Amendment No. 12 to the
North Central Illinois Laborers' Health and Welfare Fund
Summary Plan Description and Plan Document, 2007 Edition

The Board of Trustees hereby adopts the following amendment to the Summary Plan Description and Plan Document, 2007 Edition:

1. Effective July 1, 2011, a new section *Rescission of Coverage* is added on page 23 before the section entitled *Special Enrollment*, as follows:

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – going forward – once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

2. Effective July 1, 2011, the *Preauthorization* section on page 44 is deleted and is replaced with the following:

Preauthorization

You must have non-emergency Hospitalization, outpatient surgery, Rehabilitation Services, and transplant services authorized in advance. If you do not have these benefits Preauthorized, your benefits will be subject to the penalty listed in the *Schedule of Benefits*. To obtain Preauthorization, you or your Physician should call the number listed on your Plan ID card or on the Contact Information page at least three days before the Hospitalization or treatment. You do

not need to follow Preauthorization procedures for an emergency admission or treatment. In addition, the Plan does not require you to obtain Preauthorization for a colonoscopy procedure.

3. Effective July 1, 2011, the third paragraph of item 1 in the *Medical Covered Charges* section on page 45 is deleted and is replaced with the following:

Note that all non-emergency Hospital admissions must be Preauthorized in advance of the stay. However, Preauthorization for maternity admissions is not required. You do not need to follow Preauthorization procedures for an emergency admission or treatment. In addition, the Plan does not require you to obtain Preauthorization for a colonoscopy procedure. The organization responsible for Preauthorization under your medical program (as specified on your medical ID card, or the Member Assistance Program, in the case of inpatient mental health and substance abuse treatment) will evaluate the proposed admission plan and length of stay based on individual treatment needs. If you do not request Preauthorization when required, you will be subject to the penalty listed in the *Schedule of Benefits*.

4. Effective July 1, 2011, the *Prosthetic Appliances* section on page 51 is amended to remove the call-out and the last bullet in the section, as follows:

Prosthetic Appliances

You and your eligible Dependents are entitled to benefits for prosthetic appliances (artificial limbs or eyes) for the initial replacement of natural limbs or eyes. Subsequent expenses for such artificial limbs or eyes are subject to the following guidelines:

- Coverage is provided for a replacement prosthetic device for children up to age 18 when replacement is necessary due to growth of the child and is Medically Necessary as determined by the Physician.

- Coverage is provided for total replacement of such prosthetic device for adults, provided that five years have elapsed since the previous device was purchased. This replacement also must be Medically Necessary as determined by the Physician.

- Replacement because of damage, as might occur in an accident, is covered when Medically Necessary as determined by the Physician. Payment for repair or replacement may be contingent upon any third-party insurance that is liable for payments under the Plan's Subrogation and Reimbursement provisions.

5. Effective July 1, 2010, the *Wellness, Preventive, Well-Child and Well-Baby Care Benefit* section beginning on page 52 is deleted and is replaced with the following:

Preventive Services, Wellness, Well-Child and Well-Baby Care Benefits

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,

- Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics *Bright Futures* guidelines.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the Participant or Dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copay, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

Physical Examination Benefit: The Plan will cover the expense related to a routine physical examination (including routine OB/GYN exams) by a Physician. Routine physical examinations include baseline examinations, periodic examinations and those examinations performed due to a relevant family history.

Preventive Services Covered with No Cost-Sharing: The following benefits are available under the Fund's Preventive Services Benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Testing for asbestos/spirometry on Participants and Dependents will only be covered under the annual physical examination benefit charges for respiratory clearance or as required by federal law. The asbestos/spirometry tests must be performed in conjunction with an annual physical.

Physical examinations that are for purposes of meeting employment requirements will be covered by the Plan, but only if they are performed as part of the in-network annual physical examination. Such examinations will be subject to the benefit limitations listed on the Schedule of Benefits for wellness expenses and will be subject to the provisions governing the Plan's use and disclosure of your protected health information on page 102. These examinations must be performed in conjunction with an in-network annual physical examination.

