SCHEDULE OF BENEFITS (EFFECTIVE JULY 1, 2006)

Blue Cross Blue Shield of Illinois Preferred Provider Organization		
Medical Benefits	*In-Network (Illinois Providers Only)*	*Out-of-Network*
Calendar Year Deductible - Individual - Family	$400 $800	$600 $1,800
Out-Of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Calendar Year Benefit	$250,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, and Rehabilitation Services	$250 reduction in benefits	$250 reduction in benefits
Hospital Benefits (inpatient and outpatient)	90%	70%
Doctor's Office Visits	$20 Copay	40%
X-Rays And Labs, Including Pre-Admission Testing	90%	70%
Wellness, Preventative, Well Child, Well Baby Care Calendar Year Maximum Maximum In First Year Of Life	100% $400 $500	Not Covered
Emergency Room	$200 Copay	$200 Copay
Rehabilitation Services/Skilled Nursing Facility Coinsurance Inpatient Calendar Year Maximum Outpatient Calendar Year Maximum) (Includes Physical and Occupational Therapy) *Preauthorization Required - See Contact Information*	 90% if Medically Necessary 60 days per person (combined with out-of-network) 60 visits per person (combined with out-of-network)	 70% if Medically Necessary 60 days per person (combined with in-network) 60 visits per person (combined with in-network)
Mental Health Services/Substance Abuse Inpatient Coinsurance Calendar Year Maximum Outpatient Coinsurance Calendar Year Maximum Day Treatment/Partial Hospital Coinsurance Calendar Year Maximum *Preauthorization Required - See Contact Information*	 80% 30 days per person (combined with out-of-network) 60% 30 visits per person (combined with out-of-network) 80% 30 sessions per person (combined with out-of-network)	 50% 30 days per person (combined with in-network) 40% 15 visits per person (combined with in-network) 50% 15 sessions per person (combined with in-network)
Additional Surgical Opinion	90%; no deductible required	90%; no deductible required
Durable Medical Equipment/Prosthetic Devices Lifetime Maximum for Prosthetic Devices	80% (additional limitations apply) $25,000 (combined with out-of-network)	80% (additional limitations apply) $25,000 (combined with in-network)
Spinal Manipulation – Chiropractic or Medical Calendar Year Maximum Acupuncture included when Physician prescribed	$15 Copay per Visit 60 treatments up to $600 (combined with out-of-network)	70% 60 treatments up to $600 (combined with in-network)
Home Health Care Coinsurance Calendar Year Maximum	80% 40 visits (combined with out-of-network)	70% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	90% $500 (combined with out-of-network)	70% $500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy And Hospice Care	90%	70%
Treatment Of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum	90% $1,000 (combined with out-of-network) $2,000 (combined with out-of-network)	70% $1,000 (combined with in-network) $2,000 (combined with in-network)
Smoking Cessation Benefits Lifetime Maximum	50% One Smoking Cessation Program up to $500 per person (combined with out-of-network)	50% One Smoking Cessation Program up to $500 per person (combined with in-network)

Sav-Rx Prescription Drug Benefit	Prescription drug benefits are only covered when filled at a participating pharmacy.
Retail Pharmacy (34-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $10 You pay $20 You pay $35
Mail Order Pharmacy/Retail Maintenance Program (90-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $20 You pay $40 You pay $70
The Guardian Group Dental Expense Benefit	
Calendar Year Deductible - Individual - Family Deductible applies to Preventive, Primary and Major Care services, but not Orthodontic services	$50 $100
Coinsurance	80%
Calendar Year Maximum	$1,500 (combined dental and orthodontia limit)
Orthodontia (only eligible Dependent children under age 19) Coinsurance Calendar Year Maximum Lifetime Maximum	 50% $750 $1,500
Vision Care Benefits	**Administered by Professional Benefit Administrators, Inc.**
Covered Services	$200 per person in each 24-consecutive-month period
Hearing Care Benefits	**Administered by Professional Benefit Administrators, Inc.**
Hearing Exam	$75 per person per 24-consecutive-month period
Hearing Aid	$400 per person per 60-consecutive-month period

