4208 W. Partridge Way, Unit 3 • Peoria, IL 61615
Toll Free: 1-866-692-0860 • **Phone:** 309-692-0860 • **Fax:** 309-692-0862

2018

Dear Fund Member:

Recently, you returned the North Central Illinois Laborers' Health & Welfare Fund's Open Enrollment letter indicating that you may be interested in changing medical plan network that you will be covered under for 2019.

During this Open Enrollment period, you have the opportunity to choose the network under which you will receive your benefit coverage for the upcoming year. The benefit design of each of the Plans offered by the Health & Welfare Fund are outlined in the Schedule of Benefits.

Enclosed with this letter are brief descriptions of your network choices:

Blue Cross Blue Shield of Illinois network, a PPO plan network that offers both in and out-of-network benefits;

CIGNA network, a PPO plan network that offers both in and out-of-network benefits.

Each network description includes both customer service phone numbers and websites where physician and hospital participation can be reviewed.

If you decide to change from your current network to a new one for the 2019 calendar year, please complete the enclosed Enrollment Form entirely, making sure to indicate your network choice on Part A of the form. If you are adding dependents to your insurance, the Fund office will need copies of marriage and/or birth certificates. Please sign and return all required forms to the Fund office by November 30, 2018.

Please note that all changes become effective January 1, 2019 and remain effective until December 31, 2019.

If you are currently enrolled in Blue Cross Blue Shield of Illinois or CIGNA, and you decide **NOT** to change your network for the upcoming year, no further action is required.

Sincerely,

The North Central Illinois Laborers' Health & Welfare Fund

Blue Cross Blue Shield PPO Network

To: *North Central Illinois Laborers' Health & Welfare Fund Members*

Subject: **Blue Cross Blue Shield Participating Provider Option**

The Trustees are pleased to announce that your Health Benefits Plan offers the Blue Cross Blue Shield PPO Network as part of your benefit choices.

The Blue Cross Blue Shield Network includes over 225 hospitals and 22,000 physicians.

In order to receive maximum benefits, refer to the BCBS website at www.bcbsil.com or call 1-800-810-2583 to find out whether or not your hospital is in the PPO network. To determine if your physician is in the network, please either contact your physician's office, contact our customer service department or go online to www.bcbsil.com.

Blue Cross Blue Shield of Illinois
800-810-2583
www.bcbsil.com

1. Click on the *Find a Doctor or Hospital* tab
2. Click on Find a *Doctor with Provider Finder – Big box in the middle of page, a new page will open up*
3. Select the State that you are looking in, then click search
4. Under *Select Network or Plan*, Scroll to *Participating Provider Organization PPO*
5. Enter in criteria to search for a provider – Name, State, Zip Code etc…

After choosing the BCBS Network, within two weeks of the January 1st effective date, Blue Cross Blue Shield will send you a new ID card. Please utilize the new card for hospital and physician treatment only after the effective date. **In order to receive the benefits of using the BCBS network, you must show the card any time you obtain medical treatment.**

All PPO hospitals and physicians should file directly to Blue Cross Blue Shield and should not expect payment in full up front. Be sure to show your card in order to avoid a delay in claim processing. If any PPO hospitals advise differently, please notify the Fund Office.

Remember, your benefits are determined through the Fund's benefit SPD as administered by PBA. The Blue Cross Blue Shield PPO Network simply provides the network discounts, and does not determine benefits.

Let Us Welcome You to Our Community

A CIGNA PPO plan is one of your health insurance options offered through North Central Illinois Laborers' Health & Welfare Fund. We are very excited about this opportunity. As a member of the CIGNA community, you can expect all the benefits and services explained below, plus much more!

PPO

A Preferred Provider Organization (PPO) plan allows you and your covered dependents to choose where to receive health care services. Your level of coverage is determined by where you choose to receive services. You may choose to receive the highest level of coverage for services from a preferred provider. You may also choose to receive a lower level of coverage (and pay more out-of-pocket expenses) for services from a non-preferred provider.

Your Preferred Provider Network

Our extensive network of preferred providers and hospitals throughout Illinois allow our members to receive the care they need, when and where they need it.

Preferred provider health care services are paid according to the Schedule of Benefits. After members provide the necessary information, preferred providers will file claims to CIGNA for the members.

You can find network providers by calling CIGNA Customer Service Department c/o Professional Benefit Administrators, Inc at 800-435-5694. In addition, you can conveniently view providers online anytime by visiting www.cigna.com. To search for a provider on the website prior to January 1, 2019, follow these steps:

1. Click on the *Find a Doctor* tab
2. Under *Select a Directory* click on “For plans offered through work or school”
3. Click “Pick” under *Select a Plan*
4. Expand “Medical Plans” in the popup window and choose “PPO, Choice Fund PPO”
5. Click “Choose”
6. Enter your location and doctor search criteria
7. Click “Search”

Non-Preferred Providers

Benefits for services from non-preferred providers are paid according to the Schedule of Benefits, up to the usual, customary and reasonable charges after the individual or family deductible has been met. Members are responsible for submitting the claim or bill to CIGNA if the provider does not agree to send a claim on his or her behalf.