Your eligible Dependents through the age of 21 are entitled to coverage for well-child care benefits when provided by a network provider. Well-child care benefits include:

- Physical examinations; and
- Well-Child Required Immunizations, as recommended by the American Academy of Pediatrics.

The Plan also covers the immunization of girls and young women, ages 13 to 33, to prevent the human papillomavirus (HPV), a virus that can cause cervical cancer and other diseases.

Please note that Well-Child Required Immunization charges will be reimbursed when the service is rendered by a local Public Health Department but only after proof of payment is submitted to the Fund Office.

Covered Preventive Services for Adults

a. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
b. Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
c. Aspirin use is not payable because it is an over-the-counter medicine, nor is counseling for aspirin use payable, because the service is included in the payment for a Physician visit.
d. Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician visit.
e. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20 and older if they are at increased risk for coronary heart disease, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
f. Colorectal Cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient.
g. Depression screening for adults.
h. Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
i. Diet counseling for adults at higher risk for chronic disease, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
j. HIV screening for all adults at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
k. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
l. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
m. Tobacco Use screening for all adults and cessation interventions for tobacco users.
n. Syphilis screening for all adults at increased risk of infection, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.

Covered Preventive Services for Women, Including Pregnant Women

a. Anemia screening on a routine basis for pregnant women.
b. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
c. Medically Necessary BRCA counseling about genetic testing for women at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling under the MAP program if Medically Necessary.
d. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every year for women aged 40 and older.
e. Breast Cancer Chemoprevention counseling for women at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.

f. Breast Feeding interventions to support and promote breast feeding. Breast feeding intervention is not payable as a separate claim, because the service is included in the payment for a Physician or OB/GYN visit.
g. Cervical Cancer screening for sexually active women who have a cervix at intervals to be determined by the woman's Physician based on age and whether the woman has had adequate recent screening with normal Pap results.
h. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
i. Folic Acid supplements for women who are planning or capable of pregnancy, at prescription strength only if the woman obtains a prescription. Over-the-counter folic acid supplements are not covered.
j. Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors). The Plan will pay for the most cost-effective test methodology only.
k. Hepatitis B screening for pregnant women at their first prenatal visit.
l. Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Routine screening will begin at age 60 for women at increased risk for osteoporotic fractures. The Plan will pay for the most cost-effective test methodology only.
m. Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
n. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
o. Syphilis screening for all pregnant women or other women at increased risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.

Covered Preventive Services for Children

a. Well baby and well child visits from age newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." (See: http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%2010 1107.pdf). Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%.

   Visits will include the following age-appropriate screenings and assessments:
   - Developmental screening for children under age 3, and surveillance throughout childhood.
   - Behavioral assessments for children of all ages.
   - Vision screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.
   - Hearing screening.
   - Height, Weight and Body Mass Index measurements for children.
   - Autism screening for children at 9, 18, and 30 months.
   - Alcohol and Drug Use assessments for adolescents.
   - Hematocrit or Hemoglobin screening for children.
   - Lead screening for children at risk of exposure.
   - Tuberculin testing for children at higher risk of tuberculosis.

- Dyslipidemia screening for children at higher risk of lipid disorders.
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.
- Cervical Dysplasia screening for sexually active females.
- Oral Health risk assessment.

b. Newborn screenings:
   - Hemoglobinopathies or sickle cell screening.
   - Phenylketonuria (PKU) screening.
   - Hypothyroidism screening for newborns.

c. Screening for oral fluoride supplementation at recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride.

d. Screening for iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.

e. Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.

f. HIV screening for adolescents at increased risk of infection, as determined by their Physician based on medical history, family medical history, or membership in a higher risk group.

