4208 W. Partridge Way, Unit 3 • Peoria, IL 61615

Toll Free: 1-866-692-0860 • **Phone:** 309-692-0860 • **Fax:** 309-692-0862

February 2019

Dear Participant:

This notice contains important information regarding changes to your health and welfare benefits.

Inpatient Admission Preauthorization Penalties:

Currently, Participants must obtain preauthorization for certain inpatient services to avoid a $250 penalty.

Effective May 1, 2019, Participants are required to obtain preauthorization to avoid a $250 penalty for the following services:

- Outpatient surgery;
- Inpatient (out-of-network) hospitalization;
- Inpatient (out-of-network) mental health/substance abuse treatment excluding partial hospitalization;
- Outpatient Rehabilitation Services;
- Inpatient hospice care;
- Habilitation Services; and
- Transplant services.

Participants are no longer required to obtain preauthorization to avoid a $250 penalty for the following in-network services:

- Inpatient hospitalization;
- Inpatient mental health and substance use disorder;
- Long-term acute care;
- Inpatient Skilled nursing;
- Inpatient rehabilitation;
- Residential treatment; and
- Partial hospitalization.

These changes apply to the above-listed benefits provided under the BlueCross BlueShield of Illinois PPO Plan and the CIGNA Preferred Provider Organization Plan.

Off-Label Drugs:

Currently, the North Central Illinois Laborers' Health and Welfare Fund (the "Plan"), covers off-label drugs as a medical benefit solely for cancer or other life-threatening conditions. "Off-label use" is any use of a drug other than those indicated on the drug's label as approved by the Food and Drug Administration (FDA).

Effective January 1, 2019, the Plan will cover the use of off-label drugs as a medical benefit for any condition if the use of the off-label drug is:

- FDA-approved;
- supported by Medicare using peer-reviewed medical literature and is **not** listed as not indicated, insufficient data, experimental, or investigational in any one of the supporting medical literature; and
- medically necessary.

The use of the off-label drug must meet all of the above-criteria or it will be considered experimental or investigational.

The off-label drug benefits provided under the Plan do not apply to the prescription drug benefit, including under the Sav-Rx program.

Habilitative Services:

Currently, the Plan covers speech therapy for the treatment of developmental disorders that stem from mental health conditions for up to 32 visits per lifetime for habilitative purposes.

Effective January 1, 2019, the Plan will expand coverage of habilitative services for all medical and mental health conditions, subject to a combined 60-visit calendar year maximum for in-network and out-network services.

Habilitative services are generally considered to be non-restorative treatment that helps an individual keep, learn, or improve skills for functioning or daily living. Habilitative services include, but are not limited to, occupational therapy, physical therapy, behavioral therapy, speech therapy, and ABA-therapy.

For example, a physician may prescribe outpatient therapy for a child who is not walking or talking at an accepted age.

Out-of-network, in-patient habilitative services are not covered unless there is a medical emergency.

Preauthorization is required to avoid a $250 penalty.

Rehabilitative Services:

Currently, the Plan covers medically necessary outpatient physical therapy, occupational therapy, and speech therapy, subject to a combined 60-visit calendar year maximum, for rehabilitative purposes to treat medical conditions.

Effective January 1, 2019, the Plan will also expand coverage of rehabilitative services to include medical and mental health conditions, subject to a combined 60-visit calendar year maximum for in-network and out-of-network services.

Rehabilitative services are generally considered to be restorative treatment that helps an individual keep, regain, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

For example, a physician may prescribe physical therapy for a child to restore motor functioning.

Out-of-network, in-patient rehabilitative services are not covered unless there is a medical emergency.

Preauthorization for outpatient rehabilitation is required to avoid a $250 penalty.

Questions?

If you have questions about this change or your benefits in general, please contact the Fund Office. Please keep a copy of this with your Summary Plan Description Booklet for future reference.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications (SMM), contains only highlights of recent changes to the North Central Illinois Laborers' Health & Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time. Please keep a copy of this SMM with your copy of the Fund's Summary Plan Description (SPD).