The provider will bill the portion of the cost the member is responsible for directly to the member after the plan has determined its payment. Members need to make sure claims for non-preferred providers are submitted to CIGNA within 60 days from the date of service. Claims submitted more than one year from the date of service are not covered by the plan.

Office Visits and Referrals

When a member uses one of the thousands of CIGNA preferred providers, he or she will only have to pay a $20 co-payment for a primary care physician and $50 for a specialist. The member does not need to select a Primary Care Physician.

To make the most of his or her coverage, the member will want to be sure to request that any physician making a referral makes the referral to another CIGNA preferred provider.

Under this PPO plan, a member can see non-preferred providers; however, the member will incur more out-of-pocket expenses for services rendered by non-preferred providers.

Out-of-Pocket Maximums

Once a member's share of *in-network* covered expenses reaches the out-of-pocket maximum of $2,500 per person (or $7,500 for the family), the NCILHWF Plan picks up 100% of the costs for covered services rendered by preferred providers for the remainder of the plan year. The deductible is included in the out-of-pocket maximum.

Routine mammograms and pap smears are covered at 100%, without payment of a deductible or co-pay by the participant. This benefit is in addition to the plans Wellness Benefit.

Please note that preventive care services received from a non-preferred provider are not covered.

Preauthorization

Members must have non-emergency hospitalization (including mental health and substance abuse treatment), outpatient surgery, and rehabilitation authorized in advance. Failure to have these benefits preauthorized may result in a reduction of benefits.

To obtain preauthorization, a member or his or her physician should call the number listed on the plan ID card or in the Schedule of Benefits at least three days before the hospitalization or treatment. If a member has an emergency admission or treatment, the member or a family member should call the preauthorization number within 48 hours of admission or treatment.

Because providers can leave or join the network at any time, it's important for members to have access to an updated provider listing. Members can visit mycigna.com and log in to view all the current providers available.

Convenient, Online Member Tools (Available beginning January 1, 2018)

When you have more information, you'll feel better about your health and your health spending. That's why we have tools and resources to help you estimate and compare costs and improve your health and wellness.

Medical cost estimator – compare estimated costs for various procedures based on Cigna's historical cost data.

Manage your health – the “Manage My Health” section includes a wealth of tools and information to help you get healthy and stay healthy. You’ll find articles, support groups, and other resources on a variety of topics including blood pressure, cholesterol, tobacco cessation, weight management, stress and more.

To request member access:

1. Go to mycigna.com
2. Click on "Register Now" at the login screen.
3. Provide the requested information.
4. You will need to choose a user ID and a password.

To log on:

Once you are registered, you can easily view your account information in a secure environment. Just follow these easy five steps:

1. Go to mycigna.com
2. Log in with the user ID and password you chose at registration.
3. Click on "Member Services."
4. Select the service you wish to view from the menu of options.
5. Supply the requested information.

*To **view** providers:*

Log in with your user name and password. Click on "Member Services," then click on "Provider Directory." Enter your search criteria. For your convenience, you can search by physician name or location. A listing of providers matching your criteria will appear.

After selecting a physician online, you can get driving directions to his or her office or, if available, view a photograph of the provider.

Questions? Please Call Customer Service!

CIGNA has a dedicated team of Customer Service Professionals, c/o Professional Benefit Administrators, Inc available to answer your questions during this transition time and beyond. Call at 800-435-5694 for assistance. We are happy to help.

About CIGNA

CIGNA and its predecessors have been in business since 1792, over 200 years. CIGNA has been winning awards for innovative health care delivery and services since it was created by merger in 1982. It is a leading provider-sponsored health insurer in the World, covering more than 15.2 million medical customers. It is accredited by both URAC and NCQA.

Cigna.

THE NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND
4208 W PARTRIDGE WAY, UNIT 3 • PEORIA, IL 61615
PHONE - 309-692-0860 • TOLL FREE - 866-692-0860 • FAX - 309-692-0862

ENROLLMENT / CHANGE FORM

EMPLOYMENT STATUS: ☐ACTIVE ☐RETIRED ☐SURVIVING SPOUSE ☐COBRA | LABORERS' LOCAL # _____

A. MARK PLAN OF CHOICE

☐ BLUE CROSS BLUE SHIELD ☐ CIGNA ☐ SWITCHED HEALTH PLANS TO: _____

B. MEMBER DEPENDENT CHANGE

☐ INITIAL ENROLLMENT ☐ ADDRESS/PHONE CORRECTION
☐ OPEN ENROLLMENT ☐ DELETE DEPENENT (S)
☐ ADD DEPENDENT (S)
☐ NAME CHANGE: FORMER NAME: _____