Immunizations

Routine adult immunizations are covered for Participants and Dependents who meet the age and gender requirements and medical criteria recommended by the Centers for Disease Control and Prevention (CDC).

a. Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:
   - Diphtheria/tetanus/pertussis (DTP).
   - Measles/mumps/rubella (MMR).
   - Poliomyelitis.
   - Influenza.
   - Human papillomavirus (HPV).
   - Pneumococcal (polysaccharide).
   - Hepatitis A.
   - Hepatitis B.
   - Meningococca.

b. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
   - Hepatitis B.
   - Rotavirus.
   - Diphtheria, Tetanus, Pertussis.
   - Haemophilus influenzae type b.
   - Pneumococcal.
   - Inactivated Poliovirus.
   - Influenza.
   - Measles, Mumps, Rubella.
   - Varicella.
   - Hepatitis A.
   - Meningococcal.

- Human papillomavirus (HPV).

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

a. If a preventive item or service is billed separately from an office visit that is not part of a physical exam, then the Plan will impose cost sharing with respect to the office visit.
b. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
c. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit that is not a physical exam, but not for the lab work. In this case, the lab work will be paid at 100%. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Preventive Services Coverage Limitations and Exclusions

1. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable Plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or Dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

2. Services covered under the Preventive Services Benefit are not also payable under other portions of the Plan.

3. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit.

4. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.

5. Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

6. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

   a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
   b. When related to judicial or administrative proceedings;
   c. When related to medical research or trials; or
   d. When required to maintain employment or a license of any kind, unless performed as part of the in-network annual physical examination.

7. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit. For example, the following drugs, medicines, vitamins, and supplements are not covered:

   a. Aspirin for any reason, including for prevention;
   b. Chemoprevention for any indication, including but not limited to for breast cancer;
   c. Supplements, including but not limited to oral fluoride supplements and folic acid supplements; and
   d. Tobacco cessation products, drugs, or medicine.

6. Effective July 1, 2011, the call-out in the *Dental Benefits* section on page 61 is amended to remove the second sentence as follows:

The Plan pays a maximum per person each year for dental and orthodontic expenses as listed on the Schedule of Benefits. Orthodontic expenses are provided for Dependent children only up to age 19.

7. Effective July 1, 2011, the third paragraph in the *Dental Benefits* section on page 61 is deleted and is replaced with the following:

This deductible is separate from the medical deductible. After you meet the dental deductible, the Plan pays a percentage of covered dental expenses up to a per person maximum each year as listed on the Schedule of Benefits. The Plan pays a percentage of covered orthodontic expenses for each eligible Dependent child under age 19.

8. Effective July 1, 2011, the *Orthodontic Services* section on page 64 is deleted and is replaced with the following:

Orthodontic treatment is covered for eligible Dependent children only and is limited to eligible Dependent children under age 19. The Plan covers orthodontic services as listed on the Schedule of Benefits.

If you have arranged a payment plan with your orthodontist, you will need to provide the Plan with information confirming when orthodontic treatment will begin and whether payments are being made as scheduled. Whenever possible, payments are made directly to the orthodontist, so you should encourage the orthodontist to submit bills directly to Delta Dental of Illinois. The orthodontist must submit a detailed billing for services. The Plan will not make payments based on payment coupons. However, reimbursements for orthodontic expenses may be made directly to you based on the detailed bills submitted by the orthodontist.

9. Effective July 1, 2011, the *Urgent Care Claims* section on page 89 is deleted and is replaced with the following:

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment with respect to which the application of the periods for making pre-service claim determinations:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Example

You request Preauthorization of your inpatient mental health treatment after your Physician recommends the hospitalization or other inpatient treatment for your Illness.

Whether your claim is an urgent care claim is determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an urgent care claim within the meaning described above, will be treated as an urgent care claim.

The Plan may make a determination on your claim orally as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan. If the determination is provided orally, it will also be confirmed in writing within 3 days after the oral notice.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you will be notified as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be decided on the basis of the information that the Plan has and your claim may be denied. Notice of the decision will be provided no later than 24 hours after the Plan receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

10. Effective July 1, 2011, the *Notice of Claim Denial or Adverse Benefit Determination* section on page 92 is deleted and is replaced with the following:

Notice of Claim Denial or Adverse Benefit Determination

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:
    - A determination of an individual's eligibility to participate in a plan;
    - A determination that a benefit is not a covered benefit; or
    - A beneficiary's eligibility to participate in this Plan;
- A reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Contents of Notice of Adverse Benefit Determination: The Plan will provide you with a notice of the initial adverse benefit determination on your claim within certain time frames after your claim is received, as previously described. The notice will provide:

