SCHEDULE OF BENEFITS FOR BLUECROSS BLUESHIELD OF ILLINOIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JANUARY 1, 2026

The Schedule of Benefits for the BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan has been updated to remove the exclusion of certain out-of-network inpatient benefits.

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$500 $1,500	$1,000 $4,500
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	Unlimited	Unlimited
Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care, and Transplant Benefits	$250 reduction in benefits	$250 reduction in benefits
Hospital Benefits (inpatient and outpatient) *Preauthorization of out-of-network Inpatient Hospital Services Required*	80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act Preauthorization not required in the case of an Emergency Medical Condition covered by the No Surprises Act
Outpatient Surgical Procedures[1] *Preauthorization Required*	80%; no deductible required	50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Primary Care Doctor's Office Visits	$20 copay	50%
Specialist Office Visit	$50 copay	50%
X-Rays and Labs (including Pre-Admission Testing)	80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Maternity Services	80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Urgent Care	80%	80%
Emergency Services	$200 copay	$200 copay
Ambulance Service	80%	80%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate		
Telehealth Services Through RelyMD	100%; no deductible required	n/a
Telehealth Services Through Any Other Provider	Applicable cost sharing	Applicable cost sharing
Treatment of Temporomandibular Joint (TMJ)	80%	50%
Preparatory Work Lifetime Maximum	$1,000 (combined with out-of-network)	$1,000 (combined with in-network)
Surgery Lifetime Maximum	$2,000 (combined with out-of-network)	$2,000 (combined with in-network)
Smoking Cessation Benefits	80%	50%
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	50% (additional limitations apply)

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility		
Inpatient - Coinsurance	80% if Medically Necessary	50% if Medically Necessary for inpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
- Calendar Year Maximum	60 days per person (combined with out-of-network)	60 days per person (combined with in-network)
Outpatient - Coinsurance	80% if Medically Necessary	50% if Medically Necessary for outpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
- Calendar Year Maximum	60 visits per person (combined with out-of- network)	60 visits per person (combined with in- network)
Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services		
Mental Health Services/Substance Abuse		
Inpatient - Coinsurance	80%	50% if Medically Necessary for inpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Outpatient - Copay/Coinsurance	$20 copay office visit;	50% if Medically Necessary for outpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Preauthorization of Out-of-Network Inpatient Services Required – Call Hines & Associates, Inc • *For a list of in-network providers, contact BCBSIL* • *For up to 6 free visits, contact the MAP provider listed on page 3*	no deductible required (outpatient only)	no deductible required (outpatient only)
Additional Surgical Opinion[1]	80%; no deductible required	50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Spinal Manipulation (Chiropractic or Medical)	$15 copay per visit	50%
Calendar Year Maximum *Acupuncture included when Physician prescribed*	60 treatments up to $1,000 (combined with out-of- network)	60 treatments up to $1,000 (combined with in-network)
Home Health Care - Coinsurance	80%	50%
- Calendar Year Maximum	40 visits (combined with out-of-network)	40 visits (combined with in-network)
Podiatry Services	80%	50%
Orthotic Calendar Year Maximum	$500 (combined with out-of-network)	$500 (combined with in-network)
Other Covered Services, Radiation Therapy, Hospice Care and Gene Therapy Preauthorization Required for Inpatient Hospice Care and Gene Therapy	80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act

Sav-Rx Prescription Drug Benefit	***Prescription drug benefits are only covered when filled at a participating pharmacy.***
Out-of-Pocket Maximum - Individual - Family	 $4,100 $5,700
Retail Pharmacy Generic Medication Preferred Brand Name Medication Non-Preferred Brand Name Medication Specialty Medication	For up to a 34-day supply, you pay: 10% (minimum $10, maximum $20) 20% (minimum $20, maximum $50) 30% (minimum $35, maximum $125) 20% (minimum $20, maximum $50)
Mail Order Pharmacy/Retail Maintenance Program Generic Medication Preferred Brand Name Medication Non-Preferred Brand Name Medication Specialty Medication	For up to a 90-day supply, you pay: 10% (minimum $20, maximum $40) 20% (minimum $50, maximum $100) 30% (minimum $100, maximum $250) 20% (minimum $50, maximum $100)

Delta Dental of Illinois Dental Benefits	Coverage		
Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*)	$50 Individual/ $100 Family		
Dental Benefits Calendar Year Maximum	$1,500 [3]		
Type of Dental Services	**Delta Dental PPO Network[2]**	**Delta Dental Premier Network[2]**	**Out-of-Network[2]**
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	$500 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 outpatient mental health, 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 Allowable. 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.

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] www.ncilhwf.com
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] www.pbaclaims.com
Blue Cross Blue Shield of Illinois Participating Providers	Blue Cross Blue Shield of Illinois	800-810-2583 [phone] www.bcbsil.com [web site]
Preauthorization ▪ Out-of-Network Inpatient Hospitalization, Outpatient Surgeries, Outpatient Rehabilitation, Habilitation, Inpatient Hospice Care and Transplant Benefits ▪ Out-of-Network Inpatient Mental Health and Substance Abuse Treatment ▪ Gene Therapy	Hines & Associates, Inc	800-944-9401 [phone]
Member Assistance Plan (MAP)	AllOne Health	800-292-2780 [phone] www.ers-eap.com
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 may be reduced.