C. MARITAL STATUS

☐MARRIED ☐SINGLE
☐DIVORCED ☐LEGALLY SEPERATED
☐WIDOWED

D. MEMBER INFORMATION

NAME (LAST, FIRST, MIDDLE) | MAIDEN NAME OF APPLICANT OR SPOUSE:

MAILING ADDRESS | CITY | STATE | ZIP

SEX ☐MALE ☐ FEMALE	SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH	TELEPHONE NUMBER

E. FAMILY INFORMATION

List all family members to be covered. Please print name. Please attach copies of all documentation needed: e.g. birth certificates, marriage certificate, adoption paperwork, divorce decree, etc… Please use extra paper if additional room is needed.

NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	RELATION	DATE OF BIRTH	SEX
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F

F. OTHER HEALTH INSURANCE INFORMATION ** THIS SECTION MUST BE COMPLETED **

On the day your coverage begins will any family members be covered by another health plan, Medicare, Medicaid? ☐YES ☐NO If yes, fill out this section. Use extra paper if more than one additional policy will be in force.

COVERAGE TYPE : ☐MEDICAID ☐MEDICAL INSURANCE ☐MEDICARE
MEDICARE ELIGIBILITY DUE TO: ☐KIDNEY FAILURE ☐DISABILITY ☐ AGE

INSURANCE COMPANY NAME AND NUMBER	POLICY NUMBER	POLICY COVERAGE DATES TO

NAME OF POLICY HOLDER	DATE OF BIRTH	FAMILY MEMBERS COVERED

EMPLOYER NAME	EMPLOYERS ADDRESS	EMPLOYERS PHONE NUMBER

MEDICARE COVERED FAMILY MEMBERS	MEDICARE ID NUMBER	PART A. EFFECTIVE DATE	PART B. EFFECTIVE DATE

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF YES, IS HEALTH INSURANCE OFFERED? ☐YES ☐NO

NAME, ADDRESS AND PHONE NUMBER OF SPOUSES' EMPLOYER

G. CERTIFICATION

I, the undersigned applicant, apply for the healthcare coverage offered under the Plan of benefits established by the Plan Sponsor, for myself and any of my eligible dependnets listed on this application. I certify and affirm that all statements made in this Ernollment/Change Form are true.

Date: Applicant's Signature

THE NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND

4208 W PARTRIDGE WAY, UNIT 3

PEORIA, IL 61615

SPOUSAL INSURANCE COVERAGE INFORMATION

PART 1. MEMBER INFORMATION (To be completed by the Member and spouse)

Member's Name: _____ SS# _____

Spouse's Name: _____ SS# _____

Is Spouse Employed? Yes ☐ Member and spouse to sign below and continue to Part II

NO ☐ Member and spouse to sign below and return form to Fund Office

Member's Certification: I certify that the above information is correct and that I understand my responsibility to notify you of any changes. I understand that if my spouse is eligible to participat in his or her employer-sponsored group health insurance plan, then that plan will be considered primary even if my spouse does NOT enroll in the plan.

Member's Signature **Date**

Spouse's Authorization to Realease Information: I hereby authorize my employer to release the information requested below to the North Central Illinois Laborers' Health & Welfare Fund or it's claims administration, for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

Spouse's Signature **Date**

PART II. INFORMATION ON SPOUSE'S PLAN (To be completed by the spouse's employer.)

Your Employee's Name: _____

Last, First, Middle

	Medical	
	YES	NO
Is employee eligible for your employee-sponsored group health insurance plan?	☐	☐
Is this employee currently enrolled in your plan?	☐	☐
Do you, the employer, pay at elast 75% of the single coverage premium?	☐	☐
Does your plan enroll the employee in another plan and offer them a reduced medical coverage (for example, a "wrap-around" plan) based only on the fact that they are a participant/dependent in this Fund?	☐	☐

If employee is NOT enrolled in your plan, when will the employee be eligible to enroll in the plan?

_____ Comments: _____

Month/Day/Year

Employer Name: _____ Insurance Carrier Name: _____

Address _____ Address _____

_____ _____

_____ _____

Telephone Policy # _____

Group # _____

If eligible employee is NOT enrolled in your plan (at least 75% of premium paid by the employer), please send Summary Plan Document.

Completed by: _____

Signature Date

_____

Print Name and Title

You MUST enroll at your next open enrollment if your employer pays at least 75% of the single coverage premium.