North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits

May 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 Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care, and Transplant Benefits	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover out-of-network Residential Treatment, Skilled Nursing, Inpatient Rehabilitation or Inpatient Habilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of out-of-network Inpatient Hospital 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%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate		
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	80% if Medically Necessary 60 days per person 80% if Medically Necessary 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, then paid at 50% 50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services		
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Out-of-Network Inpatient Services Required – Call Medical Cost Management (MCM)* • *For a list of in-network providers, contact BCBSIL* • *For up to 6 free visits, contact the MAP provider listed on page 3*	80% $20 copay office visit; no deductible required (outpatient only)	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency, then paid at 50% 50% if Medically Necessary for outpatient services no deductible required (outpatient only)
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)

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	50% $500 (combined with in-network)
Other Covered Services, Radiation Therapy and Hospice Care *Preauthorization Required for Inpatient 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 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] 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	Medical Cost Management	800-367-9938 [phone]
Member Assistance Plan (MAP)	Employee Resource Systems (ERS)	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.

North Central Illinois Laborers' Health and Welfare Fund

Schedule of Benefits
May 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 Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care and Transplant Benefits	$250 reduction in benefits	$250 reduction in benefits NOTE: the Plan does not cover out-of network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation or Inpatient Habilitation care
Hospital Benefits (inpatient and outpatient) *Preauthorization of Out-of-Network Inpatient Hospital 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%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate		
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, then paid at 50% 50% if Medically Necessary for outpatient services 60 visits per person (combined with in-network)
Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services		
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Out-of-Network Inpatient Services Required - Call Professional Benefit Administrators (PBA)* • *For a list of in-network providers, contact PBA* • *For up to 6 free visits, contact the MAP provider listed on page3*	80% $20 copay office visit no deductible required (outpatient only)	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency, then paid at 50% 50% if Medically Necessary for outpatient services no deductible required (outpatient only)
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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]**
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Hearing Benefits Lifetime Maximum	$5,000[4]

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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

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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
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
CIGNA Participating Providers	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694 www.mycigna.com [web site] (Member sign-in required)
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 Benefits	CIGNA c/o Professional Benefit Administrators, Inc. (PBA)	800-435-5694
Member Assistance Plan (MAP)	Employee Resource Systems (ERS)	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.

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

Dear Participant and Family,

Enclosed you will find the Fund's Summary of Benefits and Coverage (SBC) for the Blue Cross/Blue Shield of Illinois network, and CIGNA network. The SBC's provide a general description of the health benefits provided by our Fund. SBC's are required by the Affordable Care Act (ACA). Please share the SBC's with your family members who are eligible for coverage.

The federal government developed the SBC form primarily to help people who will be shopping for individual coverage when the health care exchanges opened in 2014. They are designed so that individuals can compare "apples to apples" when comparing plans. For that reason, we are not allowed to customize much of the SBC.

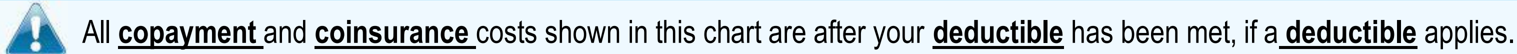
Please let our office know if you have any questions.

Sincerely,

The North Central Illinois Health & Welfare Fund

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-692-0860 or visit www.ncilhwf.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-692-0860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$750** person/**$1,500** family; Out-of-network: **$1,500** person/**$4,500** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Outpatient surgical procedures, second surgical opinion, in-network preventive care and prescription drugs, vision, hearing benefits, and dental are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$50** person/**$100** family for dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network Medical: **$2,500** person/**$7,500** family; In-network Prescription Drugs: **$4,100** person/**$5,700** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.


