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SUMMARY OF MATERIAL MODIFICATIONS

Date: January 2025

To: Plan Participants and Their Eligible Dependents Enrolled in the North Central Illinois Laborers' Health and Welfare Fund

From: The Board of Trustees

The Trustees of the North Central Illinois Laborers' Health and Welfare Fund (the "Fund") is notifying you of important changes being made to your benefits. This Summary of Material Modifications (SMM) provides details about the Plan's coverage of Telehealth Services and out-of-network Rehabilitation services, Habilitative services, Skilled Nursing Facilities, and Residential Treatment.

Please read this SMM in its entirety to make sure you understand your enhanced health care coverage.

TELEHEALTH COVERAGE AT 100% FROM RELYMD AND REGULAR COST SHARING FROM OTHER PROVIDERS EFFECTIVE MAY 12, 2023

As a reminder, the Plan provides Telehealth Service benefits through RelyMD. Through the RelyMD app, you and your family can receive treatment for many common illnesses and injuries. All services you receive through RelyMD are free. You will receive complete information on how to sign-up for this service through Professional Benefit Administrators (PBA).

Effective May 12, 2023, Telehealth Services through a Physician's office or from any other in-network provider (other than the Fund's Telehealth Service provider) are covered at applicable in-network cost sharing. Telehealth Services for an online Doctor's Office Visit is subject to a $20.00 copay, and a Specialist Office Visit is subject to a $50.00 copay. Other covered services, if applicable, are subject to standard in-network cost sharing such as coinsurance.

Telehealth Services received from out-of-network providers will continue to be paid in accordance with the Plan's out-of-network benefit provisions (e.g. 50% coinsurance for Doctor's Office Visit or Specialist Visit).

Telehealth Services are defined as the use of digital information and virtual technologies, i.e. computer, tablet, mobile device, for remote management of an individual's health.

Note that the Plan previously covered other Telehealth Services on a temporary basis during the COVID-19 Public Health Emergency.

NEW – OUT-OF-NETWORK REHABILITATION SERVICES, HABILITATIVE SERVICES, SKILLED NURSING FACILITIES, AND RESIDENTIAL TREATMENT COVERED EFFECTIVE JANUARY 1, 2025

Effective January 1, 2025, the Plan will cover both in-network and out-of-network providers and facilities for inpatient Rehabilitation Services, Habilitative Services, Skilled Nursing Facilities, and Residential Treatment. Out-of-network inpatient Rehabilitation Services, Habilitative Services, Skilled Nursing Facilities, and Residential Treatment will be subject to standard cost-sharing (coinsurance and deductible) for out-network inpatient services. In addition, please remember that you must obtain pre-authorization from the Plan prior to any out-of-network inpatient treatment to avoid a $250 penalty.

Please also refer to the Plan's Schedule of Benefits effective January 1, 2025.

FINAL NOTE

Please share this SMM with your family members and store it with your Summary Plan Description (SPD)/Plan Document booklet for easy reference.

If you have any questions regarding the benefits discussed in this SMM or your Plan benefits in general, do not hesitate to contact the Fund Office at (309) 692-0860 or (866) 692-0860.

This Summary of Material Modifications provides only highlights of recent changes to the North Central Illinois Laborers' Health and 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.

UPDATED SCHEDULE OF BENEFITS FOR BLUECROSS BLUESHIELD OF ILLINOIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JANUARY 1, 2025

The following rows of the Schedule of Benefits for the BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan have been updated to add out-of-network inpatient Rehabilitation Services, Habilitation Services, Residential Treatment and Skilled Nursing care:

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
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
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility		
Inpatient - Coinsurance	80% if Medically Necessary	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
- Calendar Year Maximum	60 days per person	60 days per person (combined with in-network)
Outpatient - Coinsurance	80% if Medically Necessary	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
- Calendar Year Maximum	60 visits per person (combined with out-of- network)	60 visits per person (combined with in-network)

Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Mental Health Services/Substance Abuse		
Inpatient - Coinsurance	80%	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Outpatient Copay/Coinsurance	$20 copay office visit;	50% if Medically Necessary for outpatient services, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Preauthorization of Out-of-Network Inpatient Services Required – Call 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*	no deductible required (outpatient only)	no deductible required (outpatient only)

UPDATED SCHEDULE OF BENEFITS FOR CIGNA PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JANUARY 1, 2025

The Schedule of Benefits for the CIGNA Preferred Provider Organization (PPO) Plan have been updated to add out-of-network inpatient Rehabilitation Services, Habilitation Services, Residential Treatment and Skilled Nursing care:

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
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
Rehabilitation Services/Habilitation Services/Skilled Nursing Facility		
Inpatient - Coinsurance	80%	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Calendar Year Maximum	60 days per person	60 days per person (combined with in-network)
Outpatient - Coinsurance	80%	50% if Medically Necessary for outpatient services, except that an Emergency Medical Condition is covered as an Emergency Service
Calendar Year Maximum	60 visits per person (combined with out-of- network)	60 visits per person (combined with in- network)

