LABORERS' WELFARE FUND

CHICAGO & VICINITY LABORERS' DISTRICT COUNCIL HEALTH & WELFARE PLAN

11465 CERMAK ROAD
WESTCHESTER, ILLINOIS 60154-5768

Telephone: (708) 562-0200
Toll Free: (866) 906-0200
Welfare Fax: (708) 562-0716
e-mail:Claims@chilpwf.com
www.chicagolaborersfunds.com

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Important Notice of Changes to Benefits under Active Plan 1

February 2021

Dear Participant:

The Board of Trustees of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan (the "Plan") is pleased to announce the following enhancements to the benefits under Active Plan 1.

Bariatric Surgery Benefits for Active Plan 1

Effective for eligible claims incurred on or after February 1, 2021, Active Plan 1 will cover Medically Necessary bariatric (weight loss) surgery at an approved in-network Blue Distinction Center (also referred to as a Center for Excellence), if the Participant:

If you are considering this procedure, please contact the Fund Office to discuss coverage.

(A) is diagnosed with "Morbidly Obesity"; and

(B) is either: (1) an adult who is at least 18 years of age or has reached full expected bone growth; or (2) an adolescent who has satisfied Tanner 4 or 5 pubertal development or has a bone age of at least 13 years in girls, or at least 15 years in boys; and

(C) Has participated in a Physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification) documented in the medical record; and

(D) Has an evaluation completed by a state licensed behavioral healthcare provider, within the 12 months preceding the request for bariatric surgery; and

(E) Utilizes a Center for Excellence for bariatric surgery.

"Morbid Obesity" means having a Body Mass Index (BMI) either: (1) equal to or greater than 40 kg/meter^2; or (2) equal to or greater than 35 kg/meter^2 with at least one of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, sleep apnea, or osteoarthritis in weight bearing joints.

Bariatric surgery means gastric stapling, gastroplasty, gastric banding, and any other Medically Necessary weight reduction or obesity-related surgery or procedure. The following treatment is also covered provided that it is related to a bariatric surgery that met the requirements of coverage under Active Plan 1: post-surgical counseling, follow-up surgery to correct a previous bariatric surgery and/or any complication due to bariatric surgery, and excess skin removal, but only if Medically Necessary. Keep in mind that, to be covered under Active Plan 1, bariatric surgery must meet requirements A-E set forth on the prior page.

To avoid surprises, we encourage Participants contemplating bariatric surgery to contact the Fund Office with a pre-service inquiry before receiving any bariatric surgery services.

Health Reimbursement Accounts for Active Plan 1

Effective for eligible claims incurred on or after February 1, 2021, expenses for services received from non-network providers are eligible for reimbursement from a Participant's Health Reimbursement Arrangement (HRA) Account **only** if the Participant does not have the option of using an in-network provider for such services. If an in-network provider is available for such service, any expenses for services from non-network provider(s) are eligible for reimbursement from the Participant's HRA Account only to the extent such expenses exceed the amounts that would be eligible for reimbursement had the Participant utilized the services of an in-network provider. For more details on the HRA, please see the summary plan description for Active Plan 1, which also serves as the Active Plan 1 plan document (2020 Edition) ("SPD/Plan").

In-Network and Non-Network Vision Benefits for Active Plan 1

Effective for eligible claims incurred on or after January 1, 2021, the Trustees have agreed to increase the frame allowance to $150. Regardless of whether you use a VSP Network Provider, the frame allowance is the maximum amount Active Plan 1 will cover, but an additional discount will apply to balances over $150 only if you use a VSP Network Provider. For more details on vision benefits, including applicable cost-sharing, please see the SPD/Plan.

Questions?

If you have questions about your benefits, please contact the Fund Office at (708) 562-0200 or (866) 906-0200, from 8:00 am to 5:00 pm, Monday through Friday.

Final Note

Please share this Notice with your family members who are eligible for coverage and keep it with your SPD/Plan and other benefits information for easy reference. The Addendum that follows contains the section by section technical conforming revisions to the SPD/Plan for the changes described above and some technical clarifications. Capitalized terms used but not defined in this Notice have the meaning as set forth in the SPD/Plan.