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

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

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

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	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	Telephone: 309-692-0860 or 866-692-0860 Fax: 309-692-0862 E-Mail Address: ncilhwf@ameritech.net
Medical, Vision and Hearing Care Benefits	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	Telephone: 800-435-5694 or 630-655-3755 Fax: 630-655-3781
Blue Cross Blue Shield of Illinois Participating Providers	Blue Cross Blue Shield of Illinois	Telephone: 800-810-2583 Web site: www.bcbsil.com
Prescription Drug Benefits	Sav-Rx	Telephone: 800-228-3108 Web site: www.savrx.com
Dental Benefits	The Guardian Group Group No. G 394470	Telephone: 800-541-7846
Member Assistance Plan (MAP)	Health Management Center, Inc. (HMC)	Telephone: 800-472-4992
Preauthorization		
Inpatient Hospitalization, outpatient surgeries, outpatient testing, and rehabilitation services	American Health Holding, Inc.	Telephone: 800-892-1893
Mental Health and Substance Abuse	Member Assistance Program (MAP)	Telephone: 800-472-4992
Transplant Benefits	American Health Holding, Inc.	Telephone: 800-892-1893

Note: If you do not obtain Preauthorization when required, your benefits may be reduced.

SCHEDULE OF BENEFITS (EFFECTIVE JULY 1, 2006)

Health Alliance Preferred Provider Organization (PPO) Plan		
Medical Benefits	*In-Network*	*Out-of-Network*
Calendar Year Deductible - Individual - Family	$400 $800	$600 $1,800
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Calendar Year Benefit	$250,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, and Rehabilitation Services *Preauthorization Required - See Contact Information*	$250 reduction in benefits	$250 reduction in benefits
Hospital Benefits (inpatient and outpatient)	90%	70%
Doctor's Office Visits	$20 Copay	40%
X-Rays and Labs, Including Pre-Admission Testing	90%	70%
Wellness, Preventative, Well Child, Well Baby Care Calendar Year Maximum Maximum In First Year Of Life	100% $400 $500	Not Covered
Emergency Room	$200 Copay	$200 Copay
Rehabilitation Services Skilled Nursing Facility Calendar Year Maximum Outpatient Calendar Year Maximum (Includes Physical and Occupational Therapy) *Preauthorization Required - See Contact Information*	90% 60 days per person (combined with out-of-network) 60 days per person (combined with out-of-network)	70% 60 days per person (combined with in-network) 60 days per person (combined with in-network)
Mental Health Services Inpatient Coinsurance Calendar Year Maximum Outpatient Coinsurance Calendar Year Maximum *Preauthorization Required - See Contact Information*	 80% 30 days per person (combined with out-of-network) 60% 30 visits per person (combined with out-of-network)	 60% 30 days per person (combined with in-network) 40% 30 visits per person (combined with in-network)
Substance Abuse Services Inpatient Coinsurance Calendar Year Maximum Outpatient Coinsurance Calendar Year Maximum *Preauthorization Required - See Contact Information*	 80% $8,000 per person (combined with out-of-network) 60% $2,000 per person (combined with out-of-network)	 60% $8,000 per person (combined with in-network) 40% $2,000 per person (combined with in-network)
Additional Surgical Opinion	90%; no deductible required	90%; no deductible required
Durable Medical Equipment/Prosthetic Devices Lifetime Maximum for Prosthetic Devices	80% (additional limitations apply) $25,000 (combined with out-of-network)	80% (additional limitations apply) $25,000 (combined with in-network)
Spinal Manipulation – Chiropractic or Medical Calendar Year Maximum Acupuncture included when Physician prescribed	$15 Copay per Visit 60 treatments up to $600 (combined with out-of-network)	70% 60 treatments up to $600 (combined with in-network)
Home Health Care Coinsurance Calendar Year Maximum	80% 40 visits per person (combined with out-of-network)	70% 40 visits per person (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	90% $500 (combined with out-of-network)	70% $500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy And Hospice Care	90%	70%
Treatment Of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum	90% $1,000 (combined with out-of-network) $2,000 (combined with out-of-network)	70% $1,000 (combined with in-network) $2,000 (combined with in-network)
Smoking Cessation Benefits Lifetime Maximum	50% One Smoking Cessation program up to $500 per person (combined with out-of-network)	50% One Smoking Cessation program up to $500 per person (combined with in-network)

