orthotics is $1,000 per person per lifetime.

35. Services and supplies required in connection with the administration of enteral or parenteral nutrition, provided such nutrition is: a) prescribed by a physician; b) medically necessary to replace oral feeding in patients who are unable to take oral nutrition as the result of sickness or injury; and c) the primary source of the patient's nutrition.

36. Well-child expenses that are covered under the Wellness Benefit but that are in excess of the maximums under that benefit.

37. Bariatric (obesity) surgery if all the following criteria are met:

    a. The patient must be at least 100 pounds over his medically desirable weight and have a body mass index (BMI) of at least 40.

    b. The obesity must be a threat to the patient's life due to the existence of complicating health factors such as diabetes, heart trouble, hypertension, etc.

    c. The patient must have a history of unsuccessful attempts to reduce weight by more conservative measures.

    d. The patient's pre-operative tests must include a psychological evaluation.

    e. Med-Care Management must pre-authorize the surgery.

    f. The surgery must be performed at a Center of Excellence that is in the Plan's PPO network. ("Center of Excellence" means a BCBSIL Blue Distinction facility for bariatric surgery, or a facility designated a Center of Excellence by the American Society of Metabolic and Bariatric Surgery's Surgery Research Corporation. Med-Care Management will be able to advise you if your facility meets this criteria.)

    Only one surgical procedure will be covered during a person's lifetime. (For adjustable lap band surgeries, the Plan will also cover follow-up adjustments more than 90 days following the original procedure.)

    Obesity surgery for a dependent child is not covered.

Comprehensive Benefit Exclusions and Limitations

Some of the exclusions and limitations which apply to the Comprehensive Benefit as well as to all other Plan benefits are listed in the section titled "What the Plan Does Not Cover" starting on page 73. Be sure to become familiar with that list.

Extension of Comprehensive Benefits

The term "extension of benefits" means that under certain circumstances Comprehensive Benefits and benefits under the Prescription Drug Program will be paid for a totally disabled person after his Plan coverage terminates. The extension of benefits rules apply separately to you and each of your dependents.

Rules Governing an Extension of Benefits

1. To qualify for an extension of benefits all the following requirements must be met:

    a. The person must be continuously totally disabled (as defined on page 88) at the time that his coverage terminates.

    b. The person's total disability must have been caused by an injury or sickness that occurred while he was covered under the Plan.

    c. The person must remain continuously totally disabled in order to continue to get the extension.

d. The person must not have already received his lifetime maximum benefit under the Comprehensive Benefit.

2. If a person qualifies for an extension, Comprehensive Benefits for his disabling condition will be continued for him after the date his coverage terminates for up to twelve (12) months or for the number of months he was covered under the Plan prior to the occurrence of his disability, whichever period is shorter.

3. Benefits are payable under an extension only for treatment of the condition which caused the person's total disability, only to the extent that they would have been payable had the person's coverage not terminated, and benefits and amounts payable are only those in effect on the date the person's coverage terminated.

4. An extension of benefits will not apply to any person whose coverage terminates because a required self-payment failed to be made on his behalf by the due date.

5. An extension of Comprehensive Benefits for a person will terminate on the first to occur of the following dates:

   a. The end of a period of 12 months after his coverage terminated.

   b. The end of a period of time equal to the number of months he was covered under the Plan prior to the occurrence of his disability.

   c. The date he has received Plan benefits totaling his Comprehensive Benefit lifetime maximum benefit or any other applicable maximum benefit.

   d. The date he becomes eligible for Medicare.

   e. The date he is no longer totally disabled.

   f. The date he becomes covered under any other welfare fund, group plan or employer-sponsored plan.

No Extensions of Other Benefits

There is no extension of the Supplemental Accident Benefit, the Wellness Benefit, the Hearing Benefit or the Chiropractic Benefit.

PRESCRIPTION DRUG PROGRAM

The Plan provides three cost-saving programs for prescription drugs—the Retail Card Program, the Mail Order Program and the Maintenance Choice Program. All three programs are administered by a prescription benefit manager in accordance with a contract with the Trustees.

What You Pay

When you use the Plan's Prescription Drug Program, you pay the following amounts for each supply of a covered prescription drug:

Retail Card Program (up to a 30-day supply):

Generic	You pay 10% ($5 minimum)
Brand	You pay 10% ($10 minimum)

Mail Order Program (up to a 90-day supply):

Generic	You pay $15
Brand	You pay $30

Maintenance Choice Program (up to a 90-day supply):

Generic	You pay $15
Brand	You pay $30

Retail Drug Card Program

When you and your covered family members use your prescription drug card at participating pharmacies, you will be required to pay 10% of the contracted price directly to the pharmacy (subject to the minimum co-pay amounts shown above). Note that contracted prices are usually lower than the pharmacy's regular retail prices. The Plan will pay the rest.

- For each purchase you make, you will be able to get up to a 30-day quantity, or the quantity prescribed by the doctor, whichever is less.
- There are no claims to file.
- You can use your drug card to get the amount of medication prescribed by your doctor plus two (2) refills. After you purchase the initial supply plus two refills of a maintenance drug, you must use the Mail Order Program for all additional refills.

  If a doctor prescribes a drug that must be taken on a long-term basis, ask the doctor for two prescriptions—one for a 30-day supply that you can have filled immediately at a local participating pharmacy under the Retail Card Program, and one for up to a 90-day supply (with refills) that you can obtain through the Mail Order Program.
- Your 10% co-pay amounts do not apply to any Plan deductibles or out-of-pocket limits.

If You Use a Non-Participating Pharmacy

If you purchase a covered prescription drug at a pharmacy that is NOT in the Plan's network, you will need to file a claim with the Fund Office for partial reimbursement under the Comprehensive Benefit.

- The amount you paid the non-participating pharmacy will be reduced by 50% and the remaining balance will be paid at 80% (provided your $200 calendar year deductible has been satisfied).
- Neither the 50% reduction nor your 20% co-pay will apply to any Plan deductibles or out-of-pocket limits.
- The 50% reduction will not apply if you live more than 15 miles from a participating pharmacy—be sure to note this information on your claim.

Mail Order Program

You will be able to save money on your long-term (maintenance) prescription drug needs if you use the Mail Order Program. Long-term (maintenance) drugs are medications that a person takes on an ongoing basis for conditions such as high blood pressure, high cholesterol, arthritis, diabetes, etc. After you purchase the initial supply plus two refills of a maintenance drug, you must use the Mail Order Program for all additional refills. The Mail Order Program is not designed to provide drugs taken on a short-term basis—you should continue to buy those drugs at a participating retail pharmacy.

The Fund Office provides all new participants with a packet of materials about this program. Be sure to read the brochure which explains the program and tells you how to order maintenance drugs from the mail-order pharmacy.

Your mail-order co-pays plus amounts paid by the Plan for the remaining costs are not applied to and are not subject to the regular Comprehensive Benefit deductibles, co-payment percentages, out-of-pocket limits or maximum benefits. Medications taken for infertility are an exception to this rule—the cost of those prescriptions will be applied to the $40,000 per-couple infertility maximum.

Maintenance Choice Program

You can also use the Maintenance Choice™ Program. This option allows you to obtain a 90-day prescription at a CVS pharmacy store for the same low co-pay you would pay through the Mail Order Program.

Covered Prescription Drugs; Exclusions

This program covers medically necessary drugs or medications which can only be obtained with a doctor's written prescription.

The Plan exclusions that start on page 73 apply to the Retail Drug Card, Mail Order and Maintenance Choice Programs. For example, the Plan does not cover over-the-counter (non-prescription) or experimental/investigative drugs, cosmetic or lifestyle drugs, or drugs for birth control, obesity, hair growth, hair removal, smoking cessation, or sexual dysfunction, even if you have a doctor's prescription.

DENTAL AND ORTHODONTIA BENEFIT

An organization called Delta Dental administers your Dental and Orthodontia Benefit and pays all dental and orthodontia benefits on behalf of the Fund.

You have a choice of how you receive your dental care and benefits from Delta Dental:

1. Delta Preferred Providers · Delta Preferred dentist fees are discounted, so your out-of-pocket expenses will be the lowest.
2. Delta Participating Dentist · Participating Dentists have agreed to base their fees on Delta Dental's usual, customary and reasonable fees (UCR fees). You are not responsible for charges exceeding Delta's UCR fee schedule.
3. Out-of-Network Dentist · Because Delta Dental has no fee arrangement with out-of-network dentists, you are responsible for the difference between the dentist's fee and Delta's payment to the dentist—in addition to your co-pay percentage of the covered dental expenses.

Lists of providers in the Delta Dental Preferred Provider and Participating Dentist networks can be obtained by calling Delta Dental's customer service department or visiting Delta's website (see the inside front cover).

You do not have to enroll or sign up with any of the three dental programs; simply make an appointment with whichever dentist you choose. You can use one program for some of your dental care and a different program for the rest of your dental care. You may switch from one program to another at any time. Some family members can use one program and others use a different program.

Dental and orthodontic services must be rendered in accordance with accepted standards of dental or orthodontic practice and must be received while a person is covered under this Dental and Orthodontia Benefit. Dental services must be performed by a licensed dentist (D.D.S. or D.M.D.), and orthodontic services must be performed by a dentist (D.D.S. or D.M.D.) licensed to practice orthodontia.

DENTAL BENEFITS

Payment of Dental Benefits

The payment percentages and the calendar year maximum benefits payable per person for each dental program are shown on the Schedule of Benefits. There are no deductibles. The Plan will pay the applicable percentage for a person's covered dental expenses each year up to the applicable calendar year maximum benefit. Once a person has received this maximum benefit for covered dental expenses incurred during a calendar year, he will not be entitled to any further dental benefits during the rest of that year.

The maximum under the Delta Preferred Provider program also includes payments made under the Delta Participating Dentist Network and Out-of-Network programs. The annual maximum under the Delta Participating Dentist Network program also includes payments made under the Out-of-Network program.

Alternate Courses of Dental or Orthodontic Treatment

Covered dental expenses or covered orthodontia expenses will be limited to the usual, customary and reasonable (UCR) charge for that service which is most commonly used nationwide in the treatment of that condition and which is recognized by the dental profession to be appropriate in accordance with the accepted nationwide standards of dental practice. In cases where you and/or your dentist choose a more expensive level of care, any charges in excess of the UCR level as determined by this provision will not be considered covered dental or orthodontia expenses.