- The identity of the claim involved;
- The specific reason or reasons for the claim denial or other adverse benefit determination, including any Plan standards used in denying the claim;
- Specific reference to the pertinent Plan provisions upon which the decision is based;
- A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- A copy of the Plan's internal appeal procedures and external review processes, time periods to appeal your claim, and information regarding how to initiate an appeal;
- A statement that you have the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- A statement that you may bring a lawsuit under ERISA Section 502(a) after the appeal of your claim is completed;

- If the denial was based on an internal rule, guideline, protocol or similar exclusion or limit, a statement that a copy of such internal rule, guideline, protocol, or similar criteria that was relied on will be provided free of charge to you, upon request;

- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of such scientific or clinical judgment for the denial will be provided free of charge to you upon request;

- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes; and

- A description of the expedited review process applicable to urgent care claims if the notice is a denial of an urgent care claim.

For urgent care claims and pre-service claims, you will receive notice of the determination even when your claim is approved.

11. Effective July 1, 2011, the *Notice of Decision on Review* section on page 94 is deleted and is replaced with the following:

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The identity of the claim involved;

- The specific reason(s) for the determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

- Reference to the specific Plan provision(s) on which the determination is based;

- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

- An explanation of the Plan's external review procedures, along with any time limits and information regarding how to initiate an external review; and

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the Plan's terms to your claim, or a statement that it is available upon request at no charge.

12. Effective July 1, 2011, the new sections *External Review Procedures* and *Elimination of Conflict of Interest* are added after the *Legal Proceedings* section on page 94, as follows:

External Review Procedures

For purposes of this section, references to "you" or "your" include you, your covered Dependents, and you and your covered Dependents' authorized representatives; and references to "Plan" include the Plan and its designees.

This External Review process is intended to comply with the external review requirements of the Patient Protection and Affordable Care Act of 2010 (ACA), as set forth in Interim Final Regulations implementing the Act, in Technical Release 2010-01, in an amendment to the Interim Final Regulations issued on June 22, 2011, and in Technical Release 2011-02.

If your appeal of a claim, whether pre-service, post-service or urgent care claim, is denied, and that adverse benefit determination involved a medical judgment or a rescission of coverage, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

I. External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all of the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good faith exchange of information or are not reflective of a pattern or practice of non-compliance.

A. *Preliminary Review*

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(b) The Adverse Determination concerns a claim involving medical judgment or rescission of coverage;

(c) The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;

(d) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and

(e) You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

(a) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(b) If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. ***Review By Independent Review Organization (IRO)***

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan will rotate assignment among IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within ten (10) business days. Information submitted after ten (10) business days may not be considered by the IRO.

2. Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.

3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

6. The assigned IRO's decision notice will contain:

   (a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);

   (b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

   (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

   (d) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

   (e) A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;

   (f) A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

   (g) A statement that judicial review may be available to you; and

   (h) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

II. Expedited External Review of Claims

You may request an expedited external review if:

(a) You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously

jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

(b) You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

A. *Preliminary Review*

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

B. *Review By Independent Review Organization*

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at the above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in section I.B.6, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

III. After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IV. Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under State or Federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

13. Effective July 1, 2011, the definition of Dependent beginning on page 112 in the *Definitions* section is deleted and is replaced with the following:

Dependent means:

- Your lawful spouse;
- Your child who has not reached his/her 26th birthday and is your:
  - Natural child;
  - Legally adopted child or child placed for adoption;
  - Step-child for whom you have completed the Fund's *Dependent Eligibility Affidavit* form; or
- Child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO).
- An unmarried child for whom you have been appointed legal guardian, as specified in the order appointing guardianship and the child lives with you for more than one-half of the calendar year and receives more than one-half of his or her financial support from you during the calendar year.
- Any unmarried child listed above, at any age, who is permanently and totally disabled due to a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more if the child:
  - Sustained such disability before the child reached age 26;
  - Is dependent on you for more than 50% of his/her financial support during the calendar year (for the full year for legal guardianship);

- Resides with you for more than 50% of the calendar year; and
- Is dependent on you for lifetime care and supervision.