NORTH CENTRAL ILLINOIS LABORERS' HEALTH AND WELFARE FUND

4208 W. PARTRIDGE WAY, UNIT 3, PEORIA, IL 61615

BENEFICIARY FORM

LAST NAME	FIRST NAME	MIDDLE INITIAL

HOME ADDRESS	CITY	STATE	ZIP	MARRIED	SINGLE

DATE OF BIRTH	SOCIAL SECURITY NUMBER	LOCAL UNION NUMBER

PRIMARY DEATH BENEFICIARY LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	RELATIONSHIP

ADDRESS OF BENEFICIARY STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

ALTERNATE BENEFICIARY LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	RELATIONSHIP

ADDRESS OF ALTERNATE BENEFICIARY STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

DATE	SIGNATURE

LIST BELOW NAMES OF YOUR SPOUSE AND UNMARRIED CHILDREN THAT ARE DEPENDENT UPON YOU FOR AT LEAST 1/2 OF THEIR SUPPORT

List full name in order of age - Eldest First	Check Relationship			Date of Birth		
	Spouse	Son	Daughter	Month	Day	Year

North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits
January 1, 2019
BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$750 $1,500	$1,500 $4,500
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	Unlimited	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Skilled Nursing Facility, Habilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover non-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of Inpatient Services Required*	80%	50%
Outpatient Surgical Procedures[1] *Preauthorization Required*	80%; no deductible required	50%; no deductible required
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%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Maternity Services	80%	50%
Urgent Care	80%	80%
Emergency Room	$200 copay	$200 copay
Ambulance Service	80%	80%
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum	 80% if Medically Necessary 60 days per person	Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, unless medical emergency, paid at 50%
Outpatient - Coinsurance - Calendar Year Maximum	80% if Medically Necessary 60 visits per person (combined with out-of-network)	50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Skilled Nursing Facility.		
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Inpatient Services Required - Call MAP.*	80% Call MAP for in-network providers $20 copay office visit;	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency, paid at 50% 50% if Medically Necessary for outpatient services
Additional Surgical Opinion[1]	80%; no deductible required	50%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	50% (additional limitations apply)
Spinal Manipulation (Chiropractic or Medical) Calendar Year Maximum *Acupuncture included when Physician prescribed*	$15 copay per visit 60 treatments up to $1,000 (combined with out-of-network)	50% 60 treatments up to $1,000 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	50% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	50% $500 (combined with in-network)

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Other Covered Services, Radiation Therapy and Hospice Care	80%	50%
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)	50% $1,000 (combined with in-network) $2,000 (combined with in-network)
Smoking Cessation Benefits	80%	50%

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 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 [2]			
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	$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 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]
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 ▪ Inpatient Hospitalization, outpatient surgeries, Skilled Nursing Facility, and Transplant Benefits ▪ Inpatient Mental Health and Substance Abuse	Medical Cost Management	800-367-9938 [phone]
Member Assistance Plan (MAP)	Employee Resource Systems (ERS)	800-292-2780 [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, your benefits may be reduced.

North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits
January 1, 2019
CIGNA Preferred Provider Organization (PPO) Plan

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$750 $1,500	$1,500 $4,500
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	Unlimited	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Skilled Nursing Facility, Habilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover non-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of Inpatient Services Required*	80%	50%
Outpatient Surgical Procedures[1] *Preauthorization Required*	80%; no deductible required	50%; no deductible required
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%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Maternity Services	80%	50%
Urgent Care	80%	80%
Emergency Room	$200 copay	$200 copay
Ambulance Service	80%	80%
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	 80% 60 days per person 80% 60 visits per person (combined with out-of-network)	Out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care services are not covered, unless medical emergency, paid at 50% 50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Skilled Nursing Facility.		
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Inpatient Services Required - Call MAP.*	80% Call MAP for in-network providers $20 copay office visit	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency, paid at 50% 50% if Medically Necessary for outpatient services
Additional Surgical Opinion[1]	80%; no deductible required	50%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	50% (additional limitations apply)
Spinal Manipulation (Chiropractic or Medical) Calendar Year Maximum *Acupuncture included when Physician prescribed*	$15 copay per visit 60 treatments up to $1,000 (combined with out-of-network)	50% 60 treatments up to $1,000 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	50% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	50% $500 (combined with in-network)

Medical Benefits	**In-Network (Illinois Providers Only)**	**Out-of-Network**
Other Covered Services, Radiation Therapy and Hospice Care	80%	50%
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)	50% $1,000 (combined with in-network) $2,000 (combined with in-network)
Smoking Cessation Benefits	80%	50%

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 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 [2]			
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	$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 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]
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]
CIGNA Participating Providers	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694 www.mycigna.com [web site] (Member sign-in required)
Preauthorization ▪ Preauthorization for inpatient Hospitalization, outpatient surgeries, Skilled Nursing Facility, and Transplant Benefits, ▪ Inpatient Mental Health and Substance Abuse Benefits	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694
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.