Predetermination of Benefits

Delta Dental provides a service called "predetermination of benefits" to help you plan ahead when you or a family member needs major dental work. While you are not required to use this service, it is to your advantage to find out in advance how much your share of the expenses will be. It is strongly recommended that your dentist submit a written request for predetermination of benefits whenever your proposed dental work is expected to exceed $200. Delta will notify you and the dentist in writing which of the proposed services are covered and how much the estimated reimbursement will be. Please keep in mind that some dental work is subject to restrictions and limitations not detailed in this booklet that may affect payment of your claim. For example, the frequency of some services may be limited to generally accepted frequency standards of practice for dental necessity.

Although a predetermination is not a guarantee of payment, neither Delta Dental nor the Fund will be responsible for claims that are denied when a written predetermination of benefits has not been received.

I.D. Cards

To alert your dentist to send his bill to Delta Dental, and to identify yourself as a participant in this program, be sure to present your Delta I.D. card when you receive dental services.

Covered Dental Expenses

Diagnostic and Preventive Treatment (Plan Payment—100%)

1. Routine oral examinations, up to two per year.
2. Prophylaxis (scaling and cleaning of teeth, including periodontal maintenance prophylaxis), up to two per year.
3. Topical application of fluoride for dependent children under age 19, once per year.
4. Emergency relief of pain (palliative treatment).
5. Dental x-rays, including full mouth x-rays (once in a period of 36 consecutive months), supplementary bitewing x-rays (twice during a year), and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.
6. For eligible dependent children under age 16 only, sealants on the 6-year and 12-year molars only, with at least five years in between a repeat sealant procedure on any tooth.

Restorative Services (Plan Payment—80%)

1. Extractions not related to orthodontia or impacted teeth.
2. Oral surgery, except for surgical extraction of impacted teeth (charges for surgical extraction of impacted teeth are considered covered medical expenses under the Comprehensive Benefit).
3. Administration of medically necessary general anesthesia in connection with covered oral surgery procedures other than simple extractions.
4. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth.
5. Space maintainers that replace prematurely lost teeth for children under 19 years of age.
6. Treatment of periodontal and other diseases of the gums and tissues of the mouth, provided the treatment is necessary, appropriate and consistent with the generally accepted treatment and frequency guidelines.
7. Endodontic treatment, including pulp infections and root canal therapy.
8. Injection of antibiotic drugs by the attending dentist.
9. Inlays, onlays, gold fillings or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration.
10. Initial installation of fixed bridgework (including inlays and crowns as abutments).
11. Initial installation of partial or full removable dentures (including precision attachments and adjustments during the six-month period following installation).

12. Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, limited to one relining or rebasing in any period of 24 consecutive months.
13. Replacement of a prosthetic appliance, crown, inlay, onlay restoration or fixed bridgework (excluding dentures) only if three years have elapsed since the last placement of such an item, unless the replacement is required as the result of an accidental injury.
14. Replacement of an existing partial or full removable denture or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that the replacement is necessary due to one of the following reasons:
    a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed.
    b. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months from the date of initial installation of the immediate temporary denture.

c. The existing denture cannot be made serviceable and, if it was installed and paid for under this Dental and Orthodontia Benefit, at least five years have elapsed prior to its replacement.

Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.

15. Tooth implants as follows:

a. As an alternative to a necessary crown or bridge. The Plan will pay only up to the UCR charges for the crown or bridge. The UCR allowance for the crown or bridge is the maximum allowable by the Plan for the tooth implant and all related surgical procedures and services. No additional benefits are payable, even if the work is not completed until the following calendar year. Implants that are not provided in lieu of a necessary crown or bridge are not covered.

b. For the sole purpose of anchoring a full denture, up to a lifetime maximum benefit of $5,000. No deductible applies. Plan benefits paid for an implant to anchor a denture do not apply to your dental calendar year maximum benefit.

If a dentist recommends a tooth implant, it is strongly recommended that you submit a request for a predetermination of benefits.

Only UCR Fees are Covered

If a covered person incurs charges from a dentist for covered dental services or supplies, the amount of the charges to be considered covered expenses will be the applicable usual, customary and reasonable (UCR) fees shown below:

- Delta Preferred Providers - Delta's discounted UCR fees.
- Delta Participating Dentists - Delta's UCR fees, not discounted.
- Out-of-Network Dentists - The UCR fees normally charged by out-of-network dentists in the area concerned for similar services and supplies.

Dental Benefits Exclusions and Limitations

No Dental Benefits are payable for:

1. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist when the treatment is rendered under the supervision and guidance of a dentist and is billed for by the dentist.
2. Services and supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures.
3. The replacement of a lost, missing or stolen removable prosthetic device.
4. Services or supplies which are for orthodontic treatment except as outlined under the "Orthodontia Benefits" section.
5. Any duplicate prosthetic device or any other duplicate appliance.

6. Sealants, except for dependent children under age 16 as stated in No. 6 under Diagnostic and Preventive Treatment.
7. Oral hygiene, dietary instruction or a plaque control program; or appliances (such as night guards) or other myofunctional therapy to control or correct harmful habits.
8. Implantology (implantation of teeth), except as specified in No. 15 under "Restorative Services."
9. Hospital charges incurred as a result of dental treatment performed in a hospital (such charges are considered for payment under the Comprehensive Benefit if hospitalization for such treatment is considered medically necessary).
10. Treatment of conditions related to the temporomandibular jaw joint (TMJ).
11. Dental appliances, restorations or procedures for the purpose of altering the vertical dimension or restoring or maintaining occlusion.
12. Splinting, or replacing tooth structure lost as a result of abrasion or attrition.
13. Dental procedures that are covered under any other benefit provided by the Plan.
14. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer.
15. Services or supplies which are not necessary according to generally accepted standards of dental practice or which do not meet generally accepted standards of dental practice.
16. Replacement of any prosthetic appliance, crown, inlay, onlay, bridgework or denture except as stated in No. 13 and No. 14 under the list of "Restorative Services."
17. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while a person is not eligible for Dental Benefits.
18. Prosthetic devices (including bridges and crowns), and the fitting of such devices, which are ordered while the person is eligible for Dental Benefits but which are finally installed or delivered to the person more than 60 days after termination of eligibility.
19. Treatment which was incurred while a person was not eligible for Dental Benefits. Treatment is considered to be incurred:
    a. For full or partial dentures, when the impression is taken for the appliances.
    b. For root canal therapy, when the tooth is opened.
    c. For fixed bridgework, crowns, and other gold restorations, when the tooth is first prepared.
20. Services, supplies, types of treatment, or charges for which benefits are excluded in the section titled "What the Plan Does Not Cover" starting on page 73.

Extension of Dental Benefits

If a person's eligibility for the Dental and Orthodontia Benefit terminates, Dental Benefits will be available for that person for 60 days after his eligibility terminates for covered dental expenses incurred for:

1. Crowns or a gold restoration, provided the tooth was prepared while the person was eligible for Dental Benefits.
2. A prosthetic device, such as a full or partial denture or bridgework, provided the impression for the appliance was taken and any abutment teeth were prepared while the person was eligible for Dental Benefits.
3. Root canal therapy, provided the tooth was opened while the person was eligible for Dental Benefits.

ORTHODONTIA BENEFITS (for Dependent Children Under Age 19 Only)

Orthodontia Benefits are separate from the Dental Benefits. Any benefits paid for a covered dependent child during a year for orthodontia do not apply to his Dental Benefits calendar year maximum benefit.

Payment of Orthodontia Benefits

The payment percentages and lifetime maximum benefits payable per child for each dental program are shown on the Schedule of Benefits. There are no deductibles. The Plan will pay the applicable percentage for the child's covered orthodontia expenses up to the applicable lifetime maximum benefit. Once the Plan has paid its applicable lifetime maximum benefit, no further orthodontia benefits will be paid. The amount you pay out-of-pocket for your child's orthodontia expenses will vary depending on whether you use a Preferred Provider, a Participating Dentist or an out-of-network dentist.

- The initial payment usually required will be considered at up to 25% of the total case fee. This includes the preliminary diagnostic work-up and initial banding. (Extractions performed as a part of an orthodontic course of treatment are considered for payment under the Orthodontia Benefits, not under the Dental Benefits.)
- The balance of the case fee should be billed to be paid on a monthly basis until the treatment is completed or until the maximum allowable benefits have been received (unless the child's eligibility for Dental and Orthodontia Benefits terminates before then). The orthodontist should submit quarterly verification to the Fund Office that a covered person's orthodontic treatment is continuing.

RULES GOVERNING ORTHODONTIA BENEFITS

1. If a child is undergoing orthodontic treatment when his eligibility starts, the Plan will pay 50% of the submitted charges that are determined to be incurred by him after he became eligible. The Plan will only provide reimbursement for payments for services rendered on or after the date a child's eligibility starts. No payment will be made for past due payments.

2. There is no extension of benefits for orthodontia expenses. All benefits for orthodontia will terminate on the date that a child's eligibility for Dental and Orthodontia Benefits terminates. No Plan payments will be made for payments that are due after a child's eligibility for Dental and Orthodontia Benefits terminates.
3. No payment will be made for replacement of lost, missing or stolen orthodontic devices.

VISION BENEFIT

VSP NETWORK DOCTORS AND NON-VSP PROVIDERS

Vision Benefits are provided and administered by an organization called Vision Service Plan (VSP) according to a contract between VSP and the Trustees. VSP gives you a choice of the way you can receive your vision care benefits.

1. You can use the VSP network doctors.
   - VSP has arranged for a number of doctors in your area (VSP network doctors) who will provide professional vision care for you and your dependents. VSP guarantees quality and cost control.
   - VSP is a prepaid program. This means that VSP network doctors provide examinations, professional services, lenses, and quality frames at no out-of-pocket expense to you. VSP pays the VSP network doctors for the services and supplies provided to you. Any additional vision services and/or eyewear not covered by VSP can be arranged between you and the VSP network doctor.
   - As a participant in the VSP program, you can take advantage of discounts and savings on laser vision correction, lens extras, and additional sets of eyewear and sunglasses. These services are NOT part of your Northern Illinois Benefit Fund benefits and you are not required to use them.
2. You can use a non-VSP provider.
   - You can go to any optometrist, ophthalmologist and/or dispensing optician for your vision care.
   - You must pay the provider his full fee and file a claim with VSP for reimbursement. You will be reimbursed according to the Non-VSP Provider Allowance column on the Schedule of Benefits (page 14).