All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% coinsurance	-- None --
	Specialist visit	$50 copay/visit	50% coinsurance	-- None --
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	10% coinsurance, minimum $10 copay/fill maximum $20 copay/fill retail, 10% coinsurance minimum $20 copay/fill maximum $40 copay/fill mail order. Deductible does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the copayment. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred Brand drugs	20% coinsurance, minimum $20 copay/fill maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/fill maximum $100 copay/fill mail order. Deductible does not apply.		
	Non-Preferred drugs	30% coinsurance, minimum $35 copay/fill maximum $125 copay/fill retail, 30% coinsurance minimum $100 copay/fill maximum $250 copay/fill mail order. Deductible does not apply.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty Drugs	20% coinsurance, minimum $20 copay/fill maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/fill maximum $100 copay/fill mail order. Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty.
	Physician/surgeon fees	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	-- None --
	Emergency medical transportation	20% coinsurance	20% coinsurance	Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate. This service is only available when emergency treatment is not available locally. Your physician must order the treatment and travel will only be covered to the nearest hospital providing the necessary medical care or treatment.
	Urgent care	20% coinsurance	20% coinsurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required for out-of-network services, call 800-367-9938. Failure to preauthorize out-of-network services will result in $250 penalty Charges limited to semi-private room rates.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visits; 20% coinsurance for day treatment and partial hospitalization. Deductible does not apply.	50% coinsurance. Deductible does not apply.	-- None --
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency. Preauthorization is required for out-of-network services, call 800-367-9938. Failure to preauthorize out-of-network services will result in $250 penalty. Charges limited to semi-private room rates.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Up to 40 visits/calendar year (combined maximum for in-network and out-of-network).
	Rehabilitation services	20% coinsurance	50% coinsurance	Up to 60 visits/calendar year (combined maximum for in-network and out-of-network for medical and mental health conditions).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Preauthorization may be required for certain services to avoid a $250 penalty. Call 800-367-9938 to confirm if preauthorization is required. Failure to preauthorize will result in $250 penalty. Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency. Out-of-network inpatient services are not covered, unless medical emergency.
	Habilitation services	20% coinsurance	50% coinsurance	Up to 60 visits/calendar year (combined maximum for in-network and out-of-network for medical and mental health conditions). Preauthorization is required, call 800-367-9938. Failure to preauthorize will result in $250 penalty. Out-of-network inpatient services are not covered, unless medical emergency.
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Out-of-network inpatient services are not covered, unless medical emergency.
	Durable medical equipment	20% coinsurance	50% coinsurance	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	Hospice services	20% coinsurance	50% coinsurance	Covered if terminally ill. Preauthorization is required for inpatient services, call 800-367-9938. Failure to preauthorize inpatient services will result in $250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	$250 annual maximum; administered separately by Professional Benefit Administrators, Inc. Deductible does not apply.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge for children under 19, deductible does not apply; No charge after $50 deductible for children 19 and over.	20% coinsurance after $50 deductible; Deductible does not apply for children under 19.	Coverage is limited to 2 exams/year. Administered separately by Delta Dental of Illinois.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S.	• Weight loss programs (except as required by the ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Covered under spinal manipulation benefit and smoking cessation benefit if prescribed by a physician) • Bariatric surgery (Based on meeting criteria for life-threatening obesity) • Chiropractic care (Up to 60 treatments or $1,000 per year)	• Dental care (Adult) (Up to $1,500 per year under separately administered plan) • Hearing aids (Up to $5,000 per lifetime; limit does not apply to exams) • Private-duty nursing (Only if medically necessary)	• Routine eye care (Adult) (Up to $250 for all vision benefits combined under separately administered plan) • Routine foot care (Up to $500 per year for orthotics)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Fund Office at 1-866-692-0860 or at www.ncilhwf.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington Street, 4th Floor, Springfield, Illinois 62767, 1-866-445-5364, http://www.insurance.illinois.gov, DOL.Director@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-692-0860.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$70
Copayments	$260
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

