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December 2008

Dear Welfare Fund Participant:

The Board of Trustees hereby adopts the following amendment to the Summary Plan Description and Plan Document, 2007 Edition:

1. Effective January 1, 2009, the paragraph before the Example and the Example in the subsection entitled *Orthodontic Services* on page 64, are deleted and are replaced with the following:

   The Plan covers orthodontic services up to a calendar year maximum benefit and a lifetime maximum as listed on the *Schedule of Benefits*. Orthodontic expenses are separate from the calendar year maximum for Dental Benefits. This means that if your eligible Dependent child reaches the maximum for dental expenses in a calendar year, your Dependent child's orthodontic services will be covered up to the Plan's Orthodontic limits for that year. If your child's orthodontic services reach the calendar year maximum, your child's dental expenses will be subject to the separate dental benefit limitations for that calendar year, as provided in the *Schedule of Benefits*.

   Example

   Jim and his dependents are covered by the Plan. Jim's daughter Ann, who is age 15, needs orthodontia treatment and her orthodontist determines that the cost of her treatment plan will be $6,000 over the two-year period from January 2009 through December 31, 2010. The Plan will pay for 50% of the treatment up to the lifetime maximum of $3,000, paying the calendar year maximum of $1,500 in 2009 and again in 2010. Jim will pay the balance of the cost of treatment of $3,000.

2. Effective January 1, 2009, the paragraph prior to the Example and the Example in the section entitled *Vision Covered Charges* on page 65, are deleted and are replaced with the following:

   Maximum benefits are payable for you and each of your eligible Dependents each calendar year, as noted in the following example.

Example

Joan has an eye examination by an optometrist on January 15, 2009 and the cost of the examination is $85. Joan receives a prescription for lenses from the optometrist at her examination and she purchases lenses and frames on January 15, 2009 at a cost of $225. Because Joan's Vision Benefits are limited to $250 per calendar year, the Plan pays $250 of Joan's covered vision expenses and Joan pays the balance of $60 ($85 + $225 = $310, minus the Plan's benefit of $250 = $60). If Joan has additional vision expenses during 2009, they will not be covered by the Plan.

3. Effective January 1, 2009, the first section entitled *Hearing Covered Charges* on page 66, is deleted and is replaced with the following:

   The Plan covers hearing expenses, up to the amount listed on the *Schedule of Benefits*.

4. Effective January 1, 2009, item 2 under the section entitled *Vision Exclusions and Limitations* on page 82, is deleted and is replaced with the following:

   2. Services and supplies that exceed the maximum listed on the *Schedule of Benefits* within a calendar year period.

5. Effective January 1, 2009, the Dental, Vision and Hearing Sections of the Schedules of Benefits for BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan, the Health Alliance Preferred Provider Organization (PPO) Plan, and the HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan are deleted and are replaced to add benefit improvements, as follows:

Delta Dental of Illinois Dental Benefits *			
Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*) Individual Family	$50 $100		
Dental Services Calendar Year Maximum	$1,500		
Type of Dental Services	Delta Dental PPO Network*	Delta Dental Premier Network*	Out-of-Network*
Preventive/Diagnostic Care Services Coinsurance paid by the Plan	100% of reduced fee (deductible applies)	100% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Primary (Basic) Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Major Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Orthodontia Benefits (only for eligible Dependent children under age 19) Coinsurance paid by the Plan	50% of reduced fee, subject to lifetime maximum	50% of maximum plan allowance, subject to lifetime maximum	50% of maximum plan allowance, subject to lifetime maximum
Orthodontia Calendar Year Maximum Orthodontia Lifetime Maximum	$1,500 (only $1,500 will be paid per year for orthodontic expenses and the orthodontic payment will be applied toward the Orthodontic Lifetime Maximum, but not the Calendar Year Maximum for Dental Services) $3,000		
* For expenses incurred from a Delta Dental PPO Network Dentist or a Delta Dental Premier Dentist, you will not be "balance billed" for charges exceeding Delta Dental's allowed PPO fees or Delta Dental's maximum plan allowances, as applicable. *For expenses incurred from an Out-of-Network dentist, you are responsible for charges exceeding Delta Dental's maximum plan allowances.*			

Vision Benefits	**Administered by Professional Benefit Administrators, Inc.**
Covered Services	$250 per person per calendar year

Hearing Benefits	**Administered by Professional Benefit Administrators, Inc.**
Hearing Benefits Lifetime Maximum	$5,000

Please retain this letter in the front pocket of your SPD booklet for future reference.

Sincerely,

Board of Trustees
North Central Illinois Laborers' Health & Welfare Fund