A list of VSP network doctors is provided automatically, without charge, to participants as a separate document. You can also locate a VSP network doctor by calling VSP's toll-free customer service center: 1 (800) 877-7195. If you call between 8 a.m. and 8 p.m. Central Standard Time, Monday through Friday, a customer service representative will be available to help you. The representative can send you a list of the VSP network doctors in your area. If you call after hours, you will reach VSP's interactive voice response system. You can use this system or go to vsp.com find out if a doctor you want to use is a VSP network doctor.

COVERED VISION SERVICES AND SUPPLIES

The following are the vision care services and supplies that you will receive at no cost if you use a VSP network doctor. If you use a non-VSP provider these are the services and supplies for which VSP will reimburse you according to the Non-VSP Provider Allowance column on the Schedule of Benefits:

1. Vision Examination - Allowable once every twelve (12) months. This includes a complete analysis of the eyes and related structure to determine the presence of vision problems or other abnormalities.

2. Lenses (plastic or glass) - Allowable every 12 months, if required.
3. Frame - Allowable once every 12 months.
4. Contact Lenses - Elective and visually necessary contact lenses are allowed under this benefit. An allowance is provided toward the cost of elective contacts and the contact lens exam (fitting and evaluation).

   Visually necessary contacts are covered in full. Contacts are considered "visually necessary" following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use.

If you use a VSP network doctor, all of the covered vision care services and supplies listed above are provided at no cost to you (except items listed under the "Exclusions and Limitations"). The VSP network doctor will provide the necessary examination, order the proper lenses if they are required, and verify the accuracy of the finished lenses. You will have a choice of a wide selection of good quality frames. If you select lenses or a frame which costs more than the amount allowed by VSP, you pay the additional charge directly to the VSP network doctor.

This benefit is designed to cover your visual needs rather than cosmetic materials. If you select any supplies that are listed in the exclusions "Vision Benefit Exclusions and Limitations" section, VSP will not reimburse any of the cost incurred from a non-VSP provider, and there will be an extra charge by a VSP network doctor for the supplies.

HOW TO GET VISION BENEFITS

Using a VSP Network Doctor

1. Make an appointment for an examination. Tell the doctor's office that you are covered by VSP through the Northern Illinois Benefit Fund. You will be asked for the following information: your name, your unique identification number or the last four digits of your Social Security number, and your birth date. Before your scheduled examination, the VSP network doctor will obtain authorization for services from VSP.
2. Keep the appointment and make any necessary payments for the additional materials agreed upon by you and the VSP network doctor. The doctor and VSP will take care of the rest.

Using a Non-VSP Provider

If you use a non-VSP provider, you must pay the provider his full fee and get an itemized paid receipt. You cannot assign these benefits. Then you must file a claim with VSP within six months from the date of service. Send your claim to VSP, P.O. Box 997105, Sacramento, CA 95899-7105. VSP will reimburse you for the reasonable and customary amount of the charges up to but not to exceed the amounts shown in the Non-VSP Provider Allowance column on the Schedule of Benefits. There is no assurance that the allowances will be sufficient to cover your expenses in full.

VISION BENEFIT EXCLUSIONS AND LIMITATIONS

Covered vision care services and supplies do not include:

1. Medical or surgical treatment of the eyes.
2. Orthoptics, vision training or subnormal vision aids.
3. Two pair of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program which are lost or broken. They will not be replaced except at the normal intervals when services are otherwise available.
5. Contact lenses (except as stated previously), aniseikonic lenses, faceted lenses, plano (non-prescription) lenses, oversize lenses, coated lenses, blended and progressive lenses, tinted and photochromatic lenses (except pink No. 1 and No. 2), multifocal plastic lenses, laminated lenses, a frame that costs more than the benefit allowance, or any other cosmetic item.
6. Any eye examination required by an employer as a condition of employment.
7. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
8. Services, supplies, types of treatment, or charges for which benefits are excluded in the section titled “What the Plan Does Not Cover” starting on page 73.

EXTENSION OF VISION BENEFITS

If a person has an examination and a prescription is ordered while he is eligible for Vision Care Benefits, benefits will be payable even if the supplies are provided to the person after his eligibility for these benefits terminates.

WHAT THE PLAN DOES NOT COVER
(Plan Conditions, Limitations and Exclusions)

No payment will be made under this Benefit Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the following:

1. Services or supplies provided to a person who is not covered under the Plan at the time a service or supply is provided, including services received prior to his effective date of benefits under this Plan, or after his coverage terminates (except as may be specifically stated in any applicable extension of benefits provision).

2. Services or supplies which are not recommended, ordered or approved by a doctor, or services or supplies rendered or recommended by a naprapath.

3. Services or supplies received from a doctor or hospital that does not meet this Plan's definition of a doctor or a hospital.

4. Any service or supply which is not rendered for the treatment or correction of, or in connection with, a specific sickness, illness or accidental bodily injury unless it is specifically stated as covered under this Plan.

5. Any treatment, care, services, supplies, procedures or facilities that are experimental or investigative in nature, or any treatment, care, services, supplies or procedures that are provided in connection with any treatment or procedure that is experimental or investigative (defined on page 86).

6. Services or supplies that are not medically necessary (defined on page 87).

7. Any charge or portion of a charge that is determined to be in excess of the amount considered to be reasonable and customary (defined on page 87).

   For example, you could have a $2,000 out-of-network surgery claim for which the data obtained by the Fund Office indicates the reasonable and customary charge is $1,800 in the zip code area in which the surgery was performed. The allowable covered expense for the surgery is therefore $1,800, and the Plan will pay its appropriate co-pay percentage of $1,800. The $200 over the R&C charge is not a covered expense and you are responsible for paying that amount.

8. Charges incurred by a person for a particular type of treatment once the person has received Plan benefits totaling any applicable maximum benefit for that type of treatment during any stated period of time as specified on the Schedule of Benefits or elsewhere in this booklet.

9. Accidental bodily injury, sickness or disease sustained while the person was performing any act of employment or doing anything pertaining to any occupation or employment for wages, compensation or profit. Exception: This exclusion does not apply to life insurance or AD&D insurance for covered employees or to the Death Benefit for covered retirees.

10. Accidental bodily injury, sickness or disease for which benefits are or may be payable in whole or in part under any workers' compensation act or any occupational diseases act or similar law. Exceptions: This exclusion does not apply to

life insurance or AD&D insurance, or asbestosis claims when the employee receives a settlement as the result of an asbestosis-related court action.

11. 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. Exception: This exclusion does not apply to life insurance.

12. Unless specifically stated as covered, any type of physical examination (employment, pre-marital, school, etc.) or any other medical examination or test for check-up purposes where not necessary for diagnosis or treatment of a sickness, disease or injury. This exclusion applies to routine mammograms and Pap smears, cancer prevention examinations and cancer detection center examinations, tuberculosis examinations, sickle cell anemia examinations, examinations to determine whether a person has AIDS, and any other type of physical examination or test which is given primarily to determine whether a person has a specific illness or disease where there have been no symptoms.

13. Unless specifically stated as covered, services or treatments which are preventive or routine in nature. This exclusion applies to inoculations and treatments which a person may receive as a result of being exposed to a particular disease or to prevent the contraction of any disease.

14. Patent medicines or drugs or medicines, nutritional supplements, food supplements, vitamins or any other over-the-counter items of a like nature which can be obtained without a doctor's prescription, or any other drugs or medicines not legally dispensed by a registered pharmacist according to the written prescription of a doctor (except for certain non-prescription diabetic supplies).

15. Birth control medications unless they are prescribed by a doctor for therapeutic treatment of a specific sickness, or for contraceptive devices or any other method of contraception other than covered surgical sterilization.

16. Services or supplies provided in connection with tobacco use or abuse or smoking cessation, including but not limited to therapy, counseling, stop-smoking programs, hypnosis, acupuncture, tapes, records, videos, or medications such as nicotine gum or patches such as Habitrol, whether prescription or non-prescription.

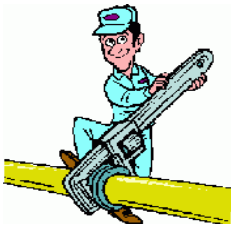
17. Care, treatment, medication or surgery that is cosmetic or elective, including non-emergency cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue).

    Exception: This exclusion does not apply to any of the following:

    - Cosmetic or reconstructive surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident.
    - Cosmetic or reconstructive surgery for the correction of congenital defects of newborn children.

- Cosmetic or reconstructive surgery for repair of effects which result from surgery for which Plan benefits were paid (or would have been payable if the person had been covered under the Plan).
- Corrective surgical procedures on organs of the body which perform or function improperly.
- Reconstructive breast surgery following a mastectomy, including reconstructive surgery on the non-affected breast to achieve a symmetrical appearance.

18. Any of the following services provided to dependent children:
    a. Sterilization procedures.
    b. Pregnancy or any other pregnancy-related conditions.
    c. Infertility testing or treatment.
    d. Abortions.
19. Any type of speech therapy or treatment except when necessary after correction of a congenital anomaly, or to restore functional loss due to injury or sickness.
20. Abortions, except for therapeutic abortions for female employees and spouses of male employees when the life of the female would be endangered if the fetus were carried to full term.
21. Lasik or any similar procedure to enhance vision or to correct nearsightedness or farsightedness.
22. Except as specifically stated in No. 37 on page 59, surgical or medical services or supplies rendered in connection with any overweight condition or condition of obesity, including but not limited to diet programs, pills, injections, vitamins, minerals, food supplements or surgical procedures.
23. Services or supplies provided for treatment of injuries sustained as a result of the following hazardous activities: sky diving, parachuting, or hang gliding; activities in ultra-light aircraft or hot air balloons; organized racing of motor vehicles, motorcycles, cars or other motorized vehicles; organized racing of motor boats or speed boats; mountain, rock or ice climbing; or bungee jumping.
24. Physical therapy or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement.
25. Hearing aids or examinations for or the fitting of hearing aids except as provided under the Hearing Benefit.
26. Eye refractions, eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), unless the service of supply is specified as payable under the Vision Benefit.
27. Dental services and supplies as follows, unless specified as payable under the Dental and Orthodontia Benefit:
    a. Services rendered for treatment of the teeth, the gums (other than for tumors) or other associated structures primarily in connection with the treatment or replacement of teeth, including treatment rendered in connection



with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, unless the charges are for services rendered for surgical extraction of impacted teeth or repair of sound natural teeth rendered within six months of and as a result of an accident.

b. Dental prosthetic appliances, including any charges made for the fitting or repair of any of these appliances, unless the service or supply was rendered as a result of non-occupational accidental bodily injury.