You must provide proof of incapacity and dependency when requested by the Plan, but not more often than once a year.

14. Effective July 1, 2011, the Schedules of Benefits are deleted and are replaced with the Schedules of Benefits at Attachment A to this Amendment.

IN WITNESS WHEREOF, as authorized by the Board of Trustees, this amendment to the North Central Illinois Laborers' Health and Welfare Fund Summary Plan Description and Plan Document, 2007 Edition, is adopted as of the _____ day of _____ 2011.

The Board of Trustees, by:

Chairman

Secretary

Appendix A

Schedules of Benefits

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	In-Network (Illinois Providers Only)	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$500 $1,000	$1,000 $3,000
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	$300,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	$250	$250
Hospital Benefits (inpatient and outpatient)	80%	60%
Outpatient Surgical Procedures[1]	80%; no deductible required	60%; no deductible required
Doctor's Office Visits	$20 copay	40%
X-Rays and Labs (including Pre-Admission Testing)	80%	60%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Emergency Room	$200 copay	$200 copay
Rehabilitation Services/Skilled Nursing Facility Coinsurance Calendar Year Maximum Per Person - Inpatient - Outpatient (Includes Physical and Occupational Therapy) *Preauthorization Required.*	 80% if Medically Necessary 60 days (combined with out-of-network) 60 visits (combined with out-of-network)	 60% if Medically Necessary 60 days (combined with in-network) 60 visits (combined with in-network)
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance Day Treatment/Partial Hospital - Coinsurance *Preauthorization of Inpatient Services Required - Call MAP.*	 80% Call MAP for in-network providers $20 copay 80%	 60% 40% 60%
Additional Surgical Opinion[1]	80%; no deductible required	80%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	80% (additional limitations apply)
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)	60% 60 treatments up to $600 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	60% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	60% $500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy and Hospice Care	80%	60%
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)	60% $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)

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Sav-Rx Prescription Drug Benefit	***Prescription drug benefits are only covered when filled at a participating pharmacy.***		
Retail Pharmacy Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 34-day supply, you pay: $10 $20 $35		
Mail Order Pharmacy/Retail Maintenance Program Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 90-day supply, you pay: $20 $40 $70		
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 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 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 the Summary Plan Description for information about additional benefits that are applicable only to Eligibility A Employees.

BlueCross BlueShield of Illinois Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Continuing Eligibility For Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail]
Medical, Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
Blue Cross Blue Shield of Illinois Participating Providers	Blue Cross Blue Shield of Illinois	800-810-2583 [phone] www.bcbsil.com [web site]
Preauthorization ▪ Inpatient Hospitalization, outpatient surgeries, rehabilitation services, and Transplant Benefits	American Health Holding, Inc.	800-892-1893 [phone]
▪ Inpatient Mental Health and Substance Abuse	Member Assistance Program (MAP) through MHN	800-472-4992 [phone]
Member Assistance Plan (MAP)	MHN	800-472-4992 [phone]
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

Note: If you do not obtain Preauthorization when required, you will be subject to the penalty listed in the *Schedule of Benefits*.

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	In-Network	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$500 $1,000	$1,000 $3,000
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	Unlimited Unlimited
Maximum Medical and Prescription Drug Calendar Year Benefit	$300,000 per person	
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health Services, and Inpatient Substance Abuse Treatment	$250	$250
Hospital Benefits (inpatient and outpatient)	80%	60%
Outpatient Surgical Procedures[1]	80%; no deductible required	60%; no deductible required
Doctor's Office Visits	$20 copay	40%
X-Rays and Labs (including Pre-Admission Testing)	80%	60%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Emergency Room	$200 copay	$200 copay
Rehabilitation Services/Skilled Nursing Facility Coinsurance Calendar Year Maximum Per Person - Inpatient - Outpatient (Includes Physical and Occupational Therapy) *Preauthorization Required.*	80% 60 days (combined with out-of-network) 60 days (combined with out-of-network)	60% 60 days (combined with in-network) 60 days (combined with in-network)
Mental Health and Substance Abuse Services Inpatient - Coinsurance Outpatient - Copay/Coinsurance *Preauthorization of Inpatient Services Required -*	 80% $20 copay	 60% 40%
Additional Surgical Opinion[1]	80%; no deductible required	80%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	80% (additional limitations apply)
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)	60% 60 treatments up to $600 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with out-of-network)	60% 40 visits (combined with in-network)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	60% $500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy and Hospice Care	80%	60%
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)	60% $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 (combined with out-of-network)	50% One Smoking Cessation program up to $500 (combined with in-network)