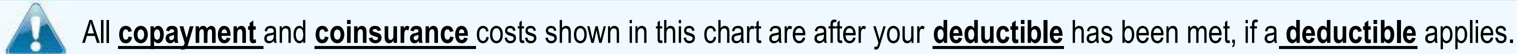
Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-692-0860 or visit www.ncilhwf.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-692-0860 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$750** person/**$1,500** family; Out-of-network: **$1,500** person/**$4,500** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Outpatient surgical procedures, second surgical opinion, in-network preventive care and prescription drugs, vision, hearing benefits, and dental are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$50** person/**$100** family for dental. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network Medical: **$2,500** person/**$7,500** family; In-network Prescription Drugs: **$4,100** person/**$5,700** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, dental benefits administered separately by Delta Dental, vision and hearing benefits administered separately by Professional Benefit Administrators, Inc., and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.mycigna.com or call 1-800-435-5694 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% coinsurance	-- None --
	Specialist visit	$50 copay/visit	50% coinsurance	-- None --
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	-- None --
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	10% coinsurance, minimum $10 copay/fill maximum $20 copay/fill retail, 10% coinsurance minimum $20 copay/fill maximum $40 copay/fill mail order. Deductible does not apply.	Not covered	Covers up to a 34-day supply (retail); up to 90-day supply (mail order). If your Physician has not indicated Dispense as Written on your prescription and you choose to receive the brand name medication rather than the available generic medication, you will have to pay the difference in cost between the generic and the brand name medication in addition to the copayment. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Preferred Brand drugs	20% coinsurance, minimum $20 copay/fill maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/fill maximum $100 copay/fill mail order. Deductible does not apply.		
	Non-Preferred drugs	30% coinsurance, minimum $35 copay/fill maximum $125 copay/fill retail, 30% coinsurance minimum $100 copay/fill maximum $250 copay/fill mail order. Deductible does not apply.		

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Specialty Drugs	20% coinsurance, minimum $20 copay/fill maximum $50 copay/fill retail, 20% coinsurance minimum $50 copay/fill maximum $100 copay/fill mail order. Deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-435-5694. Failure to preauthorize will result in $250 penalty.
	Physician/surgeon fees	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	-- None --
	Emergency medical transportation	20% coinsurance	20% coinsurance	Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate. This service is only available when emergency treatment is not available locally. Your physician must order the treatment and travel will only be covered to the nearest hospital providing the necessary medical care or treatment.
	Urgent care	20% coinsurance	20% coinsurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required for out-of-network services. Call in c/o Professional Benefit Administrators, Inc., 800-435-5694. Failure to preauthorize out-of-network services will result in $250 penalty. Charges limited to semi-private room rates.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visits; 20% coinsurance for day treatment and partial hospitalization. Deductible does not apply.	50% coinsurance	-- None --
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency. Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-435-5694. Failure to preauthorize out-of-network services will result in $250 penalty Charges limited to semi-private room rates.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive screenings. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Charges limited to semi-private room rates.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Up to 40 visits/calendar year (combined maximum for in-network and out-of-network).
	Rehabilitation services	20% coinsurance	50% coinsurance	Up to 60 visits/calendar year (combined maximum for in-network and out-of-network for medical and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				mental health conditions). Preauthorization may be required for certain services to avoid a $250 penalty. Call 800-435-5694 to confirm if preauthorization is required. Failure to preauthorize will result in $250 penalty. Out-of-network Residential Treatment, Skilled Nursing or Inpatient Rehabilitation care services are not covered, unless medical emergency. Out-of-network inpatient services are not covered, unless medical emergency.
	Habilitation services	20% coinsurance	50% coinsurance	Up to 60 visits/calendar year (combined maximum for in-network and out-of-network for medical and mental health conditions). Preauthorization is required. Call in c/o Professional Benefit Administrators, Inc., 800-435-5694. Failure to preauthorize will result in $250 penalty. Out-of-network inpatient services are not covered, unless medical emergency.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Maximum of 60 inpatient days per year. Maximum of 60 outpatient visits per year (combined maximum for in-network and out-of-network). Out-of-network inpatient services are not covered, unless medical emergency.
	Durable medical equipment	20% coinsurance	50% coinsurance	Rental benefit not to exceed the purchase price. For medical purpose, not for comfort or convenience.
	Hospice services	20% coinsurance	50% coinsurance	Covered if terminally ill. Preauthorization is required for inpatient services, call 800-435-5694. Failure to preauthorize inpatient services will result in $250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	$250 annual maximum; administered separately by Professional Benefit Administrators, Inc. Deductible does not apply.
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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$70
Copayments	$260
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

Your costs may be less if you participate in the Disease Management Program and qualify for the Sav-Rx vouchers.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.