28. Nursery care, or circumcision of a male child, after the period of joint confinement of the mother and child after the child's birth or after the end of the period that either the mother or newborn child is no longer medically required to remain in the hospital.

29. Any operation or treatment in connection with a sex transformation.

30. Diagnosis and/or treatment (including penile implants) for any type of sexual dysfunction, including any complications arising from any such conditions.

31. Diagnosis and/or treatment provided for or in connection with growth disorders, including but not limited to pituitary dwarfism. Exception: The Plan will cover charges for human growth hormone for the treatment of documented human growth hormone deficiency due either to congenital defect or exogenous cause with an underlying medical diagnosis of growth hormone deficiency when the review organization has verified that the treatment meets the Plan's coverage criteria.

32. Shoes and work/specialty boots, even if prescribed or recommended by a doctor.

33. Non-surgical treatment of TMJ.

34. Travel or transportation except as specifically provided in the "Covered Medical Expenses" section.

35. Treatment of a mental health disorder other than treatment provided by an M.D., D.O. or covered mental health practitioner (as defined on page 87).

36. Any consultation or session with, or treatment of, any family member which is primarily in connection with the treatment of a another family member's medical condition, mental health disorder or substance abuse disorder.

37. Marriage or family counseling.

38. Transplants for organs other than those specified on the Schedule of Benefits.

39. Individual or private nursing care except as provided by an R.N. according to a doctor's written recommendation.

40. Any care, treatment, services, supplies, procedures or hospital confinements which are not provided in accordance with generally accepted professional medical standards.

41. In-hospital items such as telephones, TV's, cosmetics, newspapers, magazines, laundry, guest trays, or beds or cots for guests or other family members, or any other personal comfort items or items that are not medically necessary.

42. Rental or purchase of any covered durable medical equipment or other equipment that is not used solely for therapeutic treatment of a single individual's injury or sickness.

43. Any of the following items or items of a similar nature or purpose, regardless of intended use: air conditioners, air purifiers, whirlpools, swimming pools, humidifiers, dehumidifiers, pillows (including allergy-free pillows), blankets or mattress covers, commodes, electric heating units, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, chiropractic braces, wigs, devices or surgical implantations for simulating natural body contours, communication devices, breast pumps, or health club memberships.

44. Special education, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individuals providing the education.

45. Education, training or room and board while a person is confined in an institution which is primarily a school or institution of learning or training.

46. Services or supplies provided while a person is confined in an institution which is primarily a place of rest, a place for the aged or a nursing or convalescent home or facility.

47. Any type of custodial care, which is any care intended primarily to help a disabled person meet basic personal needs when: a) there is no plan of active medical treatment to reduce the disability; or b) the plan of active medical treatment cannot reasonably be expected to reduce the disability. This exclusion applies to all such care regardless of what the care is called.

48. Services provided to you or a dependent by an individual who ordinarily lives in your home or in the home of the dependent receiving the services, or who is your or your spouse's close relative. A "close relative" means your spouse, or your or your spouse's child, son-in-law, daughter-in-law, brother, brother-in-law, sister, sister-in-law, parent, father-in-law or mother-in-law.

49. Any injury or sickness sustained as a result of or in connection with or contributed to by a person's participation in a riot, by a person's commission or attempted commission of an illegal act, by a person's engagement in an illegal occupation, or by a person's participation as an aggressor in any act of violence.

50. Completing of claim forms (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies.

51. Accidental bodily injury or sickness for which you or a covered dependent, whether or not a minor, have a right to recover payment from a third party, except to the extent provided in the section titled "Subrogation" starting on page 95.

52. Military service-connected injury or sickness, including:

    a. Services or supplies furnished, paid for or otherwise provided or made available by any military facility due to past or present service of any person in

the armed forces of a government or while engaged on active duty or training in the Armed Forces, National Guard, or Reserves of any state or country; or

b. Bodily injury, disease or sickness caused by any act of war, whether war is declared or undeclared, any act of international armed conflict or any conflict involving the armed forces of any international body, or insurrection.

53. Treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the U.S. Government or its agency, provided, however, that if charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges will be considered covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.

54. Charges incurred by a covered family member which you or the family member are not legally required to pay, or charges which would not have been made if this Plan did not exist.

55. With respect to a PPO provider's fee which is or should be reduced in accordance with a negotiated fee arrangement between the Trustees and the PPO, any amount charged by the provider in excess of the negotiated amount.

56. Services by Professional Neurological Services, 5241 S. Cicero Ave., Suite 104, P.O. Box 388241, Chicago, IL, or any other address at which, or name under which, the provider is doing business or billing. This exclusion applies to all claims, regardless of the circumstances under which the claim was incurred. For example, the Plan will not pay a claim from this provider even if it is only for interpretation of a test, such as a sensory nerve study, that was physically performed elsewhere.

57. Surrogacy or surrogate fees. This exclusion applies to, but is not limited to, charges in connection with:

    a. The medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan.

    b. A female employee's or dependent's carrying and delivering a child for someone else.

    Any child born of a covered person acting as a surrogate mother will not be considered a dependent of the surrogate mother or her spouse.

    This exclusion does not apply to complications of pregnancy incurred by a surrogate who is an eligible employee or eligible dependent under this Plan.

THE ABOVE IS NOT AN ALL-INCLUSIVE LISTING OF THE PLAN'S LIMITATIONS AND EXCLUSIONS. IT IS ONLY REPRESENTATIVE OF THE TYPES OF SERVICES AND SUPPLIES FOR WHICH NO PLAN PAYMENT IS MADE AND OF THE TYPES OF SITUATIONS IN WHICH LOSS MAY BE SUSTAINED OR IN WHICH EXPENSES MAY BE INCURRED FOR WHICH NO PAYMENT IS MADE.

HOW TO FILE A CLAIM

CLAIM FILING TIME LIMIT
Claims must be submitted within **one year** after the date the claim is incurred. No benefits will be paid for bills submitted more than one year after the date of loss.

MEDICAL CLAIMS

Blue Card PPO Doctors and Hospitals - You do not have to file claims when you use Blue Card PPO doctors and hospitals (PPO providers). All PPO providers send their bills to their local Blue Cross Blue Shield (BCBS) affiliate. Most out-of-network physicians will also file their claims with their local Blue plan. After the Plan's share of your covered medical expenses has been paid to the providers, the Fund Office will send you an "Explanation of Benefit Payments" form showing what was paid. The providers will then bill you for any amounts or charges which are in excess of the Plan's share of the expenses. Do not send these excess bills to the Fund Office—they are your responsibility. Note: If coordination of benefits applies and this Plan is secondary, you should file a claim with the Fund Office instead of with BCBS.

All Other Medical Claims - You must file a claim for benefits if you receive a bill from an out-of-network doctor or from any other non-doctor or non-hospital service provider. You must also file a claim for benefits if an out-of-network hospital requires payment from you instead of sending the bill to BCBS.

How to File Medical Claims

1. Call or go to the Fund Office to get a claim form. Claim forms are also available for printing on the Fund's website www.ualocal501.org.
2. Send in separate claim forms each year for each family member. You must also send in a separate claim form for each unrelated injury. To submit additional bills during a calendar year, mail out-of-network hospital bills to the Fund Office with your (employee's or retiree's) name, address and unique identification or Social Security number on them. If the additional bills are for a dependent, add the dependent's name and birth date. If you receive treatment for an injury over more than one calendar year, you will need to submit a new claim form each calendar year. If you are a full-time college student, you will need to submit a claim form each school year.
3. Complete the claim form as follows:
   - Fill in all applicable information on the front of the claim form and sign it. If the claim is in connection with an accident, be sure to fill in all required accident information.
   - If the accident was someone else's fault, you may be required to sign a subrogation agreement (see pages 95-97) before the Plan will pay any benefits on the claim.
4. Attach all your itemized bills to the claim form and mail it to the Fund Office (the address is on the inside front cover) AS SOON AS POSSIBLE.

- Each bill should show: patient's name, date and charge for each service or supply, procedure codes, diagnosis and provider name, address and telephone number.
- Bills for prescription drugs must include: patient's name, drug name, date filled, drug charge, prescribing doctor's name and prescription receipt.
- Original bills must be submitted unless this Plan is the secondary payer under the coordination of benefits rules. Cash register receipts, payment receipts or cancelled checks are not acceptable proof of claim. Please do not tape bills together or to the claim form.

5. If an out-of-network doctor or hospital, or any other non-doctor or non-hospital service provider, requires you to make a partial or full payment at the time of service, just follow the above steps to file a claim for reimbursement from the Plan. Make sure that you attach the bill (which indicates that it was paid in full or indicates how much of the bill you paid.) The Fund Office will send you a check for the Plan's share of your covered expenses along with an Explanation of Benefits form explaining the Plan's payment. You must pay the provider any amount not paid by the Plan.
6. Out-of-network doctors and other service providers may allow you to "assign" benefits. This means you sign a form supplied by the service provider (doctor, laboratory, x-ray facility, etc., as well as a dentist when filing a claim for Dental Benefits) which allows the provider to send its bill to the Fund Office (or Delta Dental) for payment instead of to you. Or you can file a claim for benefits, sending in unpaid bills with a claim form that has a signed statement that assigns benefits to the provider. In either case, the Fund Office will pay the Plan's share of your expenses directly to the provider and will send you an Explanation of Benefits form explaining the Plan's payment to the provider. You must pay the provider any amount not paid by the Plan.

DENTAL CLAIMS

Do not send dental claims to the Fund Office.

Delta Dental handles all the Plan's dental claims. All claims should be sent to Delta no matter what dentist you use.

Your dentist should send your claim to Delta for payment at:

Delta Dental Plan of Illinois
P.O. Box 5402
Lisle, IL 60532

(Delta's address is also on your dental ID card and on the inside front cover of this booklet.)

