

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible ¹ - Individual - Family	\$500 \$1,000	\$1,000 \$3,000
Out-of-Pocket Maximum - Individual - Family	\$2,500 \$7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	\$300,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	\$250	\$250
Hospital Benefits (inpatient and outpatient)	80%	60%
Outpatient Surgical Procedures ¹	80%; no deductible required	60%; no deductible required
Doctor's Office Visits	\$20 copay	40%
X-Rays and Labs (including Pre-Admission Testing)	80%	60%
Wellness, Preventive, Well Child, Well Baby Care ¹	100%; no deductible required	Not Covered
Emergency Room	\$200 copay	\$200 copay
Rehabilitation Services/Skilled Nursing Facility Coinsurance Calendar Year Maximum Per Person - Inpatient - Outpatient (Includes Physical and Occupational Therapy) <i>Preauthorization Required.</i>	80% if Medically Necessary 60 days (combined with out-of-network) 60 visits (combined with out-of-network)	60% if Medically Necessary 60 days (combined with in-network) 60 visits (combined with in-network)
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance Day Treatment/Partial Hospital - Coinsurance <i>Preauthorization of Inpatient Services Required - Call MAP.</i>	80% Call MAP for in-network providers \$20 copay 80%	60% 40% 60%
Additional Surgical Opinion ¹	80%; no deductible required	80%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	80% (additional limitations apply)
Spinal Manipulation (Chiropractic or Medical) Calendar Year Maximum <i>Acupuncture included when Physician prescribed</i>	\$15 copay per visit 60 treatments up to \$600 (combined with out-of-network)	60% 60 treatments up to \$600 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	60% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% \$500 (combined with out-of-network)	60% \$500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy and Hospice Care	80%	60%
Treatment of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum	80% \$1,000 (combined with out-of-network) \$2,000 (combined with out-of-network)	60% \$1,000 (combined with in-network) \$2,000 (combined with in-network)
Smoking Cessation Benefits Lifetime Maximum	50% One Smoking Cessation Program up to \$500 per person (combined with out-of-network)	50% One Smoking Cessation Program up to \$500 per person (combined with in-network)

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Sav-Rx Prescription Drug Benefit		<i>Prescription drug benefits are only covered when filled at a participating pharmacy.</i>		
Retail Pharmacy Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 34-day supply, you pay: \$10 \$20 \$35			
Mail Order Pharmacy/Retail Maintenance Program Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 90-day supply, you pay: \$20 \$40 \$70			
Delta Dental of Illinois Dental Benefits ²				
Calendar Year Deductible (<i>applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services</i>)	\$50 Individual/ \$100 Family			
Dental Benefits Calendar Year Maximum	\$1,500 ³			
Type of Dental Services	Delta Dental PPO Network²	Delta Dental Premier Network²	Out-of-Network²	
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	50% of maximum plan allowance	50% of maximum plan allowance	
Vision Benefits		Administered by Professional Benefit Administrators, Inc.		
Covered Services	\$250 per person per calendar year ³			
Hearing Benefits		Administered by Professional Benefit Administrators, Inc.		
Hearing Benefits Lifetime Maximum	\$5,000 ⁴			

- 1 The deductible applies to all covered benefits, except that you do not need to satisfy the deductible and it does not apply to surgical procedures performed on the day of surgery, second surgical opinion benefits, or in-network wellness, preventive, well-child, and well-baby care services.
- 2 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.*
- 3 The maximums do not apply to children under the age of 19 for preventive dental, orthodontia, and vision exams.
- 4 The maximum does not apply toward hearing exams.

Payments made by the Plan will be made only if the expenses are Medically Necessary and Usual and Customary. Benefits are subject to other limitations contained in the Summary Plan Description.

Calendar Year limitations and maximums are calculated based on the date you incur the claim, which is the date service is rendered, and not the date the claim is paid.

See the Summary Plan Description for information about additional benefits that are applicable only to Eligibility A Employees.

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Continuing Eligibility For Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers! Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail]
Medical, Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
Blue Cross Blue Shield of Illinois Participating Providers	Blue Cross Blue Shield of Illinois	800-810-2583 [phone] www.bcbsil.com [web site]
Preauthorization		
<ul style="list-style-type: none"> ▪ Inpatient Hospitalization, outpatient surgeries, rehabilitation services, and Transplant Benefits 	Medical Cost Management	800-367-9938 [phone]
<ul style="list-style-type: none"> ▪ Inpatient Mental Health and Substance Abuse 	Member Assistance Program (MAP) through MHN	800-472-4992 [phone]
Member Assistance Plan (MAP)	MHN	800-472-4992 [phone]
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

Note: If you do not obtain Preauthorization when required, you will be subject to the penalty listed in the *Schedule of Benefits*.