Preauthorization Required for Habilitation Services and Outpatient Rehabilitation Services

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Mental Health Services/Substance Abuse		
Inpatient - Coinsurance	80%	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Outpatient - Copay/Coinsurance	$20 copay office visit	50% if Medically Necessary, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Preauthorization of Out-of-Network Inpatient Services Required - Call 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*	no deductible required (outpatient only)	no deductible required (outpatient only)

UPDATED SCHEDULE OF BENEFITS FOR BLUECROSS BLUESHIELD OF ILLINOIS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JANUARY 1, 2025

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

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

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

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

Delta Dental of Illinois Dental Benefits	Coverage		
Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*)	$50 Individual/ $100 Family		
Dental Benefits Calendar Year Maximum	$1,500 [3]		
Type of Dental Services	**Delta Dental PPO Network[2]**	**Delta Dental Premier Network[2]**	**Out-of-Network[2]**
Preventive/Diagnostic Care Services Coinsurance paid by the Plan	100% of reduced fee (deductible applies)	100% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Primary (Basic) Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Major Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Orthodontia Benefits (only for eligible Dependent children under age 19) - Coinsurance paid by the Plan	50% of reduced fee	50% of maximum plan allowance	50% of maximum plan allowance
Vision Benefits	**Administered by Professional Benefit Administrators, Inc.**		
Covered Services	$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 ▪ Gene Therapy	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.

UPDATED SCHEDULE OF BENEFITS FOR CIGNA PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - EFFECTIVE JANUARY 1, 2025

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

Medical Benefits		In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1]	- Individual - Family	$500 $1,500	$1,000 $4,500
Out-of-Pocket Maximum	- Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit		Unlimited	Unlimited
Penalty for Failure to Preauthorize Outpatient Surgeries, Outpatient Rehabilitation, Habilitation Services, Inpatient Hospice Care and Transplant Benefits		$250 reduction in benefits	$250 reduction in benefits
Hospital Benefits (inpatient and outpatient) *Preauthorization of Out-of-Network Inpatient Hospital Services Required*		80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act Preauthorization not required in the case of an Emergency Medical Condition covered by the No Surprises Act
Outpatient Surgical Procedures[1] *Preauthorization Required*		80%; no deductible required	50%; no deductible required, except 80%; no deductible required in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Primary Care Doctor's Office Visits		$20 copay	50%
Specialist Office Visit		$50 copay	50%
X-Rays and Labs (including Pre-Admission Testing)		80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Wellness, Preventive, Well Child, Well Baby Care1		100%; no deductible required	Not Covered
Maternity Services		80%	50%, except 80% in the case of an Emergency Medical Condition or a Non-Emergency Medical Condition covered by the No Surprises Act
Urgent Care		80%	80%
Emergency Services		$200 copay	$200 copay
Ambulance Service		80%	80%
Eligible air ambulance services will be paid at 300% of the Medicare Reimbursement Rate			
Telehealth Services through RelyMD		100%; no deductible required	n/a
Telehealth Services Through Any Other Provider		Applicable cost sharing	Applicable cost sharing
Treatment of Temporomandibular Joint (TMJ)		80%	50%
Preparatory Work Lifetime Maximum		$1,000 (combined with out-of-network)	$1,000 (combined with in-network)
Surgery Lifetime Maximum		$2,000 (combined with out-of-network)	$2,000 (combined with in-network)
Smoking Cessation Benefits		80%	50%
Durable Medical Equipment/Prosthetic Devices		80% (additional limitations apply)	50% (additional limitations apply)

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

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

Delta Dental of Illinois Dental Benefits [2]	Coverage		
Calendar Year Deductible (*applies to Preventive/Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*)	$50 Individual/ $100 Family		
Dental Benefits Calendar Year Maximum	$1,500 [3]		
Type of Dental Services	**Delta Dental PPO Network2**	**Delta Dental Premier Network2**	**Out-of-Network2**
Preventive/Diagnostic Care Services Coinsurance paid by the Plan	100% of reduced fee (deductible applies)	100% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Primary (Basic) Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Major Care Services Coinsurance paid by the Plan	80% of reduced fee (deductible applies)	80% of maximum plan allowance (deductible applies)	80% of maximum plan allowance (deductible applies)
Orthodontia Benefits (only for eligible Dependent children under age 19) – Coinsurance paid by the Plan	50% of reduced fee	50% of maximum plan allowance	50% of maximum plan allowance
Vision Benefits	**Administered by Professional Benefit Administrators, Inc.**		
Covered Services	$250 per person per calendar year[3]		
Hearing Benefits	**Administered by Professional Benefit Administrators, Inc.**		
Hearing Benefits Lifetime Maximum	$5,000[4]		

1 The deductible applies to all covered benefits, except that you do not need to satisfy the deductible and it does not apply to surgical procedures performed on the day of surgery, second surgical opinion benefits, or outpatient mental health, in-network wellness, preventive, well-child, and well-baby care services.

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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

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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 ▪ Gene Therapy	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.