It is strongly recommended that you submit a request for a predetermination of benefits from Delta before having any dental work done that will cost more than $200. This can help you avoid being confronted with unexpected out-of-pocket costs for your share of covered dental expenses. For more details, please see "Predetermination of Benefits" on page 64.

VISION CLAIMS

VSP Network Doctors - You don't have to file any claims for benefits. Simply follow the procedures explained on page 71.

Non-VSP Providers - Follow these steps to get reimbursement from VSP:

1. Pay the doctor in full. Get a paid receipt for the itemized bill showing the services performed and supplies provided. The bill must be itemized, especially with regard to showing the type of lenses prescribed, i.e., single vision, bifocal, trifocal or contacts.
2. Complete a VSP Member Reimbursement form and attach an itemized bill. Be sure the bill includes your name, address and your unique identification or Social Security number (if the patient is a dependent, the dependent's name should also be on the bill).

Do not send vision claims to the Fund Office.

3. Send the completed form and itemized paid bill to:

   VSP
   P.O. Box 997105
   Sacramento, CA 95899-7105

The time limit for submitting non-VSP claims is six months.

CLAIMS FOR LOSS OF TIME BENEFITS

1. Call or go to the Fund Office to get a claim form or print a disability claim form from the Fund's website at www.ualocal501.org.
2. You and your doctor must fill in all appropriate areas on the claim form.
   - If loss of time continues for an extended period, you and your doctor will be asked to complete additional claim forms. In order for you to continue to receive weekly Loss of Time Benefits, your doctor must certify on the physician's portion of each claim form that you are still disabled.
   - You may be asked to complete this form monthly until your doctor gives a release date.
3. The Fund Office must receive a "Return to Work Notice" completed by your doctor.

<u>To avoid receiving benefits that must later be refunded, call the Fund Office when you are released for work.</u>

COORDINATION OF BENEFITS (C.O.B.) CLAIMS

When this Plan is the secondary payer on claims, be sure to keep copies of all original bills that you send to the primary plan. After the primary plan sends you reimbursement and/or an Explanation of Benefits, you must submit BOTH a copy of the fully itemized bill AND the other plan's Explanation of Benefits form to the Fund Office. Be sure to include your (employee's or retiree's) name and your unique identification or Social Security number, whether the claim is for you or for a dependent.

GENERAL PROVISIONS AND INFORMATION

DEFINITIONS

There are words in this book which have special meanings. The meanings of some of those words are summarized in this section. When a word or phrase defined below is used in this book, the definition shown below for that word or phrase will apply unless it is defined differently elsewhere in the book for a special purpose.

Ambulatory Surgical Center - A freestanding facility that is licensed and operated for the primary purpose of performing surgery on an outpatient basis and to which and from which a patient is normally admitted and discharged within 24 hours or within the same working day.

Ambulatory surgical centers also include facilities known as an "outpatient surgical centers," "free-standing surgical centers," "surgi-centers," or similar names, and include any other facility which is comparable except for the name.

For the purposes of the Plan, an office maintained primarily by a physician or dentist for the practice of medicine or dentistry is not considered an ambulatory surgical center.

The Plan does not cover services by out-of-network ambulatory surgical centers except when Medicare is primary and covers that facility.

Association; Employer Association - The Plumbing and Mechanical Contractors Association of Northern Illinois Alliance, referred to as the "PAMCANI Alliance."

Calendar Year; Year - The twelve-month period starting on January 1 of any year and ending on December 31 of that year.

Covered Dependent - An individual who meets the Plan's definition of a dependent and who is eligible to receive the Plan of benefits provided for dependents.

Covered Employee - An employee who has met and continues to meet the eligibility requirements for coverage under the Plan of benefits provided for employees.

Covered Family Member - You, the covered employee or covered retiree and any person in your family or household who meets the definition of a dependent.

Covered Person - A covered employee, covered retiree or covered dependent.

Covered Retiree - A retired employee who has met and continues to meet the eligibility requirements for coverage under the Plan of benefits provided for retirees.

Dependent

1. Your legal spouse, provided you and your spouse are living together in a bona fide marital relationship.

   If you and your spouse cease 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 applies regardless of the reason for the sepa-

ration, except for medically necessary events such as long-term confinement in a nursing home.

2. A person who is your unmarried child and who meets the requirements of a, b or c below:

   a. Less than 19 years old.

   b. Age 19 but less than age 24 at the end of the current calendar year (coverage terminates on December 31 of the year in which the child's 23rd birthday occurs), provided he is a registered student in an accredited secondary school, college or university, or vocational, technical, or trade school, is enrolled for a minimum of the credit hours required to meet the school's criteria for "full-time" status, and is dependent on you for more than 50% of his support and maintenance. Proof of dependency and/or full-time student status for each school term is required before the child can be considered a covered dependent.

      A child who meets all the requirements above except that he will be age 24 or age 25 at the end of the current calendar year can make self-payments for continued coverage under the Self-Pay Program for Older Students (described on page 22) or the child can elect and make self-payments for COBRA coverage.

      Proper legal documentation of a child's status must be furnished to the Fund Office before the child will be considered a covered dependent.

      In addition, Plan coverage may be extended for up to one year if a child who is a full-time student age 19 or over has to take a medical leave of absence from school. The child must be a covered full-time student immediately before the leave causes him or her to lose full-time student status, and the child's physician must certify in writing to the Plan that the leave is medically necessary because of a serious illness or injury. It is your responsibility to submit the physician's written certification in a timely manner. The extension can last for up to one year, but will end earlier if the child's coverage terminates for any other reason, such as reaching the limiting age, or the employee's loss of eligibility. A medical leave cannot extend a child's coverage beyond the Plan's limiting age of 24 at the end of the current calendar year.

   c. Age 19 or older and who is permanently and totally disabled because of mental retardation, mental incapacity or physical disability as certified by a doctor. The child must have become disabled before becoming age 19; must remain disabled and be incapable of self-sustaining employment and be dependent upon you for the major portion of his financial support and maintenance, and specifically not provide more than 50% of his own support during any calendar year. Within 31 days after the child's 19th birthday, you must furnish, at your own expense, initial proof of the child's disability and that he became disabled before he became age 19. Subsequent proof of the child's continued disability may be required by the Trustees, but not more often than once a year after the child reaches age 21. If the Trustees request proof of the child's disability in the future, you must furnish the proof or the child's coverage will terminate.

Definition of Child - For purposes of this definition, a "child" means any of the following:

1. A child born of a valid marriage of yours, including a child legally adopted by you or placed in your home for adoption, who is living with you in a regular parent-child relationship, or a child born of a valid marriage of yours, including a child legally adopted by you or placed in your home for adoption, who is not living with you, but is living in the custody of his other parent, for whom you are required to provide health care coverage according to the terms of an order in divorce or separation proceedings or a Qualified Medical Child Support Order. The child must not provide more than 50% of his own support for the calendar year.

2. A child not born of a valid marriage of yours, of whom you have been determined to be the legal parent, for whom you are responsible to provide health care coverage under an order in divorce or separation proceedings or a Qualified Medical Child Support Order, who lives in the custody of either you or his other parent, for whom you or the other parent, combined, pay more than 50% of the child's support for the calendar year, and who does not provide more than 50% of his own support for the calendar year.

3. A child as set forth below who is dependent on you for more than 50% of his support and maintenance, who does not provide more than 50% of his own support for the calendar year, and lives with you in a regular parent-child relationship. Proper legal documentation of such a child's status must be furnished to the Fund Office before the child will be considered a covered dependent:

   - A foster child, provided that the child is not placed in your home by the DCFS or similar agency. Any such child must be your or your spouse's grandchild (excluding a child of your dependent child), niece, nephew, brother, sister or other child placed in your home under the terms of a court order of guardianship. In addition, any such child must have lived in your home for at least 180 consecutive days prior to the incurral of the first claim submitted on the child's behalf.

   - A stepchild of yours (meaning any child of your spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to your spouse).

4. A natural child of yours who is not a legitimate child born of a valid marriage of yours, provided the child is determined to be an "alternate recipient" under the terms of a court order which the Trustees determine to be a Qualified Medical Child Support Order (QMCSO). A copy of the court order will be required by the Fund Office before claims for the child will be considered for payment. This child must meet the Plan's definition of "child" set forth in No. 2 above, as being a child who lives in the custody of either you or his other parent, for whom you or the other parent, combined, pay more than 50% of the child's support for the calendar year, and who does not provide more than 50% of his own support for the calendar year.

   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.

Payment of benefits for any child is subject to the terms of the Plan's Coordination of Benefits provisions which start on page 81.

A child who works for a contributing employer or who is eligible for benefits under this Plan as an employee is not considered a dependent under this Plan. If a child is a full-time active member of the military or armed forces of any country, the child is not considered a dependent under this Plan (see "Military Leave" on page 19 for a possible exception).

If both you and your spouse are covered under this Plan as employees (or retirees), a child will be considered a dependent of either the husband or the wife, but not as a dependent of both.

If a husband and wife are both covered as employees under this Plan, the Plan will pay benefits on a claim for either spouse only as one employee's claim.

If a dependent child ceases to meet the definition of a dependent as outlined above, his status as a covered dependent may be reinstated under certain circumstances. (Refer to page 23 for an explanation of those circumstances and the rules governing the reinstatement.)

Doctor; Physician - A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), a Doctor of Chiropractic (D.C.), a Doctor of Dentistry (D.D.S.), a Podiatrist (D.P.M.), or a Doctor of Optometry (O.D.), provided that any such individual renders treatment only within the scope of his license and specialty. (Also refer to "Mental Health Practitioner").

Employee - Any of the following:

1. An individual who is employed by a contributing employer who is legally obligated to make contributions to the Fund on his behalf.
2. An individual who is a full-time employee of the Union, of the Northern Illinois Benefit Fund or of the Northern Illinois Pension Fund or any successor fund or any other pension fund designated by the Trustees, or of the Joint Education Fund.
3. An individual who is not a member of the bargaining unit, who is employed by a contributing employer as defined in No. 3 under the definition of "Employer; Contributing Employer," and who meets the following requirements: a) the individual is an officer, director or shareholder of the contributing employer, or the spouse or close blood relative of any controlling officer, director or shareholder of the contributing employer; b) the individual has performed or does perform bargaining unit work, or supervises, lays out and/or prepares bids or contract documents for such work; c) the individual is specifically named as a person who meets the definition of a "Participant" as defined in the Participation Agreement between the contributing employer and the Union; d) the individual agrees to make contributions to the Fund for the purpose of obtaining certain benefit coverage under the Plan for himself and any dependents; and e) the individual is covered by a Participation Agreement which has been accepted by the Trustees.