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	In-Network	Out-of-Network
Calendar Year Deductible ¹ - Individual - Family	\$500 \$1,000	\$1,000 \$3,000
Out-of-Pocket Maximum - Individual - Family	\$2,500 \$7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	\$300,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	\$250	\$250
Hospital Benefits (inpatient and outpatient)	80%	60%
Outpatient Surgical Procedures ¹	80%; no deductible required	60%; no deductible required
Doctor's Office Visits	\$20 copay	40%
X-Rays and Labs (including Pre-Admission Testing)	80%	60%
Wellness, Preventive, Well Child, Well Baby Care ¹	100%; no deductible required	Not Covered
Emergency Room	\$200 copay	\$200 copay
Rehabilitation Services/Skilled Nursing Facility Coinsurance Calendar Year Maximum Per Person - Inpatient - Outpatient (Includes Physical and Occupational Therapy) <i>Preauthorization Required.</i>	80% 60 days (combined with out-of-network) 60 days (combined with out-of-network)	60% 60 days (combined with in-network) 60 days (combined with in-network)
Mental Health and Substance Abuse Services Inpatient - Coinsurance Outpatient - Copay/Coinsurance <i>Preauthorization of Inpatient Services Required -</i>	80% \$20 copay	60% 40%
Additional Surgical Opinion ¹	80%; no deductible required	80%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	80% (additional limitations apply)
Spinal Manipulation (Chiropractic or Medical) Calendar Year Maximum <i>Acupuncture included when Physician prescribed</i>	\$15 copay per visit 60 treatments up to \$600 (combined with out-of-network)	60% 60 treatments up to \$600 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	60% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% \$500 (combined with out-of-network)	60% \$500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy and Hospice Care	80%	60%
Treatment of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum	80% \$1,000 (combined with out-of-network) \$2,000 (combined with out-of-network)	60% \$1,000 (combined with in-network) \$2,000 (combined with in-network)
Smoking Cessation Benefits Lifetime Maximum	50% One Smoking Cessation program up to \$500 (combined with out-of-network)	50% One Smoking Cessation program up to \$500 (combined with in-network)

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Sav-Rx Prescription Drug Benefit		<i>Prescription drug benefits are only covered when filled at a participating pharmacy.</i>		
Retail Pharmacy	For up to a 34-day supply, you pay:			
Generic Formulary Medication	\$10			
Brand Name Formulary Medication	\$20			
Non-Formulary Medication	\$35			
Mail Order Pharmacy/Retail Maintenance Program	For up to a 90-day supply, you pay:			
Generic Formulary Medication	\$20			
Brand Name Formulary Medication	\$40			
Non-Formulary Medication	\$70			
Delta Dental of Illinois Dental Benefits ²				
Calendar Year Deductible (<i>applies to Preventive/ Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services</i>)	\$50 Individual/ \$100 Family			
Dental Benefits Calendar Year Maximum	\$1,500 ³			
Type of Dental Services	Delta Dental PPO Network²	Delta Dental Premier Network²	Out-of-Network²	
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	50% of maximum plan allowance	50% of maximum plan allowance	
Vision Benefits		Administered by Professional Benefit Administrators, Inc. (PBA)		
Covered Services	\$250 per person per calendar year ³			
Hearing Benefits		Administered by Professional Benefit Administrators, Inc. (PBA)		
Hearing Benefits Lifetime Maximum	\$5,000 ⁴			

- 1 The deductible applies to all covered benefits, except that you do not need to satisfy the deductible and it does not apply to surgical procedures performed on the day of surgery, second surgical opinion benefits, or in-network wellness, preventive, well-child, and well-baby care services.
- 2 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.*
- 3 The maximums do not apply to children under the age of 19 for preventive dental, orthodontia, and vision exams.
- 4 The maximum does not apply toward hearing exams

Payments made by the Plan will be made only if the expenses are Medically Necessary and Usual and Customary. Benefits are subject to other limitations contained in the Summary Plan Description.

Calendar Year limitations and maximums are calculated based on the date you incur the claim, which is the date service is rendered, and not the date the claim is paid.

See your Summary Plan Description for information about additional benefits that are applicable only to Eligibility A Employees.

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Continuing Eligibility for Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail]
Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
Medical and Mental Health Benefits <ul style="list-style-type: none"> ▪ Participating providers ▪ Preauthorization for inpatient Hospitalization, outpatient surgeries, Rehabilitation Services, Transplant Benefits, and inpatient Mental Health and Substance Abuse Benefits 	Health Alliance Medical Plan 301 S. Vine St. Urbana, IL 61801-3347	800-322-7451 or 217-337-8400 [phone] www.healthalliance.org [web site] (Member sign-up required)
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

Note: If you do not obtain Preauthorization when required, your benefits will be subject to the penalty listed in the *Schedule of Benefits*.