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Sav-Rx Prescription Drug Benefit	***Prescription drug benefits are only covered when filled at a participating pharmacy.***		
Retail Pharmacy Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 34-day supply, you pay: $10 $20 $35		
Mail Order Pharmacy/Retail Maintenance Program Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 90-day supply, you pay: $20 $40 $70		
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. (PBA)**		
Covered Services	$250 per person per calendar year[3]		
Hearing Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**		
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 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 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.

Health Alliance Preferred Provider Organization (PPO) Plan – Effective 7/1/11

Continuing Eligibility for Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers' Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail]
Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
Medical and Mental Health Benefits ▪ Participating providers ▪ Preauthorization for inpatient Hospitalization, outpatient surgeries, Rehabilitation Services, Transplant Benefits, and inpatient Mental Health and Substance Abuse Benefits	Health Alliance Medical Plan 301 S. Vine St. Urbana, IL 61801-3347	800-322-7451 or 217-337-8400 [phone] www.healthalliance.org [web site] (Member sign-up required)
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 will be subject to the penalty listed in the *Schedule of Benefits*.

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan – Effective 7/1/11

Schedule of Benefits

Medical Benefits	HFN EPO Network Only Hospital-Based Benefits	PPO Network	Out-of-Network
Calendar Year Deductible[1] - Individual - Family	$100 $200	$500 $1,000	$1,000 $3,000
Hospital Benefits	100%	80%	60%
Outpatient Surgical Procedures[1] (no deductible required)	100%	80%	60%
X-Rays and Labs (including Pre-Admission Testing)	100%	80%	60%
Out-of-Pocket Maximum - Individual - Family	$2,500 $7,500	$2,500 $7,500	Unlimited Unlimited
Emergency Room	$200 copay	$200 copay	$200 copay
Penalty for Failure to Preauthorize Inpatient Hospitalization, Outpatient Surgeries, Rehabilitation Services, Inpatient Mental Health and Inpatient Substance Abuse Treatment	$250	$250	$250
Maximum Medical/Prescription Drug Calendar Year Benefit	$300,000 per person		

Medical Benefits	PPO Network	Out-of-Network
Doctor's Office Visits	$20 copay	40%
Wellness, Preventive, Well Child, Well Baby Care[1]	100%; no deductible required	Not Covered
Mental Health Services/Substance Abuse Inpatient - Coinsurance Outpatient - Copay/Coinsurance Day Treatment/Partial Hospital Coinsurance *Preauthorization of Inpatient Services Required Call MAP:*	Call MAP for in-network providers 80% $20 copay 80%	 60% 40% 60%
Rehabilitation Services/Skilled Nursing Facility Inpatient - Coinsurance - Calendar Year Maximum Outpatient - Coinsurance - Calendar Year Maximum	100% if Medically Necessary 60 days per person 100% after $25 copay per visit 60 visits per person	60% 60 days per person 60% 60 visits per person
Maximums are combined for all providers. Preauthorization Required		
Additional Surgical Opinion[1]	80%; no deductible required	60%; no deductible required
Durable Medical Equipment/Prosthetic Devices	80% (additional limitations apply)	60% (additional limitations apply)
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)	60% 60 treatments up to $600 (combined with in-network)
Home Health Care - Coinsurance - Calendar Year Maximum	80% 40 visits (combined with all providers)	60% 40 visits (combined with all providers)
Podiatry Services Orthotic Calendar Year Maximum	80% $500 (combined with out-of-network)	60% $500 (combined with in-network)
Other Covered Services, Ambulance Services, Radiation Therapy, and Hospice Care	80%	60%
Treatment of Temporomandibular Joint (TMJ) Preparatory Work Lifetime Maximum Surgery Lifetime Maximum *Maximums are for all providers combined*	80% $1,000 $2,000	60% $1,000 $2,000