Employer; Contributing Employer - Any of the following:

1. Any person, firm, association, partnership or corporation which is legally obligated to make contributions to the Fund on behalf of its employees.
2. The Union, the Northern Illinois Benefit Fund; the Northern Illinois Pension Fund, any successor fund or any other pension fund designated by the Trustees; and the Joint Education Fund on behalf of their full/part-time employees.
3. An employer as defined in No. 1 above which is a duly licensed corporation in the State of Illinois and which has in effect a Participation Agreement accepted by the Trustees which allows stated employees (as defined in No. 3 under the definition of "Employee") of the employer to make contributions to the Fund for the purpose of obtaining certain benefit coverage for themselves and any dependents.

Experimental or Investigative - A treatment, procedure, facility, equipment, drug, device or supply will be considered to be experimental or investigative if it falls within any one of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition.
2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.
3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical experts of their choosing.

Fund - The Northern Illinois Benefit Fund.

Hospital - An institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients' expense and which fully meets all of the requirements set forth in No. 1 or No. 2 or No. 3 below:

1. It is a hospital, a psychiatric hospital, or a tuberculosis hospital which is qualified to participate in Medicare and to receive Medicare payments.
2. It is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. It is an institution which: a) provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick persons under the supervision of a staff of doctors licensed to practice medicine; b) provides on the premises 24-hour-a-day nursing services by or under the supervision of R.N.'s; and c) is operated continuously with organized facilities for operative surgery on the premises.

A hospital is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics or a nursing or convalescent home or similar establishment.

Medically Necessary - Only those services, treatments or supplies provided by a hospital, a doctor, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's injury or sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the individual's injury, disease or sickness, including premature birth, congenital defects and birth defects;
2. Are appropriate according to generally accepted standards of good medical practice;
3. Are not mainly for the convenience of the patient, doctor, hospital or other provider;
4. Are not experimental or investigative; and
5. Are the most appropriate services, supplies or level of services required to provide safe and adequate care. When applied to confinement in a hospital or other facility, this means that the covered person needs to be confined as an inpatient due to the nature of services rendered or due to the person's condition, and that the person cannot receive safe and adequate care through outpatient treatment.

The fact that the treating doctor finds that the treatment is medically necessary is not binding on the Trustees.

Mental Health Disorder - Disorders listed in the *International Classification of Diseases (ICD)* as mental disorders.

Mental Health Practitioner - Subject to the benefit limitations described in this booklet, the Plan covers outpatient/office mental health services provided by the following types of practitioners: 1) an M.D. or D.O.; 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; or 5) a licensed marriage and family therapist (L.M.F.T.).

Plan; Benefit Plan; Plan of Benefits - The self-funded program of health and welfare benefits provided by the Northern Illinois Benefit Fund as described in this book.

Reasonable and Customary; Reasonable and Customary Charge; Usual and Customary Charge - The maximum allowable charge to be considered a covered expense under this Plan. The amount of a reasonable and customary (or usual and customary) charge is determined by comparing a charge with the charges made by persons with similar professional training and experience in the locality concerned (zip code

area in which the service is performed) for comparable services and supplies provided to persons of similar age, sex, and medical, dental or orthodontic condition. (Refer to page 73 for an example of how covered expenses are determined using the reasonable and customary standard.)

Self-Payments - Payments made to the Fund by employees, retirees and dependents on their own behalf for the purpose of maintaining coverage under the Plan in accordance with the applicable eligibility rules.

Substance Abuse Disorder - Disorders listed in the *International Classification of Diseases (ICD)* as substance abuse disorders, except tobacco and nicotine use disorders.

Totally Disabled; Total Disability

1. An employee will be considered totally disabled if he is completely prevented from engaging in any occupation or employment for compensation, wages or profit solely as the result of accidental bodily injury or sickness.
2. A retiree or dependent is considered totally disabled if he is prevented from engaging in substantially all of the normal activities of a person of like age or sex in good health as a result of non-occupational accidental bodily injury or sickness.

If a person receives an award of disability benefits from the Social Security Administration, that person is automatically considered to have met the definition of "totally disabled."

Trustees; Board of Trustees - The individuals responsible for the operation of the Northern Illinois Benefit Fund in accordance with the terms of the Trust Agreement, together with such Trustees' successors. The Board is divided equally between Trustees selected by the Union and by Trustees appointed by contributing employers. The names and addresses of the individual Trustees are shown on page 107.

Union - The Plumbers & Pipefitters Local 501 or its successor local affiliated with the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry in the United States and Canada, AFL-CIO.

The Plan Document that governs your Plan includes other definitions which apply to your Plan, such as Accident, Accidental Bodily Injury, Contributions, Covered Under the Plan, Custodial Care, Participation Agreement, Sickness, Trust Agreement, and others. If you want to read the entire list of the Plan's definitions, you can write to the Fund Office for a copy.

CLAIM AND APPEAL PROCEDURES

In order for the Plan to pay benefits, a claim must be filed with the Fund Office (or the office designated for handling your claim) in accordance with the procedures described in the "How to File a Claim" section starting on page 79. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.

A "claim" is a request for Plan benefits, normally because the claimant has incurred a healthcare expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.

Claims must be filed within twelve months following the date on which the claim was incurred. Exception: Claims for out-of-network vision care should be submitted to VSP within six months.

You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing.

- Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you.
- A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative.

Claim Processing Time Limits

The amount of time the Plan can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

1. A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested. Most claims are post-service claims.
2. A "disability claim" is a claim for Loss of Time Benefits.
3. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining the care.
4. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
5. A "concurrent care claim" is also a type of pre-service claim. A claim that is a concurrent care claim is a request made to extend a course of treatment beyond the period of time or number of treatments previously approved.

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

- Post-service claims—30 days.
- Disability claims—45 days.
- Pre-service claims—15 days.

- Urgent care claims—24 hours.
- Concurrent care claims—24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

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 provider, 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 begin to run once the Fund Office has received a response to its request. If you do not provide the missing information within 45 days (48 hours for an urgent care claim), the Fund Office will make a decision on your claim without it, and your claim could be denied as a result.

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:

- Post-service claims—15 days.
- Disability claims—30 days (a second 30-day extension may be needed in special circumstances).
- Pre-service claims—15 days.

Claim Denials - If all or a part of your claim is denied after the Fund Office has received 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. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following the procedures. It will also include a statement concerning your right to bring a civil action under section 502(a) of ERISA. In cases where the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the notice will state that the specific internal rule, guideline, protocol or criterion will be provided to you free of charge upon request. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include 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. For urgent claims, a description of the Plan's expedited review process will be provided.

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 60502-8879

You may orally request a review of a denied urgent care claim by calling the Fund Office at (630) 978-4600 or you may submit your request in writing to the address shown above. You may be notified of the Trustee's decision on an urgent care claim by telephone or facsimile.

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.

Permission for you to utilize a representative does not provide the representative (particularly a health care provider) with an independent right to payment of benefits in the representative's name, to file or proceed with a review of a claim for benefits in the representative's name or to obtain any rights as a "participant" or "beneficiary" under the Plan. Any appeal can only be brought in the name of yourself or your dependent who are the only entities permitted to be a "participant" or "beneficiary" under this Plan.

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 your appeal is for an urgent care claim, you will be notified of the decision about your appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of your request for review. In the case of non-urgent pre-service claims, you will be notified no later than 30 days after receipt of your request for review.

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 five 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. A claimant may not file suit against the Plan until the claimant has exhausted all of the procedures described in these procedures.

COORDINATION OF BENEFITS (C.O.B.)

Benefits are coordinated when both you and your spouse (and/or your children) are covered by this Plan as well as by one or more other group health plans. Coordination allows benefits to be paid by two or more plans, up to but not to exceed 100% of the allowable expenses on the claim.

- The C.O.B. provision applies only to other group plans and Medicare. It doesn't apply to Medicaid or individual medical policies. Also, C.O.B. applies only to health care benefits (medical, prescription drugs, dental/orthodontia, vision). It doesn't apply to life or AD&D insurance, or Loss of Time Benefits.

- Benefits are paid under C.O.B. for "allowable expenses," which are expenses that are eligible to be considered for reimbursement.
- You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled from the other sources, even if you have not.
- When anyone in your family who is covered under another group health plan has a claim, be sure that claims are filed with all plans and that all required information about other coverage is provided on all forms.
- If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.
- If you have a claim that is covered by two or more plans, one plan (the "primary" plan) pays its benefits first regardless of any other plans. The other plans ("secondary" plans), adjust their benefits so that the total benefits available to you are not greater than the allowable expenses.

Determination of Benefits

A plan without a C.O.B. provision is always considered the primary plan.

If all plans have a C.O.B. provision, benefits are determined based on the first of the following rules that applies:

1. **Dependent vs. Non-Dependent -** The plan that covers the claimant (the person for whom the claim is filed) as an employee is primary over a plan that covers him other than as an employee (unless, the claimant is covered under Medicare and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent).

   If a husband and wife are both covered as employees under this Plan, the Plan will pay benefits on a claim for either spouse only as one employee's claim.

2. **Claims for Children**

   a. The plan that covers the child as a dependent of a parent whose date of birth, excluding year of birth, occurs the earliest in a calendar year will be the primary plan, if:

      - The parents are married.

- The parents are not separated (whether or not they were ever married to each other).
- A court decree awards joint custody of the child without specifying that one parent has the responsibility to provide health care coverage.

This Plan will not at any time coordinate benefits under a gender-based rule.

b. If the parents are not married and not living together, or are separated or divorced:
   - If a court has ordered one of the parents to provide health care coverage or to have primary responsibility for the child's health care expenses, that parent's plan is primary.
   - If there is no court decree stating which parent is responsible for the child's health care expenses or health care coverage, or if a court decree states that the custodial parent is responsible, the plans pay in the following order:
     ~ The plan of the custodial parent.
     ~ The plan of the spouse of the custodial parent.
     ~ The plan of the noncustodial parent.
     ~ The plan of the spouse of the noncustodial parent.

3. **Active or Inactive Employee -** The Plan that covers a person as an employee is primary on behalf of the employee and his dependents over a Plan that covers the person as other than an employee (such as a retired employee).