Sincerely,

Board of Trustees

ADDENDUM

Conforming Changes and Clarifications to the SPD/Plan: The following conforming changes are made to the section references contained in the Active Plan 1 SPD/Plan:

1. Effective for eligible claims incurred on or after February 1, 2021, the following provisions of the SPD/Plan are changed as follows:

    a. In the section entitled “Medical Covered Expenses”, on page 22 of the Plan/SPD, the following bullets are added after “Assistant Surgeon charges” and before “Breast Reduction Surgery” as follows:

- *Bariatric (weight loss) surgery* that is Medically Necessary and at an approved in-network Blue Distinction Center (also referred to as a Center for Excellence), if the Participant satisfies all of the following requirements:
    - Is diagnosed with “Morbidly Obesity” (as defined below); and
    - Is either: (1) an adult who is at least 18 years of age or has reached full expected bone growth; or (2) an adolescent who has satisfied Tanner 4 or 5 pubertal development or has a bone age of at least 13 years in girls, or at least 15 years in boys; and
    - Has participated in a Physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification) documented in the medical record; and
    - Has an evaluation completed by a state licensed behavioral healthcare provider, within the 12 months preceding the request for bariatric surgery; and
    - Utilizes an in-network Blue Distinction Center (also known as a Center for Excellence) for bariatric surgery.

“Morbid Obesity” means having a Body Mass Index (BMI) either: (1) equal to or greater than 40 kg/meter^2; or (2) equal to or greater than 35 kg/meter^2 with at least one of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management: hypertension, dyslipidemia,

diabetes mellitus, coronary heart disease, sleep apnea, or osteoarthritis in weight bearing joints.

Bariatric surgery means gastric stapling, gastroplasty, gastric banding, and any other Medically Necessary weight reduction or obesity related surgery or procedure. The following treatment is also covered provided that it is related to a bariatric surgery that met the requirements of coverage of this Plan/SPD: post-surgical counseling; follow-up surgery to correct a previous bariatric surgery and/or any complications due to bariatric surgery; and excess skin removal, but only if Medically Necessary.

b. In the section entitled "Expenses Not Covered Under Medical Benefits," item #9, on page 28 of the SPD/Plan, is amended as follows:

"Any expenses relating to appetite control, food addictions, eating disorders, weight reduction, or obesity, except for (i) documented cases of bulimia or anorexia that meet standard Diagnostic Service criteria as determined by the Fund Office and the Plan's medical consultants, and (ii) Medically Necessary bariatric (weight loss) surgery at an approved in-network Blue Distinction Center, described in the *Medical Covered Expenses* section."

c. In the section entitled "Expenses Not Covered Under Medical Benefits," item #11, on page 28 of the SPD/Plan, is amended as follows:

"[Intentionally omitted]"

d. In the section entitled "Eligible Healthcare Expenses", on page 46 of the SPD/Plan, the last sentence is amended as follows:

In addition, expenses for services received from non-network providers are eligible for reimbursement from your HRA Account **only** if you do not have the option of using an in-network provider for such services. If an in-network provider is available for such service, any expenses for services from non-network provider(s) are eligible for reimbursement from your HRA Account only to the extent such expenses exceed the amounts that would be eligible for reimbursement had you utilized the services of an in-network provider.

2. Effective for eligible claims incurred on or after January 1, 2021, the row entitled "Frames Maximum", on page 41 of the SPD/Plan, in the section entitled "Schedule of Vision Benefits", is amended as follows:

Routine Vision Benefits	**VSP Network Provider Plan Pays**	**Non-Network Provider** **Plan Pays up to the Following Allowances:**
Frames Maximum	100% up to $150; 20% off balance over	$150

3. Effective for eligible claims incurred on or after June 1, 2020, the following provisions of the SPD/Plan are changed as follows:

    a. In the section entitled "Initial Claim Denial", on page 61 of the SPD/Plan, the eleventh bullet (that begins "For Healthcare Claims, information...") is deleted in its entirety.

    b. In the section entitled "Appeal Review", on page 63 of the SPD/Plan, the 10th bullet (that begins "For Healthcare Claims, information…") is deleted in its entirety.

    c. The Section entitled "Fund Name", on page 80 of the SPD/Plan, is amended as follows:

> "The Fund's legal name is the Chicago & Vicinity Laborers' District Council Health & Welfare Fund. It is sometimes commonly referred to as the Laborers' Welfare Fund."

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Statement of the Plan's Grandfathered Status. The Board of Trustees of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act), which means that the Plan existed when the health care reform law was signed on March 23, 2010. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and do not apply to a grandfathered health plan and what might cause the Plan to change from grandfathered health plan status can be directed to the Fund Office at (708) 562-0200 or 866-906-0200. You may also contact the Employee Benefits Security

Administration, U.S. Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The information contained in this Notice only highlights certain features of the Chicago & Vicinity Laborers' District Council Health & Welfare Plan and is intended to be a Summary of Material Modifications to the SPD/Plan. The Board of Trustees of the Plan ("Board of Trustees") reserves the right and has the authority to amend, modify, or eliminate benefits at any time, or terminate the Plan when financial conditions dictate. Receipt of this Notice does not confer or guarantee eligibility for benefits. In addition, the Board of Trustees, or such other persons as delegated by the Board of Trustees, has the discretion to interpret and construe the Plan's provisions, as set forth in the SPD/Plan.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2151212 Plan No.: 501
February 2021