Sav-Rx Prescription Drug Benefit	Prescription drug benefits are only covered when filled at a participating pharmacy.
Retail Pharmacy (34-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $10 You pay $20 You pay $35
Mail Order Pharmacy/Retail Maintenance Program (90-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $20 You pay $40 You pay $70
The Guardian Group Dental Expense Benefit	
Calendar Year Deductible - Individual - Family Deductible applies to Preventive, Primary and Major Care services, but not Orthodontic services	$50 $100
Coinsurance	80%
Calendar Year Maximum	$1,500 (combined dental and orthodontia limit)
Orthodontia (only eligible Dependent children under age 19) Coinsurance Calendar Year Maximum Lifetime Maximum	 50% $750 $1,500
Vision Care Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**
Covered Services	$200 per person in each 24-consecutive-month period
Hearing Care Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**
Hearing Exam	$75 per person per 24-consecutive-month period
Hearing Aid	$400 per person per 60-consecutive-month period

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

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

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

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	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	Telephone: 309-692-0860 or 866-692-0860 Fax: 309-692-0862 E-Mail Address: ncilhwf@ameritech.net
For Vision and Hearing Care Benefits	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	Telephone: 800-435-5694 or 630-655-3755 Fax: 630-655-3781
Medical and Mental Health and Substance Abuse Benefits From Health Alliance Plan	Health Alliance Medical Plan 301 S. Vine St. Urbana, IL 61801-3347	Telephone: 217-337-8400 or 800-322-7451
Health Alliance Participating Providers	Health Alliance Medical Plan 301 S. Vine St. Urbana, IL 61801-3347	Telephone: 800-322-7451 Web site: www.healthalliance.org (Member sign-up required)
Prescription Drug Benefits	Sav-Rx	Telephone: 800-228-3108 Web site: www.savrx.com
Dental Benefits	The Guardian Group Group No. G 394470	Telephone: 800-541-7846
Preauthorization		
Inpatient Hospitalization, outpatient surgeries, outpatient testing, and rehabilitation services	Health Alliance Plan	Telephone: 800-322-7451
Mental Health and Substance Abuse	Health Alliance Plan	Telephone: 217-337-8400 or 800-322-7451
Transplant Benefits	Health Alliance Plan	Telephone: 800-332-7451

Note: If you do not obtain Preauthorization when required, your benefits may be reduced.

SCHEDULE OF BENEFITS (EFFECTIVE JULY 1, 2006)

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan			
Medical Benefits	*HFN EPO Network – Only Hospital-Based Benefits*	*PPO Network*	*Out-of-Network*
Calendar Year Deductible - Individual - Family	$100 $200	$400 $800	$600 $1,800
Hospital Benefits Inpatient Outpatient	$200 Copay per admission $100 Copay per incident	90% 90%	60% 60%
X-Rays And Labs. Including Pre-Admission Testing	100%	90%	60%
Out-Of-Pocket Maximum - Individual - Family	$2,500 $7,500		Unlimited Unlimited
Maximum Calendar Year Benefit	$250,000 per person		
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, and Rehabilitation Services	$250 reduction in benefits		$250 reduction in benefits
Doctor's Office Visits	$20 Copay		40%
Wellness, Preventative, Well Child, Well Baby Care Calendar Year Maximum Maximum In First Year Of Life	100% $400 $500		Not Covered
Emergency Room	$200 Copay		$200 Copay
Rehabilitation Services/Skilled Nursing Facility Inpatient Coinsurance Calendar Year Maximum Outpatient Coinsurance Calendar Year Maximum *Maximums are combined for all providers* *Preauthorization Required - See Contact Information*	 100% if Medically Necessary 60 days per person 100% after $25 Copay per visit 60 visits per person		 70% 60 days per person 70% 60 visits per person
Mental Health Services/Substance Abuse Inpatient Coinsurance Calendar Year Maximum Outpatient Coinsurance Calendar Year Maximum Day Treatment/Partial Hospital Coinsurance Calendar Year Maximum *Preauthorization Required - See Contact Information*	 80% 30 days per person (combined with out-of-network) 60% 30 visits per person (combined with out-of-network) 80% 30 sessions per person (combined with out-of-network)		 50% 30 days per person (combined with in-network) 40% 15 visits per person (combined with in-network) 50% 15 sessions per person (combined with in-network)
Additional Surgical Opinion (No Deductible)	90%; no deductible required		60%; no deductible required
Durable Medical Equipment/Prosthetic Devices Lifetime Maximum for Prosthetic Devices	80% (additional limitations apply) $25,000 (all providers combined)		60% (additional limitations apply) $25,000 (all providers combined)
Spinal Manipulation – Chiropractic or Medical Calendar Year Maximum (all providers combined) Acupuncture included when Physician prescribed	$15 Copay per Visit 60 treatments up to $600		60% 60 treatments up to $600
Home Health Care Coinsurance Calendar Year Maximum	80% 40 visits (combined with EPO and out-of-network)		60% 40 visits (combined with EPO and PPO)
Podiatry Services Orthotic Calendar Year Maximum	90% $500 (combined with out-of-network)		60% $500 (combined with in-network)