   This rule applies in the same way to a dependent of a person who is covered under a plan as an employee and also under a plan as a retired employee.

4. **COBRA -** COBRA coverage is secondary to a plan that covers the person as an active employee or dependent of an active employee.

5. **Length of Coverage -** The plan that has covered the claimant for the longest period of time will pay primary.

C.O.B. With Medicare

Retirees (and Their Dependents) Eligible for Medicare - If you are an eligible retiree, and if you and/or any of your covered dependents are eligible for Medicare and have enrolled in both Medicare Part A and Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays based on amounts not paid by Medicare.

Active Employees and Their Dependents

1. If you are an active employee age 65 or older and continue to work for an employer with *20 or more total employees*, this Plan will pay primary benefits for you unless you choose Medicare as your only health care coverage. If your spouse is age 65 or older while you are still working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays. If she has her own plan, her plan will be primary, this Plan will be secondary, and Medicare will

pay last. She can also choose Medicare as her only health care coverage instead of having coverage under this Plan or her own plan.

2. If you are an active employee age 65 or over and continue to work for a contributing employer who employs *less than* 20 total employees, this Plan will usually pay benefits for you and your spouse after Medicare pays its benefits unless this Plan is legally required to pay first.

3. If you or any of your dependents are eligible for Medicare for reasons other than being 65 or older, Medicare will usually pay primary benefits except under the following circumstances:

   - If a person is totally disabled and eligible for Medicare under the Medicare disability rules, this Plan will pay its normal benefits for that person before Medicare pays benefits unless the Plan is legally permitted to pay after Medicare.
   - If a person is an End Stage Renal Disease beneficiary under Medicare, for a period of up to 30 months this Plan will pay its normal benefits for that person before Medicare pays benefits unless the Plan is legally permitted to pay after Medicare.

Enrollment in Medicare - Any person who is eligible to participate in Medicare is responsible for enrolling in Medicare Part A and Part B when eligible to do so. If a person is eligible to participate in Medicare, this Plan will pay benefits, including C.O.B. calculations, as if he is enrolled in both Part A and Part B of Medicare, even if he is not actually enrolled in both Parts. This means that this Plan will only pay benefits equal to the benefits it would have paid if the person were enrolled in both Parts. If a person is not enrolled, he will have to pay the amount normally paid by Medicare out of his own pocket.

At present there is no charge for Part A, which provides benefits for hospital and certain other expenses. Part B covers such items as doctors' services. The government makes a monthly charge for Part B. If you or a dependent want information about Medicare enrollment or benefits, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

SUBROGATION

In the event the Fund pays or is obligated to pay benefits on behalf of a participant or his dependents for illness or injury to the participant or dependents and the participant or dependents have the right to recover the amounts of such benefits from any other person, corporation, insurance carrier or governmental agency, including uninsured or underinsured insurance coverage, or any other first-party contract or claim, the Trustees of the Funds and the Fund shall be subrogated to all of the participant's or dependents' right of recovery against such person, corporation, insurance, carrier, governmental agency or uninsured or underinsured insurance coverage or any other first-party or third- party contract or claim and shall have a right of reimbursement from the participant or dependent to the full extent of payments made by the Fund and for the cost of collection of these amounts, including attorney's fees. The full amount of benefits paid shall include any Preferred Provider Organization Charge or other payment to a medical discount provider paid with respect to the involved benefits which shall be considered part of the amount of benefits paid. The Trustees and

the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph and this equitable lien by agreement shall be enforceable as part of an action to enforce plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed. The Trustees' and the Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the participant or dependents, as opposed to the general assets of the participant or dependents, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be "traced" to a specific account or other destination after they are received by the participant or dependents. The Trustees' and the Fund's equitable lien by agreement is from the first dollar received and its enforcement does not require that the participant or dependents be "made-whole" or that the entire debt be paid to the participant or dependents prior to the lien's payment. The Trustees' and the Fund's equitable lien by agreement is also not reduced by the legal fees incurred by the participant or dependents in recovering the amounts or by any state law doctrine, such as the "common fund" doctrine, which would purport to impose such a reduction.

The participant or his or her dependents or the participant acting on behalf of a minor dependent shall execute and deliver such documents and papers, including but not limited to an assignment of the claim against the other party or parties, assignment to the minor child or any parental claim to recover medical expenses of the minor child, and/or a Subrogation or Reimbursement Agreement to the Fund, as the Trustees may require. The participant or dependents shall do whatever else is necessary to secure the rights of the Trustees and the Fund including allowing the intervention by the Trustees or the Fund or the joinder of the Trustees or the Fund in any claim or action against the responsible party or parties or any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim.

If the participant or dependents do not attempt a recovery of the benefits paid by the Fund or for which the Fund may be obligated, the Trustees or the Fund shall, if in the Fund's best interest and at the Trustees' sole discretion, be entitled to institute legal action or claim against the responsible party or parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all benefit amounts paid to the participant or dependents or paid on their behalf, together with the costs of collection, including attorney's fees.

In the event of any recovery by judgment or settlement against the responsible party or parties or by payment by an uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim, payment of the lien from the proceeds of the recovery shall take place in the following fashion. Initially, the reasonable costs of collection of the equitable lien by agreement, including the Fund's attorney's fees, shall be distributed to the Fund. Next, the amount of benefits paid from the Fund to and on behalf of the participant or dependents, to the full extent of benefits paid or due as a result of the occurrence causing the injury or illness, shall be distributed to the Fund. The remainder or balance of any recovery shall then be paid to the participant or dependents and their attorneys if applicable.

In the event of any failure or refusal by the participant or dependents to execute any document requested by the Trustees or the Fund or to take other action requested by the Trustees or the Fund to protect the interests of the Trustees or the Fund, the

Trustees may withhold payment of benefits from the Fund or deduct the amount of any payments from amounts otherwise payable form the Fund for future claims of the participants or dependents. After making claim for benefits from the Fund, the participant or dependents shall take no action which might or could prejudice the rights of the Trustees or the Fund.

In the event the participant or dependents recover any amount by settlement or judgment from or against another party or by payment from any uninsured or underinsured insurance coverage or any other first-party or third-party contract or claim the Fund will request repayment of the amount of its equitable lien for the full amount of benefits paid by the Fund. If the participant and/or dependents refuses or fails to repay such amount, then in that event, the Fund shall be entitled to recover such amounts from participant and/or dependents by instituting legal action against the participant and/or dependents and/or by reducing such amounts as may be due on future claims submitted by the participant and dependents. Once a settlement or judgment is reached on the claim additional bills cannot be submitted with respect to the same injury.

The participant or dependents shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Trustees shall pay no legal costs or fees from the Fund without receiving a recovery and then only, in their sole discretion, within the terms of this provision. In the event that an attorney is hired by or on behalf of the participant or his dependents and the Fund is given notice and an opportunity to pursue its own subrogation recovery, the Fund shall not be required to hire such attorney. If the attorney representing the eligible individual nevertheless wishes to proceed, and creates a common fund from which the Trustees can recover pursuant to their equitable lien by agreement for subrogation and reimbursement, the Trustees, on behalf of the Fund, may agree to pay up to 10% of its recovery to include the attorney's legal fees. This 10% shall also include any prorated portion of the cost of recovery. If the attorney agrees to proceed, he will be considered to have waived the common fund doctrine.

These provisions shall apply to any case in which the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of this provision, and any subrogation and reimbursement claim or lien presented by the Fund or Trustees, where the Fund or Trustees have not been repaid the full amount of benefits made for and on behalf of a participant or beneficiary, together with cost of collection, as of the date of these provisions, shall be construed to involve an equitable lien by agreement under these provisions.

(If you want more information about Subrogation, contact the Fund Office.)

TRUSTEE INTERPRETATION, AUTHORITY AND RIGHT

The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. However, no amendment may be adopted which alters the basic principles of the Trust Agreement founding the Fund, is in conflict with Collective Bargaining Agreement provisions applicable to contributions to the Fund, is contrary to laws governing multiemployer ERISA trust funds, or is contrary to agreements entered by the Trustees. In addition, and as more fully explained in the "Plan Discontinuation or Termination" section, the Trustees or, the Union and Employer Association by a written agreement, may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependents at any time and in their sole discretion, since the Retiree Benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though an employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participants and beneficiaries.

PLAN DISCONTINUATION OR TERMINATION

The Plan of Benefits and the Trust Agreement under which the Plan was founded may be terminated under certain conditions: if there is no longer a Collective Bargaining Agreement or Participation Agreement requiring contributions to the Fund; or, if it is determined that the Fund is inadequate to carry out the purposes for which the Fund was founded. The Plan may be terminated at any time by a vote of the Trustees or by a written mutual agreement of the Union and the Association to terminate the Trust, if the action is taken in conformity with applicable law. In such a case, benefits for covered expenses incurred before the termination date will be paid on behalf of covered persons as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets; and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

CIRCUMSTANCES WHICH MAY RESULT IN CLAIM DENIALS OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny payment of a claim, and the reasons for denial may include one or more of the following:

1. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.
2. The claim wasn't filed within the Plan time limits.
3. The expenses that were denied are not covered under the Plan or were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.
5. No payment, or a reduced payment, was made because some or all of the expenses for which the claim was filed were applied against a deductible or co-payment.
6. Another party (such as the driver of a car that caused an accident for which medical expenses were incurred) was responsible for paying the incurred medical expenses and you or your dependent did not comply with the rules governing subrogation.
7. Another plan was primarily responsible for paying benefits for the expenses.
8. The Trustees amended the Plan eligibility rules or decreased Plan benefits.
9. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf.
10. The Plan of Benefits was terminated.

The preceding list is not an all-inclusive listing of the circumstances which may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Office.

ADDITIONAL PLAN PROVISIONS

Overpayments; Duty of Cooperation

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Plan has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Plan, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, or institute legal action to collect the overpayment.

You and your covered dependents must provide the Plan with any information the Plan deems necessary to determine eligibility, process claims or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

A claim for benefits will be rejected and the Plan will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Plan may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

HIPAA Privacy Rights

The Plan has responsibilities under the Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: 1) identifies you or may reasonably be used to identify you; 2) is created or received by a health care provider, health plan, employer or health care clearinghouse; and 3) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact:

Mr. Robert E. Niksa
Administrative Manager
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879
Telephone: 630-978-4600
Fax: 630-978-4616

Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death and to examine any and all hospital or medical records relating to a claim.