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan – Effective 7/1/11

Medical Benefits	**All Providers**		
Smoking Cessation Benefits Lifetime Maximum (for all providers combined)	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 Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 34-day supply, you pay: $10 $20 $35		
Mail Order Pharmacy/Retail Maintenance Program Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	For up to a 90-day supply, you pay: $20 $40 $70		
Delta Dental of Illinois Dental Benefits *			
Calendar Year Deductible (*applies to Preventive/ Diagnostic, Primary (Basic), and Major Care, but not Orthodontic services*) Individual Family	 $50 $100		
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)	
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. (PBA)**		
Covered Services	$250 per person per calendar year[3]		
Hearing Benefits	**Administered by Professional Benefit Administrators, Inc. (PBA)**		
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 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 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 allowance.

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 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.

HFN Exclusive Provider Organization/Preferred Provider Organization (EPO/PPO) Plan – Effective 7/1/11

Continuing Eligibility For Eligibility A Employees

After you satisfy the initial eligibility requirements, your eligibility will continue for each succeeding three-month period if contributions are made on your behalf that satisfy one of the requirements for that three-month eligibility period according to the following schedule:

If you work . . .	You will be eligible for Plan benefits during . . .
250 contribution hours in September, October, November; or 500 contribution hours in June through November; or 750 contribution hours in March through November; or 1,000 contribution hours in December through November.	January, February, and March
250 contribution hours in December, January, February; or 500 contribution hours in September through February; or 750 contribution hours in June through February; or 1,000 contribution hours in March through February.	April, May, and June
250 contribution hours in March, April, May; or 500 contribution hours in December through May; or 750 contribution hours in September through May; or 1,000 contribution hours in June through May.	July, August, and September
250 contribution hours in June, July, August; or 500 contribution hours in March through August; or 750 contribution hours in December through August; or 1,000 contribution hours in September through August.	October, November, and December

Contact Information

If you need information about	Contact	Contact Information
Eligibility, Life Insurance Benefits, and Accidental Death and Dismemberment Insurance Benefits	North Central Illinois Laborers Health and Welfare Fund 4208 W. Partridge Way, Unit 3 Peoria, IL 61615-2467	866-692-0860 or 309-692-0860 [phone] 309-692-0862 [fax] ncil@ncil.us [e-mail]
Medical, Vision, Hearing, and Loss of Time Benefits and Claim Forms	Professional Benefit Administrators, Inc. (PBA) P.O. Box 4687 Oakbrook, IL 60522-4687	800-435-5694 or 630-655-3755 [phone] 630-655-3781 [fax]
HFN Participating Providers	HFN	800-295-5444 [phone] www.fhninc.com [web site] Log on to HFN, click Provider Search, enter Client Code **NCILF** and select HFN CHC, click next
Preauthorization ▪ Inpatient Hospitalization, outpatient surgeries, rehabilitation services, and Transplant Benefits	American Health Holding, Inc.	800-892-1893 [phone]
▪ Inpatient Mental Health and Substance Abuse	Member Assistance Program (MAP) through MHN	800-472-4992 [phone]
Member Assistance Plan (MAP)	MHN	800-472-4992 [phone]
Prescription Drug Benefits	Sav-Rx Mail Order P.O. Box 8 Fremont, NE 68026	800-228-3108 [phone] www.savrx.com [web site]
Dental Benefits	Delta Dental of Illinois P.O. Box 5402 Lisle, IL 60532 Group # 20141	800-323-1743 [phone] www.deltadentalil.com [web site]

Note: If you do not obtain Preauthorization when required, your benefits will be subject to the penalty listed in the *Schedule of Benefits*.

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