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan			
Medical Benefits	*HFN EPO Network – Only Hospital-Based Benefits*	*PPO Network*	*Out-of-Network*
Other Covered Services, Ambulance Services, Radiation Therapy, and Hospice Care	90%		60%
Treatment Of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum *Maximums are for all providers combined*	90% $1,000 $2,000		70% $1,000 $2,000
Smoking Cessation Benefits Lifetime Maximum (for all providers combined)	50% One Smoking Cessation program up to $500 per person		50% One Smoking Cessation program up to $500 per person
Sav-Rx Prescription Drug Benefit	**Prescription drug benefits are only covered when filled at a participating pharmacy.**		
Retail Pharmacy (34-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $10 You pay $20 You pay $35		
Mail Order Pharmacy/Retail Maintenance Program (90-Day Supply) Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	 You pay $20 You pay $40 You pay $70		
The Guardian Group Dental Expense Benefit			
Calendar Year Deductible - Individual - Family Deductible applies to Preventive, Primary and Major Care services, but not Orthodontic services	$50 $100		
Coinsurance	80%		
Calendar Year Maximum	$1,500 (combined dental and orthodontia limit)		
Orthodontia (only eligible Dependent children under age 19) Coinsurance Calendar Year Maximum Lifetime Maximum	 50% $750 $1,500		
Vision Care Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**		
Covered Services	$200 per person in each 24-consecutive-month period		
Hearing Care Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**		
Hearing Exam	$75 per person per 24-consecutive-month period		
Hearing Aid	$400 per person per 60-consecutive-month period		

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

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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	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	Telephone: 309-692-0860 or 866-692-0860 Fax: 309-692-0862 E-Mail Address: ncilhwf@ameritech.net
Medical, Vision, or Hearing Care Benefits	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	Telephone: 800-435-5694 or 630-655-3755 Fax: 630-655-3781
HFN Participating Providers	HFN	Telephone: 800-295-5444 Web site: www.hfninc.com Log on to HFN 20 under Provider Search
Prescription Drug Benefits	Sav-Rx	Telephone: 800-228-3108 Web site: www.savrx.com
Dental Benefits	The Guardian Group Group No. G 394470	Telephone: 800-541-7846
Member Assistance Plan (MAP)	Health Management Center, Inc. (HMC)	Telephone: 800-472-4992
Preauthorization Inpatient Hospitalization, outpatient surgeries, outpatient testing, and rehabilitation services	American Health Holding, Inc.	Telephone: 800-892-1893
Mental Health and Substance Abuse	Member Assistance Program (MAP)	Telephone: 800-472-4992
Transplant Benefits	American Health Holding, Inc.	Telephone: 800-892-1893

Note: If you do not obtain Preauthorization when required, your benefits may be reduced.

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