Payment of Benefits

Health care benefits are payable individually for you and each of your dependents up to but not to exceed the maximum benefits stated on the Schedule of Benefits according to the following provisions:

1. Blue Card PPO providers and out-of-network hospitals should send their bills directly to Blue Cross Blue Shield (the address is on your BCBS I.D. card). The Plan's share of the expenses will be paid directly to the PPO provider or to the out-of-network hospital. The BCBS PPO provider or the out-of-network hospital will bill you for your share of the expenses, which you must pay directly to the provider. (If an out-of-network hospital requires payment from you, see No. 2 below for how benefits are paid.)

2. Out-of-network doctors and other non-doctor and non-hospital service providers may send bills directly to the Fund Office if you "assign" benefits. The Fund Office will pay the Plan's share of the expenses directly to the provider. If an out-of-network doctor (or hospital) or other non-doctor or non-hospital provider requires payment, you must pay the bill and file a claim with the Fund Office for reimbursement. The Plan will reimburse you the Plan's share of the expenses.

3. In most other cases, benefit payments on claims for yourself and for your dependents will be made to you (employee or retiree) unless you assign benefits. Life insurance and loss of life benefits under the AD&D insurance proceeds will be paid to your beneficiary. Benefits are payable only when the required forms and information have been received by the Fund Office.

4. The Trustees may, from time to time, enter into negotiated fee arrangements with health care providers under the terms of which the Fund will receive discounts on fees charged for such services. In such cases, any amount in excess of the negotiated (discounted) fee will not be considered a covered expense.

5. If the Trustees decide that a person isn't mentally, physically, or otherwise capable of handling his business affairs, the Plan may pay benefits to his guardian or, if there is no guardian, to the individual who has assumed his care and principal support. If the person dies before all due amounts have been paid, the Trustees may make payment to the executor or administrator of his estate, to his surviving spouse, parent, child or children, or to any individual the Trustees believe is entitled to the benefits.

6. In determining the satisfaction of any deductible amounts and the amount of benefit payments, a charge for any service, treatment, or supply will be considered incurred on the date the service or treatment was rendered or on the date the supply was provided.

Any payments made by the Plan in accordance with these rules will fully discharge the Plan's liability to the extent of its payments.

Non-Assignability of Fund Assets

No covered person who is entitled to any benefit under this Plan shall have the right to assign, alienate, transfer, encumber, pledge, mortgage, hypothecate, anticipate or impair in any manner his or her legal or beneficial interest in any assets of the Fund

or benefits to this Fund. Neither the Fund nor any of the assets thereof shall be liable for the debts of any covered person entitled to any benefits under this Plan, nor be subject to attachment or execution or process in any court action or proceeding.

No assignment of any present or future right, interest, or benefit under this Plan shall bind the Trustees without their written consent thereto. The Trustees may, at their option, accept validly executed assignments of benefits made by an eligible employee or eligible retiree or the spouse of the employee or retiree when such assignments are executed in favor of a provider of covered medical services or supplies. However, no assignment of benefits can assign more than the assignor's right to payment of benefits and will not be deemed to assign any other right or interest that the assignor has under the Plan, including, but not limited to, the right to seek review of a benefit denial.

Medicaid Benefits

Eligibility under the Plan and the payment of benefits under the Plan for you and each of your dependents are not affected by the fact that you or a dependent is eligible to receive Medicaid benefits. In addition, the Plan will pay benefits for you and any of your dependents in accordance with any assignment of rights required by Medicaid which was made by you or any of your dependents. Also, if Medicaid previously paid for items or services that the Plan was required to pay, the Plan will make payments directly to Medicaid for such items or services if required by any state law that states that Medicaid has acquired your right to payment for such items or services.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any workers' compensation law, occupational diseases law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

Release of Information

You must provide the Fund Office with any required authorization for release of necessary information relating to any claim you have filed.

Breast Cancer Rights

The Plan provides benefits for post-mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Your Rights Under ERISA

As a participant in the Northern Illinois Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage - In certain cases you can continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA coverage rights.

You will be provided a certificate of creditable coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve months after your enrollment date in your new coverage.

Prudent Actions by Plan Fiduciaries - In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants, covered dependents and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights - If your claim for a health and welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and

do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you believe that Plan fiduciaries misuse the Plan's money, or if you believe you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

Assistance With Your Questions - If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

How to Read or Get Plan Material - You can read the material listed in the previous section by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than the Fund Office. The Fund Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material. Before requesting material, call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Fund Office address and phone number are shown on the inside front cover.

GENERAL INFORMATION ABOUT YOUR PLAN

Name of Plan/Fund - The name of your Plan is the Northern Illinois Benefit Plan of Benefits. The name of the Trust Fund through which your Plan is provided is the Northern Illinois Benefit Fund.

Plan Sponsorship and Administration - Your Plan is sponsored by a joint labor-management Board of Trustees. The Board of Trustees is the Plan Administrator. The Board is divided equally between Trustees elected by the Union membership and by Trustees appointed by contributing employers. The names and addresses of the individual Trustees are shown on page 107.

Union members of the Board of Trustees are elected by the members of Plumbers & Pipefitters Local 501, U.A., 1295 Butterfield Road, Aurora, IL 60502-8879. The

Employer Association that appoints the employer members of the Board of Trustees is the Plumbing and Mechanical Contractors Association of Northern Illinois Alliance, referred to as the "PAMCANI Alliance," 603 Rogers Street, Suite 2, Downers Grove, IL 60515. A complete list of employers and the employee organizations sponsoring the Fund may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and 2520.104b-30. This right includes a "superseded" Collective Bargaining Agreement if such agreement controls any duties, rights or benefits under the Plan.

The Trustees are assisted in the administration of the Fund by a salaried Administrative Manager, who is an employee of the Fund. The name and address of the Fund Administrative Manager, which is also the address of the Fund Office, is shown on the inside front cover of this book and on page 108.

Service of Legal Process - Service of legal process may be made on the Board of Trustees or on any individual Trustee. Service may also be made on the Administrative Manager.

Source of Financing/Plan Participation - The Fund receives contributions from employers under the terms of Collective Bargaining Agreements and Participation Agreements and from the Union, the Benefit Fund itself and the Pension Fund. The Fund also receives self-payments from employees, retirees and dependents for the purpose of continuing coverage under the Plan. It may also receive rebates from its prescription benefit manager.

Employees are entitled to participate in this Plan if they work under one of the Collective Bargaining Agreements or Participation Agreements and if the required contributions are made to the Fund on their behalf. Administrative employees of the Union, the Joint Education Fund, the Benefit Fund and Pension Fund are also entitled to participate in the Plan.

Type of Plan/Accumulation of Assets/Payment of Benefits - The Northern Illinois Benefit Fund is classified as a health and welfare benefit plan, providing benefits of the type described in the following paragraph. Employer contributions and self-payments by employees and dependents are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses.

The Fund provides medical, surgical, hospital, disability, dental/orthodontia, and vision benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes. Although, as described earlier in the Summary Plan Description, Blue Cross re-prices PPO claims involving medical, surgical and hospital benefits, Delta Dental processes claims involving dental/orthodontia benefits, and VSP processes claims involving vision benefits, the services of these companies are in the nature of claim processing and/or limited to the amount the Fund must pay providers, and all benefits paid remain self-insured.

This Benefit Plan is not an insurance policy and no benefits other than the life insurance and AD&D insurance are provided by or through an insurance company. The Fund provides life insurance and AD&D insurance benefits through the Union Labor

Life Insurance Company, 1625 Eye St. N.W., Washington D.C. 20006, telephone (202) 682-0900.

Plan/Fund Year - The Fund's financial records are maintained on a 12-month fiscal year basis, beginning July 1 of each year and ending June 30 of the following year.

Plan/Fund Identification Numbers - The Employer Identification Number (EIN) assigned to this Fund by the I.R.S. is 36-2522076. The Plan Number (PN) assigned to the Plan of Benefits is 501.

BOARD OF TRUSTEES OF THE NORTHERN ILLINOIS BENEFIT FUND

Union Trustees

Mr. Tom Andrews (Fund Secretary)
Plumbers and Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Mr. Jim Mansfield
Plumbers & Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Mr. Charles Seibert
Plumbers & Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Mr. Randy Sosolik
Plumbers and Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Mr. Steven Tortorici
Plumbers and Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Mr. Tim Vasquez
Plumbers and Pipefitters Local 501
1295 Butterfield Road
Aurora, IL 60502-8879

Employer Trustees

Mr. Michael Bestler (Fund Chairman)
Bestler Corporation
246 Keyes Avenue
Hampshire, IL 60140

Ms. Lori Abbott
Abbott Industries
225 William Street
Bensenville, IL 60106

Mr. Tom Bargiel
40W705 Burlington Road
St. Charles, IL 60175

Mr. Brian Burns
C.W. Burns, Inc.
1536 Brook Drive
Suite E
Downers Grove, IL 60515

Mr. Dieter Holz
Apex Plumbing
300 E. Irving Park Road
Wood Dale, IL 60191-1665

Mr. S.J. Peters
PAMCANI
603 Rogers Street
Suite 2
Downers Grove, IL 60515-3774

HOW TO CONTACT THE FUND OFFICE OR TRUSTEES

To Contact the Fund Office

- Call (630) 978-4600, or
- Send an e-mail to benefitfunds@ualocal501.org, or
- Write a letter to:

Mr. Robert E. Niksa
Administrative Manager
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879

You may also visit the Fund's website at www.ualocal501.org to access information about your health and welfare plan.

To Write to the Board of Trustees, address your letter as follows:

Board of Trustees
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879

FUND PROFESSIONALS

Administrative Manager

Mr. Robert E. Niksa
Administrative Manager
Northern Illinois Benefit Fund
1295 Butterfield Road
Aurora, IL 60502-8879

Fund Legal Counsel

Mr. Hugh Arnold
Attorney at Law
Arnold & Kadjan
19 West Jackson Boulevard
Chicago, IL 60604

Fund Consultant

Blomquist & Company
One Oakbrook Terrace
Suite 812
Oakbrook Terrace, IL 60181

Fund Auditor

Bansley & Kiener
Certified Public Accountants
O'Hare Plaza
8745 W. Higgins Road, Suite 200
Chicago, IL 60631