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	HFN EPO Network Only Hospital-Based Benefits	PPO Network	Out-of-Network
Calendar Year Deductible ¹ - Individual - Family	\$100 \$200	\$500 \$1,000	\$1,000 \$3,000
Hospital Benefits	100%	80%	60%
Outpatient Surgical Procedures ¹ (no deductible required)	100%	80%	60%
X-Rays and Labs (including Pre-Admission Testing)	100%	80%	60%
Out-of-Pocket Maximum - Individual - Family	\$2,500 \$7,500	\$2,500 \$7,500	Unlimited Unlimited
Emergency Room	\$200 copay	\$200 copay	\$200 copay
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health and Inpatient Substance Abuse Treatment	\$250	\$250	\$250
Maximum Medical/Prescription Drug Calendar Year Benefit	\$300,000 per person		
Medical Benefits	PPO Network	Out-of-Network	
Doctor's Office Visits	\$20 copay	40%	
Wellness, Preventive, Well Child, Well Baby Care ¹	100%; no deductible required	Not Covered	
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance Day Treatment/Partial Hospital Coinsurance <i>Preauthorization of Inpatient Services Required</i> <input type="checkbox"/> <i>Call MAP:</i>	Call MAP for in-network providers 80% \$20 copay 80%	60% 40% 60%	
Rehabilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	100% if Medically Necessary 60 days per person 100% after \$25 copay per visit 60 visits per person	60% 60 days per person 60% 60 visits per person	
<i>Maximums are combined for all providers. Preauthorization Required</i>			
Additional Surgical Opinion ¹	80%; no deductible required	60%; no deductible required	
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	60% (additional limitations apply)	
Spinal Manipulation <input type="checkbox"/> Chiropractic or Medical Calendar Year Maximum <i>Acupuncture included when Physician prescribed</i>	\$15 copay per visit 60 treatments up to \$600 (combined with out-of-network)	60% 60 treatments up to \$600 (combined with in-network)	
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with all providers)	60% 40 visits (combined with all providers)	
Podiatry Services Orthotic Calendar Year Maximum	80% \$500 (combined with out-of-network)	60% \$500 (combined with in-network)	
Other Covered Services, Ambulance Services, Radiation Therapy, and Hospice Care	80%	60%	
Treatment of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum <i>Maximums are for all providers combined</i>	80% \$1,000 \$2,000	60% \$1,000 \$2,000	

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan – Effective 7/1/11

Medical Benefits		All Providers	
Smoking Cessation Benefits Lifetime Maximum (for all providers combined)	50% One Smoking Cessation program up to \$500 per person		
Sav-Rx Prescription Drug Benefit		<i>Prescription drug benefits are only covered when filled at a participating pharmacy.</i>	
Retail Pharmacy Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 34-day supply, you pay: \$10 \$20 \$35		
Mail Order Pharmacy/Retail Maintenance Program Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 90-day supply, you pay: \$20 \$40 \$70		
Delta Dental of Illinois Dental Benefits *			
Calendar Year Deductible (<i>applies to Preventive/ Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services</i>)	Individual Family	\$50 \$100	
Dental Benefits Calendar Year Maximum		\$1,500 ³	
Type of Dental Services	Delta Dental PPO Network²	Delta Dental Premier Network²	Out-of-Network²
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)	
Orthodontia Benefits (only for eligible Dependent children under age 19) - Coinsurance paid by the Plan	50% of reduced fee	50% of maximum plan allowance	50% of maximum plan allowance
Vision Benefits		Administered by Professional Benefit Administrators, Inc. (PBA)	
Covered Services		\$250 per person per calendar year ³	
Hearing Benefits		Administered by Professional Benefit Administrators, Inc. (PBA)	
Hearing Benefits Lifetime Maximum		\$5,000 ⁴	

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250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

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Medical, Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
HFN Participating Providers	HFN	800-295-5444 [phone] www.fhninc.com [web site] Log on to HFN, click Provider Search, enter Client Code NCILF and select HFN CHC, click next
Preauthorization		
<ul style="list-style-type: none"> ▪ Inpatient Hospitalization, outpatient surgeries, rehabilitation services, and Transplant Benefits 	Medical Cost Management	800-367-9938 [phone]
<ul style="list-style-type: none"> ▪ Inpatient Mental Health and Substance Abuse 	Member Assistance Program (MAP) through MHN	800-472-4992 [phone]
Member Assistance Plan (MAP)	MHN	800-472-4992 [phone]
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

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